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

Audit Committee Meeting
July 16, 2024
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **MINUTES**

A. Approval of the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, February 20, 2024
(EXHIBIT A-1)

IV. **REVIEW AND TAKE ACTION**

A. FY25 Compliance Workplan
(EXHIBIT A-2 Demetria Luckett)

B. Internal Audit FY2024 Q/Q3 Reports
(EXHIBIT A-3 David Fojtik)

V. **REVIEW AND COMMENT**

A. Compliance Department Report
(EXHIBIT A-4 Demetria Luckett)

VI. **EXECUTIVE SESSION**

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

VII. **RECONVENE INTO OPEN SESSION**

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

IX. **INFORMATION ONLY**

A. Compliance Department Binder
(EXHIBIT A-5)

B. Internal Department Binder
(EXHIBIT A-6)

X. **ADJOURN**

Veronica Franco

Veronica Franco, Board Liaison
Dr. Lois J. Moore, BSN, MEd,LHD, FACHE
Chairperson, Audit Committee
The Harris Center for Mental Health and IDD

EXHIBIT A-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
AUDIT COMMITTEE MEETING
TUESDAY, FEBRUARY 20, 2024
MINUTES

Dr. R. Gearing, Committee Chair, called the meeting to order at 8:36 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

Committee Members in Attendance: Dr. R. Gearing, Dr. G. Santos , Dr. L. Moore, Dr. M. Miller, Mr. G. Womack

Committee Member in Absence:

Other Board Member Present: Mr. J. Lykes

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 8:36 a.m. noting that a quorum was present.

II. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS

Dr. Gearing designated Mr. J. Lykes as a voting member of the committee.

III. PUBLIC COMMENTS

There were no requests for Public Comment.

IV. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 17, 2023.

MOTION: SANTOS SECOND: MILLER

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 17, 2023 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND COMMENT

A. Audit Committee will review the Internal Audit Reports by David Fojtik
B. Audit Committee will review the Compliance Department Report by Demetria Luckett.

VI. REVIEW AND TAKE ACTION

A. External Audit

MOTION: MILLER SECOND: SANTOS

THEREFORE, BE IT RESOLVED that the External Audit as presented, is approved, and recommended to the Full Board for acceptance.

VII. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VIII. ADJOURN-

MOTION: WOMACK SECOND: MILLER
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:10 a.m.

Veronica Franco, Board Liaison
Dr. Robin Gearing, PH.D.
Chairperson, Audit Committee
The* HARRIS CENTER *for
Mental Health and IDD

EXHIBIT A-2

The Harris Center for Mental Health and IDD

The Harris Center for Mental Health MH and IDD (The Harris Center):
Compliance Department (Compliance) FY 2025 Work Plan

Work Plan Description: The Work Plan briefly describes the various areas that we perceive as critical to the mission of The Harris Center.

Presenter: Demetria Luckett, Compliance Director

Focus Reviews- are designed to address a variety of issues, including, but not limited to, billing and procedural coding, individual information, confidentiality, service activities, corrective actions, etc. A focused review may be initiated by sources other than Compliance, including, but not limited to, directors, program managers, and administrative or direct care staff.

Twenty-six (26) Follow-up Reviews:

- Youth Diversion Center
- Hillcroft, Pasadena, and Humble Day Programs
- TxHmL Provider
- Substance Use Disorder Outreach Program (SUDOP)
- Community Mental Health Contracts
- Projects for Assistance in Transition from Homelessness (PATH)
- Southwest Community Service Center (SWCSC)
- Youth Empowerment Services (YES) Waiver
- Psychiatric Emergency Services (PES)
- Northeast Community Service Center (NECSC)
- Youth Empowerment Services (YES) Waiver
- Homeless Outreach Team (HOT)
- Clinical High Risk for Psychosis (CHR-P)
- Integrated Healthcare
- The PEERS for Hope House
- STARS
- Texas Correctional Office on Offenders with Medical or Mental Impairments Jr. (TCOMMI Jr.)
- Multisystemic Therapy (MTS)
- Coffeehouse
- The Harris Center Independent Living
- Northwest/Southeast Community Service Center (NW/SECSC ACT/FACT
- Outpatient Biopsychosocial Approach for IDD Service (OBI)
- Crisis Stabilization Unit (CSU)
- Optum Integrated Behavioral Health Home
- Northwest Community Service Center (NWCSC)
- Policy/Code of Conduct Acknowledgements

Fourteen (14) Focus Reviews:

- ANSA/CANS/Treatment Plans (MH Division)
- Telehealth Services
- Community First Choice Service Coordination
- HCS Service Coordination
- Credentialing
- Texas Home Living (TxHmL) Service Coordination
- Policies and Procedures (MH Division)
- Enhanced Community Coordination Service Coordination
- Training
- PASRR Service Coordination
- Eligibility-Intake and Scheduling
- Eligibility-HCS/TxHmL Interest List
- Service Coordination: Basic GR
- Consents (All Divisions)

Operational Review – a review to determine if agency facilities/programs meet federal/state requirements and city ordinances, postings, accessibility, appearance, safety, and consumer service. It identifies systemic and potential operational hazards, flaws, and deficiencies in operational practice before they lead to an accident.

Four (4) Operational Reviews:

- Forensics Division
- MH Division
- CPEP Division
- IDD Division

Comprehensive Review – A review of The Harris Center' adherence to regulatory guidelines related to, Operations, Medical, Environment, Personnel Requirements, Clinical Record Review, and others as assigned. Records are selected randomly; the size of the programs and the frequency of entries are contributing factors to the number of records reviewed.

Forty-five (45) Comprehensive reviews:

- Mobile Outreach Crisis Team (MCOT)
- Dual Diagnosis Residential Program (DDRP)
- Pasadena Cottages A/B
- Assisted Outpatient Treatment (AOT)
- TxHmL Provider
- Crisis Residential (CRU)
- TRIAD Children Mental Health Services
- Youth Empowerment Services (YES Waiver)
- Outpatient Competency Restoration
- Community Assistance and Referral Program (CARP)
- IDD Contracts
- OSAR
- Behavioral Health Response Team (BHIRT)

- Infirmary Discharge Treatment Planning (HCSO)
- Westbury
- Southeast Community Service Center Children's Services (SECSC)
- The Enrichment Center at the Villas of Eastwood
- Forensic Front Door
- Southwest Community Service Center Children's Services (SWCSC)
- Rapid Response
- Forensic Specialty
- Northwest Community Service Center (NWCSC)
- The Navigation Center: Harris Center Support Team
- Forensic Outpatient
- Applewhite
- CAS Co-Location Clinics
- Clinician Officer Remote Evaluation
- Peer Support and Re-Entry Services
- IDD Network Development and Management
- Continuity of Care Services
- Chronic Consumer Assistance Program
- New Start Residential (TCOOMMI Adult)
- Jail Diversion Aftercare
- Declaration of Mental Health Treatment
- Donsky
- New Start (TCOOMMI Jr: MH Portion)
- Crisis Call Diversion
- Transitional Services
- IDD Clinical Services
- Early Childhood Intervention (ECI)
- Community Unit Probation Services (CUPS)
- CIRT
- Southeast Community Service Center (SECSC)
- Consents
- Policy/Code of Conduct Acknowledgements

Billing and Coding- Reviews of medical financial records and/or other source documents that support claims for reimbursement to ensure accuracy of claims.

Twenty-Five (25) Billing and Coding Audits:

- AMH Coding Audit
- CAS Coding Audit
- CAS Counseling Services Audit
- AMH Case Management Audit
- Medicaid Coding Requirements Audit
- CAS Medication Training Support Audit
- Harris Center Pharmacy Operations Audit
- CAS Case Management Audit

- AMH Counseling Audit (CBT)
- Family Partner Support Services Audit
- AMH Counseling Services Audit (CPT)
- AMH Medication Training & Support Audit
- AMH Skills Training & Development Audit
- Adult Withdrawal Medication Services Audit
- CAS Crisis Intervention Audit
- SUD Medication Assisted Treatment Program Audit
- IDD Progress Notes Audit
- Forensics Progress Notes
- IDD Billing & Coding Audit
- PES Billing Audit
- CSU Billing Audit
- CRU Billing Audit
- SUD Billing Audit
- AMH Billing Audit
- CAS Billing Audit

Program Self-Monitoring- To determine if programs are conducting documentation reviews to identify deficiencies.

Four (4) Program Self-Monitoring

- Forensics Division
- MH Division
- CPEP Division
- IDD Division

External Audits- medical record review of dates of service, patients enrolled, and such plans.

Other Compliance Activities-

- Maintenance of The Harris Center's Policy and Procedures (Ongoing)
- Compliance Education and Development (Ongoing)
- Corporate Compliance and Ethics Week November 5-11, 2024

EXHIBIT A-3

FY2024 Q2/Q3 Audits

Internal Audit Department

David W. Fojtik, CPA, MBA, CIA, CFE
July 16, 2024

FY2024 Q2/Q3 Reports

Agenda

- **Proposed FY 2025 Audit Plan (Action Item)**
- **Internal Audits to be presented (Discussion):**
  - FY 2024 Board Approved Audit - Bank Reconciliation Audit
  - Follow-Up Audit: Fleet Management (last reviewed in FY 2023)
  - Follow-Up Audit: Fixed Assets and Inventory Control (last reviewed in FY 2023)
  - Follow-Up Audit: Travel Reimbursements Audit (last reviewed in FY 2023)
  - Special Audit Request: Petty Cash and Change Funds Audit
  - Special Management Request: Cybersecurity
  - Continuous Auditing

FY2024 Q2/Q3 Reports

Proposed FY 2025 Audit Plan (Action Item):

1. **Reimbursable Services Contracts Review – (100 Hours Scheduled)**
2. **Review of Misappropriated Fixed Assets – (100 Hours Scheduled)**
3. **Payroll Audit – (100 Hours Scheduled)**
4. **RM Third-Party Billings and Refunds Audit – (100 Hours Scheduled)**
5. **PC Software License Compliance Audit – (100 Hours Scheduled)**
6. **Cybersecurity Audit – (100 Hours Scheduled)**
7. **Conflict of Interest Audit – (100 Hours Scheduled)**
8. **Overtime Usage and Premium Holidays – (100 Hours Scheduled)**
9. **Follow-Up Audit: Fleet Management Audit – (100 Hours Scheduled)**

Plus:

1. **Audit Follow Up/Special Audit Requests – (400 Hours Scheduled)**
2. **Consulting Activities – (70 Hours Scheduled)**
3. **Provide Assistance to External Auditors – (70 Hours Scheduled)**

FY2024 Q2/Q3 Reports

Bank Reconciliation Audit:

Observations – Internal Audit met with the Financial Services accountant for a review of the Center's primary bank account reconciliation process with J. P. Morgan Chase, which is the Center's primary bank account.

1) The process requires following a routine of steps, and the accountant who performed the reconciliation has worked in a similar capacity in another industry, but the process is widely performed to see that account payable payments completed successfully and to identify NSF checks that did not process. Bank reconciliations are useful to identify the amount of cash on hand available for the Center's needs.

Summary - We found no issues with the current reconciliation process, which is performed in a timely (monthly) basis.

FY2024 Q2/Q3 Reports

Follow-up Fleet Management Audit:

Observations – The audit disclosed:

1) As of February 29, 2024, there were 21 agency-owned vehicles in inventory.

2) The average vehicle age of the remaining vehicles was 3.38 years.

3) The cost for operating 21 vehicles through February 29, 2024) was $188,265.

4) Enterprise Leasing invoices from 09/01/2023 - 02/29/2024 totaled $335,285 for 119 cars.

5) As of 02/29/2024, total fleet vehicle cost (Leased and Owned) totaled $523,550.

FY2024 Q2/Q3 Reports

Follow-up Fleet Management Audit:

Management Response #1 (Director of Transportation): *"Entering into the contract with Enterprise just as the nation faced the COVID crisis presented some very real challenges with the nation shutting down for several months and that coupled with the semi-conductor shortage drove the fleet replacement time from months to years. With the conditions improving in FY 2024, we expect the fleet replacement to be completed late FY 2024 to early FY 2025. Once the fleet is replaced with only the rental fleet, I expect to see a drop in operating cost across the board; maintenance, fuel cost, etc. The enterprise management team has been very good in helping navigate this crisis and has kept the transportation team informed and engaged in the replacement process and options available to the Center. Internally we are working on purchasing internal software to assist in managing the fleet for our end, this should result in reduced cost fleet wide. Once the fleet is replaced it is my recommendation an audit be conducted on vehicle use by program to determine if the actual car count could be reduced which would also result in reduced yearly expenditures."*

FY2024 Q2/Q3 Reports

Follow-up Fleet Management Audit:

Internal Audit Response

Once the leasing process is completed, we will perform a review of the leased vehicles by program to determine if actual car counts are adequate or could decreased based on usage which would result in reduced yearly expenditures.

FY2024 Q2/Q3 Reports

Follow-Up Fixed Assets and Inventory Control:

Finding #1 - Internal Audit generated the Fixed Assets Inquiry online report, dated 01/31/2024, and found 73 fixed assets, such as personal computers, scanners, cameras, and installed medical equipment that were still assigned to former and terminated employees.

Recommendation: Internal Audit recommends that the records containing names of former employees should be reassigned to show "general use" status if assets are not redeployed to another employee.

UPDATES

As of 06/04/2024, the Fixed Asset team ensured that all corrective activity had occurred to address this issue, and in Internal Audit's follow-up review found no laptops or other fixed assets assigned to former employees. This was accomplished by ongoing intensified emails sent by the FA team to the Fixed Asset Designees (FADs) to provide the required paperwork. Also, the FADs' supervisors and Internal Audit were added to these emails.

Note to Finding: The Fixed Asset Team is doing what it is empowered, by the agency, to do to keep the Fixed Asset inventory up to date. The Fixed Asset Team cannot make any updates to devices (location and employee assignment) without the proper paperwork, which is required by agency policy to authorize any updates.

FY2024 Q2/Q3 Reports

Follow-up Fixed Assets and Inventory Control:

Staff Comments – Internal Audit spoke with a number of fixed assets designees (FADs) who maintain the fixed assets inventory process. Here is a short list of additional comments from our conversations:

1. *Challenges include work environments where employees may trade or borrow laptops without the FAD's knowledge. but that type of exchange would occur after hours or weekends without the FAD's knowledge.*
2. *Another challenge is assigning a fixed location for equipment items when room numbers are updated during construction, or the equipment is a laptop used in the employee's home.*
3. *Whenever terminated employees leave employment, there is no automated process to identify the records that are no longer correct and require and amendment to show that or this laptop should be reassigned to "general use" or to "disposal" if it is no longer functional, or should be reassigned to another current employee in the business unit.*

FY2024 Q2/Q3 Reports

Follow-up Fixed Assets and Inventory Control:

Comments (cont'd)

4. *Fixed Asset Tags are placed in tough-to-read locations (back side, underneath side) of the equipment, which sometimes requires disassembling computer components to find Tag #.*
5. *There appears to be no tie-in to the Center's budgeting process or with the Ross financial system.*

FY2024 Q2/Q3 Reports

Follow-up Fixed Assets and Inventory Control:

Management Response #1 (Fixed Asset Examiner):

- ✓ "Remove all ASSIGNED GENERAL USE designations as an employee assignment. Replace with either your (FAD) name or the unit manager's name.
- ✓ *Remove all former employees and old unit staff data and replace it with the new staff names. If the position is vacant for now, replace that data with either your name or the unit manager's name*
- ✓ *Update locations if devices are moved or the Program relocates."*

FY2024 Q2/Q3 Reports

Follow-up Travel Reimbursements Audit:

Observation #1 – Travel reports were reviewed between September 1, 2023 and February 28, 2024.

1) The six-month reimbursements totaled **1,145,215 miles** compared to **1,276,975 miles** reported in a prior six-month period from September 1, 2022 through February 28, 2023.

2) We determined that **95.7%** of the First Trip segment miles started from the employee's assigned Harris Center location and **88.2%** of Last Trip segment miles ended at their assigned Harris Center location.

3) Internal Audit noted that the current Center's travel policies rely on IRS business travel guidelines which require employees to compute mileage by subtracting "normal commute miles" to their assigned Center location.

4) The Harris Center paid out $775,079 to 635 employees in Travel Reimbursements during the period September 1, 2023 through February 28, 2024.

FY2024 Q2/Q3 Reports

Follow-up Travel Reimbursements Audit:

Observation #1 – Travel reports were reviewed between September 1, 2023 and February 28, 2024.

5) Internal Audit found 26 employees submitted at least $6,000 in mileage claims over this six-month period, however, per our review none of these individuals submitted reimbursements for excessive mileage.

Currently, although 4.3% of reimbursed travel reimbursements included starting from residential locations on the first trip of the day and 11.2% of last trip reimbursements ended at residential locations are immaterial in amount, these routes are not 100% compliant with current Travel Expense Reimbursement Policies and Procedures.

Internal Audit recommends the Travel Policies be revised to reflect compliancy.

FY2024 Q2/Q3 Reports

Special Audit Request: Petty Cash and Change Funds Audit:

Observation #1 – Internal Audit performed unannounced petty cash audits and found the counted contents of currency agreed with the designated target cash balances that were listed in the Petty Cash Custodian Listing.

Internal Audit has noticed that the petty cash fund balances have decreased over the past years, and many petty cash custodians do not reconcile the petty cash funds timely due to fewer transactions that require petty cash as online purchases continue to reduce the usage of the current 17 petty cash funds.

The valuation of the funds in FY 2019 was $9,350.00 compared to the current total value of $4,150.00.

FY2024 Q2/Q3 Reports

Special Management Request: Cybersecurity Audit:

Observation #1 – Internal Audit met with the Center's Information Security Officer (ISO) to discuss the Center's stabilization following a cybersecurity attack on November 7, 2023.

1) We learned that at the time a previously unidentified "bad actor" emerged and made their entry through the Center's Citrix Netscaler system, then pursued a systematic encryption of our data files, to make them unavailable to the Center's users.

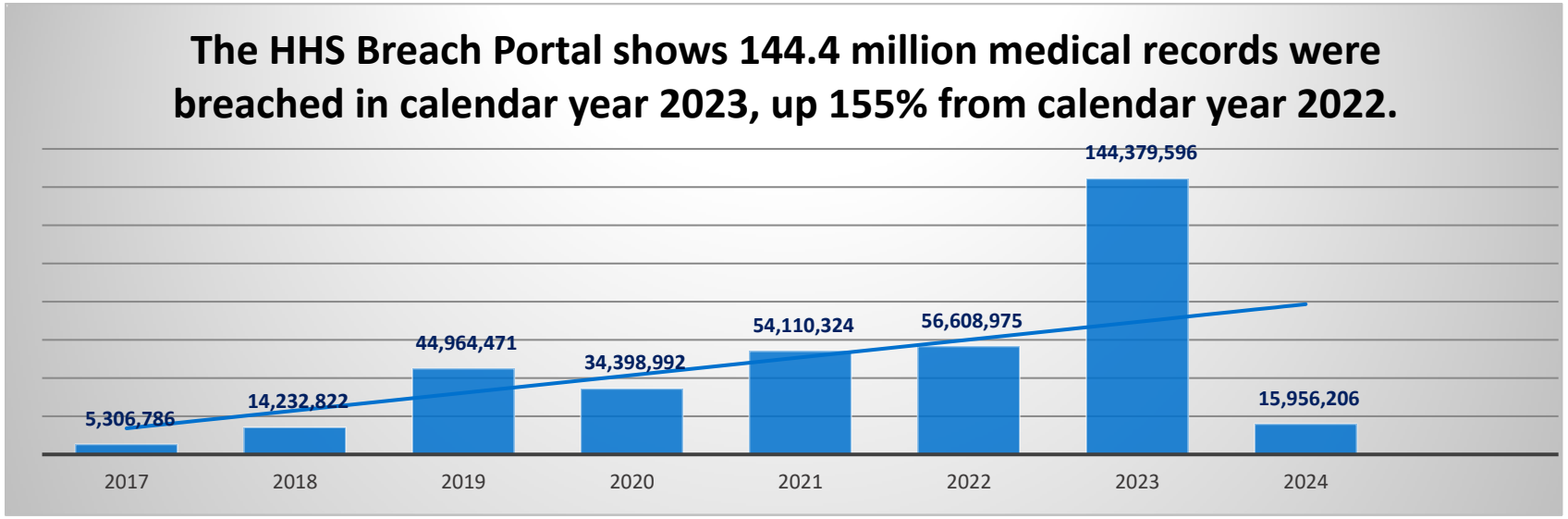
2) The ISO reported that granting system access quickly was essential to restoring the Center's operations and Information Technology consultants were brought in to assist. The objective was to "reduce our attack surface" without shutting down service to end-users, which could have halted services in the Center's offices.

Summary - No ransom was paid and the Center's operations continued with moderate delays after the breach occurred. Work arounds after the breach enabled operations to continue at a measured pace.

FY2024 Q2/Q3 Reports

Special Management Request: Cybersecurity Audit:

Observation #2 – Internal Audit attended a Clearwater Security debrief which reported that the HHS Breach Portal counted 144.4 million medical records breached in CY2023 versus 56.6 million in CY2022, thus posting the 155.0% increase. The report stated 76% of the reported medical breaches were due to hacking incidents.



Source: HHS Breach Portal (data pulled March 3, 2024), presented at recent Clearwater Security presentation, April 8, 2024

FY2024 Q2/Q3 Reports

Continuous Auditing:

The Harris Center Internal Audit Department has implemented “continuous auditing” scripts to review Accounts Payable and Travel Expense reimbursement transactions.

FY2024 Q2/Q3 Reports

Continuous Auditing (cont'd):

Continuous Auditing enables Internal Audit to:

- Collect from processes, transactions, and accounts data that support internal audit activities.
- Achieve more timely, less costly compliance with the Center's policies, procedures, and regulations.
- Shift from cyclical or episodic reviews with limited focus to continuous, broader, more proactive reviews to detect misappropriations/fraud.
- Evolve from a traditional, static annual audit plan to a more dynamic plan based on continuous auditing results.
- Reduce audit costs while increasing effectiveness through IT solutions.

In summary, the value of continuous auditing is that it enables Internal Audit to move from sampling a limited number of accounts and transactions to complete coverage of 100% of accounts and transactions (whenever and where desired).

Questions

EXHIBIT A-4

Compliance Department

FY24 Q2 and Q3 Audit Reports

Presented by: Demetria Luckett, Compliance Director
April 2024

Summary of Audits Completed – 12/23 thru 5/24

Focus Review – A review concentrating on specific areas such as billing and procedural coding, individual information, confidentiality, service activities, etc. A focus review may be initiated by sources other than Compliance, including, but not limited to, Directors, Program Managers, and Administrative or Direct care staff.

Fifteen (15) Focus Reviews were conducted during the reporting period to ensure regulatory compliance in the following areas:

Eleven (11) Plan of Improvement (POI) Follow-up Reviews

- 12/05/2023 Southwest Community Service Center (SWCSC)
- 12/06/2023 Northeast Community Service Center (NECSC)
- 12/08/2023 Projects for Assistance in Transition from Homelessness (PATH)
- 12/15/2023 Southeast Community Service Center (SECSC)
- 01/29/2023 Crisis Residential Unit (CRU)
- 02/05/2024 Youth Empowerment Services (YES) Waiver
- 02/09/2024 Psychiatric Emergency Services (PES)
- 02/21/2024 Mobile Crisis Outreach Team (MCOT)
- 05/09/2024 Northwest Community Service Center (NWCSC)
- 04/23/2024 Community Unit Probation Services (CUPS)
- 04/25/2024 Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI, Jr.)

Four (4) Billing and Coding Reviews

- 02/09/2024 Children and Adolescent Services (CAS) Physician Documentation Review
- 02/14/2024 Adult Mental Health (AMH) Physician Documentation Review
- 04/03/2024 Psychiatric Emergency Services (PES) Physician Documentation Review
- 04/03/2024 Crisis Stabilization Unit (CSU) Physician Documentation Review

Summary of Audits Completed – 12/23 thru 5/24

Comprehensive Review – A review of The Harris Center's adherence to regulatory guidelines related to Operations, Medical, Environment, Personnel Requirements, Clinical Record Review, and others as assigned. Records are selected randomly—the size of the programs and the frequency of entries are contributing factors to the number of records reviewed.

Thirteen (13) Comprehensive Reviews were conducted to ensure the programs are compliant with Texas Administrative Codes, Agency Policy and Procedure, and programmatic guidelines.

- 12/15/202 Intellectual and Developmental Disabilities (IDD): Specialized Therapies and Rehabilitation Services (STARS) and STARS Disorders Feeding Clinic
- 01/02/2024 Intellectual and Developmental Disabilities (IDD): Outpatient Biopsychosocial Approach for IDD Services (OBI)
- 01/12/2024 Comprehensive Psychiatric Emergency Program (CPEP): Step Down State Hospital Transition Project (STEP DOWN)
- 01/18/2024 Mental Health (MH): Integrated Care
- 02/06/2024 Intellectual and Developmental Disabilities (IDD): Texas Home Living (TxHmL) Provider
- 02/19/2024 Comprehensive Psychiatric Emergency Program (CPEP): Homeless Outreach Team (HOT)
- 02/20/2024 Mental Health (MH): Multisystemic Therapy (MST)
- 02/26/2024 Comprehensive Psychiatric Emergency Program (CPEP): P.E.E.R.S for Hope House (Hope House)
- 03/07/2024 Mental Health (MH): Assertive Community Treatment (ACT) & Forensic Community Treatment (FACT)
- 03/18/2024 Forensics: Youth Diversion Center
- 04/12/2024 Comprehensive Psychiatric Emergency Program (CPEP): The Harris Center Independent Living (IL)
- 04/18/2024 Mental Health (MH): Optum Integrated Behavioral Health Home Care
- 04/29/2024 Comprehensive Psychiatric Emergency Program (CPEP): Substance Use Recovery Services Detoxification (DETOX)

Southwest Community Service Center (SWCSC)

The HARRIS CENTER for Mental Health and IDD

Southwest Community Service Center (SWCSC) Psychoactive Medication Documentation Plan of Improvement (POI) Follow-Up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: proper documentation of informed consent and compliance with AIMS assessment requirements.

The threshold score for this review is 95%.

The Program had an overall score of 92%.

The Program did not meet standards in the following areas:

- 92% Documentation of informed Medication Consent
- 92% Quarterly completion of Abnormal Involuntary Movement Scale (AIMS) assessments

The Program will continue its corrective actions implemented on December 9, 2022.

Action Plan: Compliance referred the program to Performance Improvement (PI) to assist with its processes in documenting informed Medication Consents and AIMS assessments.

Northeast Community Service Center (NECSC)

The HARRIS CENTER for Mental Health and IDD

Northeast Community Service Center (NECSC) Psychoactive Medication Documentation Plan of Improvement (POI) Follow-Up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: *recovery plan documentation requirements, documentation of informed consent, and AIMS assessment requirements.*

The threshold score for this review is 95%.

The Program had an overall score of 78%.

The Program met and exceeded standards in the following areas:

- 100% Recovery Plan

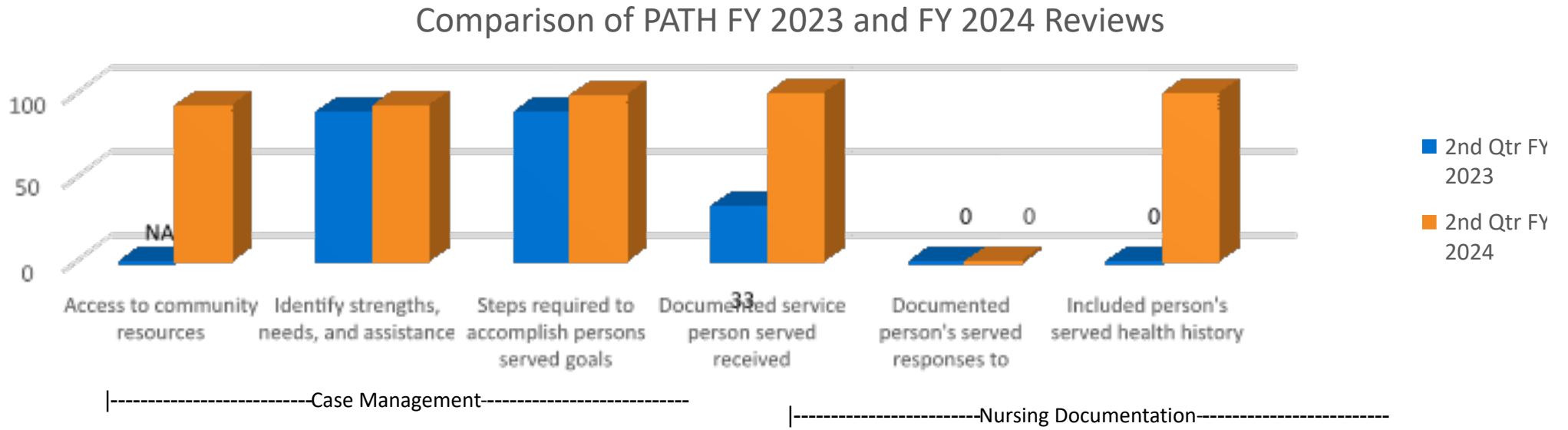
The Program did not meet standards in the following areas:

- 67% Documentation of Informed Medication Consent
- 67% Quarterly Completion of Abnormal Involuntary Movement Scale (AIMS)

The Program will continue its corrective actions implemented on December 9, 2022.

Action Plan: Compliance referred the Program to Performance Improvement (PI) to assist with its processes in competing Medication Consents and AIMS forms.

PATH



Threshold score= 95%

Projects for Assistance in Transition from Homelessness (PATH) POI Follow-up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: case management activities and Nursing documentation.

The Program had an overall score of 87%.

The Program exceeded standards in the following area:

- 98% for case management activities.

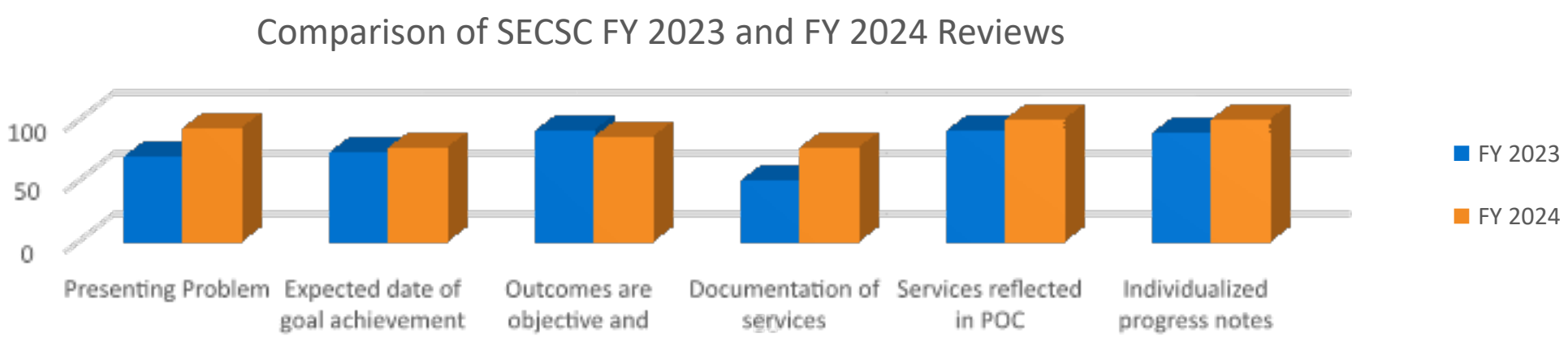
The Program did not meet standards in the following area:

- 75% for nursing documentation.

The Program will continue the corrective actions implemented on January 7, 2023.

Action Plan: The Compliance Department will conduct an additional follow-up plan of improvement review in 180 days.

Southeast Community Service Center (SECSC)



Threshold score= 95%

Southeast Community Service Center (SECSC) Plan of Care and Progress Note Plan of Improvement (POI) Follow-up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: plan of care documentation and Progress note documentation.

The SECSC program had an overall score of 88%.

The program exceeded standards in the following areas:

- 100% The services reflected on POC
- 100% Individualized progress notes

The program did not meet standards in the following areas:

- 92% Presenting Problem
- 77% Expected date of goal achievement
- 85% Outcomes are objective and measurable.
- 77% Documentation of services

The Program will continue its corrective actions implemented on July 5, 2023.

Action Plan: Compliance will continue to provide essential support for program compliance with POC and progress note documentation. Compliance will not refer the program to Performance Improvement but will follow up in the next one hundred eighty (180) days for compliance with corrective action steps.

Specialized Therapies and Rehabilitative Services (STARS) & STARS Feeding Disorders Clinic

The HARRIS CENTER for Mental Health and IDD

Specialized Therapies and Rehabilitative Services (STARS) and STARS Feeding Disorders Clinic Programs Comprehensive Review

Purpose: The objective of this review was to validate the STAR's programs adherence to governing regulations, agency policy and procedure, program guidelines with respect to service delivery, documentation, and personnel requirements.

The threshold score for this review is 95%.

The Programs had an overall score of 99%.

The Program met and exceeded standards in the following areas:

- 97% Service Compliance: Eligibility, Plan of Care, Behavioral Support Plans, Discharge Summaries, Diagnosis, Demographics, Required Credentials, Consents
- 100% Progress Notes

The Programs were not previously under a Plan of Improvement (POI).

Action Plan: The Compliance Department will continue to complete audits to ensure the program follows the TAC, Agency Policy and Procedures, and completes notes within two (2) business days.

Outpatient Biopsychosocial Approach for IDD Services (OBI)

The HARRIS CENTER for Mental Health and IDD

Outpatient Biopsychosocial Approach for IDD Services (OBI) Comprehensive Review

Purpose: The purpose of this review was to ensure the OBI program documentation, employee credentials, and operational guidelines are complying with the rules and regulations of the HHSC OBI Learning Collaborative, Code of Federal Regulations (CFR), Texas Administrative Code (TAC), and Agency Policy and Procedures.

The threshold score for this review is 95%.

The Program had an overall score of 98%.

The Program met and exceeded standards in the following areas:

- 96% Service Compliance: Consents, Biopsychosocial Assessment, Person Centered Recovery Plan, Vineland Adaptive Behavior Scale, Behavioral Support Plans, Encounters, Required Credentials and Staff Training
- 100% Progress Notes

Action Plan: The Compliance Department will continue to complete audits to ensure the program is following the TAC, Agency Policy and Procedures, and in the development of the Plan of Care.

Step-Down State Hospital Transition (Step-Down)

The Harris Center for Mental Health and IDD

Step-Down State Hospital Transition (Step-Down) Program Comprehensive Review

Purpose: This review was conducted to determine if the Step-Down Program was compliant with *Texas Administrative Code (TAC)*, *the Step-Down Statement of Work (SOW)*, *Performance Contract Attachment A-1 Supported Living Group Home Standards (SLGHS)*, and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%.

The Program had an overall score of 92%.

The Program exceeded standards in the following areas:

- 97% Policy requirements
- 99% Personnel requirements
- 100% Environment and Medical requirements

The Program did not meet standards in the following areas:

- 72% Client Records requirements

The Program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Step-Down Program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Integrated Care (IC)

Integrated Care (IC) Comprehensive Review

Purpose: This review was conducted to assess the IC program for compliance with the Texas Administrative Code (TAC), *Certified Community Behavioral Health Clinic Improvement Grant (CCBH) criteria Section 2. B, Adult Integrated Collaborative Care Clinic (ICC) Policy, CCBHC-A.1, Proposed Implementation Approach, CCBH B.*

The threshold score for this review is 95%.

The Program had an overall score of 78%.

The Program met and exceeded standards in the following areas:

- 100% Service Compliance
- 100% Requisite
- 100% Case Management Activity
- 100% Progress notes

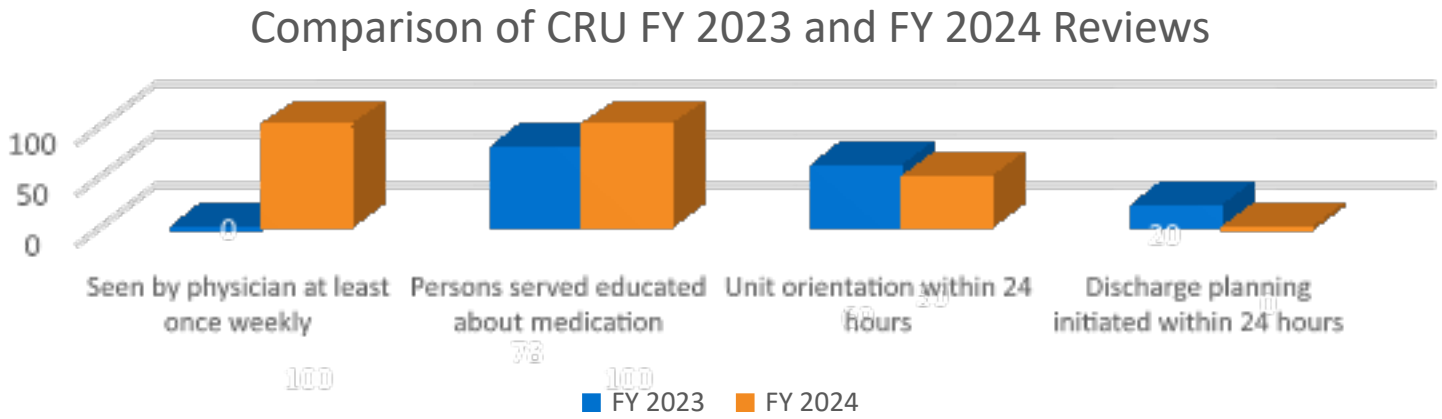
The program did not meet standards in the following areas:

- 25% Staff Training

The program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Integrated Care Program in the next one hundred (180) days to ensure the program has implemented its POI.

Crisis Residential Unit (CRU)



Threshold score= 95%

Crisis Residential Unit (CRU) POI Follow-up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: physician activities, medication education, unit orientation, and discharging.

The Program had an overall score of 63%.

The Program exceeded standards in the following areas:

- 100% of Clients were seen by a physician at least weekly.
- 100% of Clients were educated about their medications.

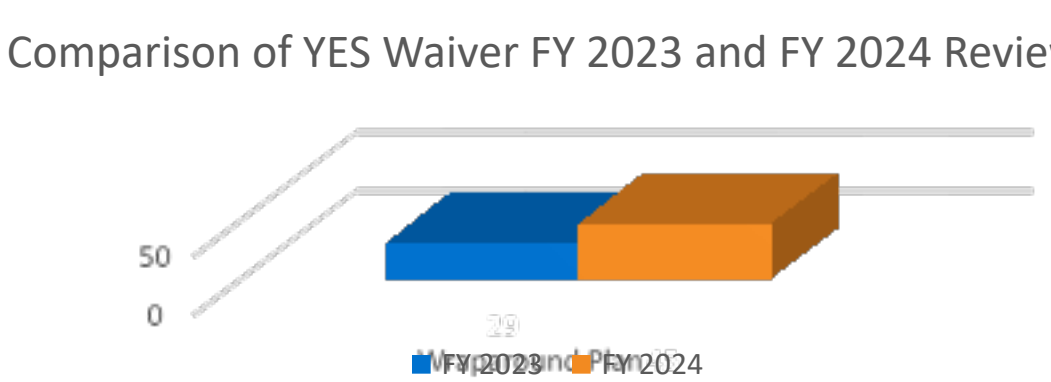
The Program did not meet standards in the following areas:

- 50% Unit orientation
- 0% Discharge planning

The Program will continue its corrective action implemented on March 2, 2023.

Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred eighty (180) days.

YES Waiver



Threshold score= 95%

Youth Empowerment Services (YES) Waiver POI Follow-up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: wraparound plan activities.

The Program had an overall score of 45%.

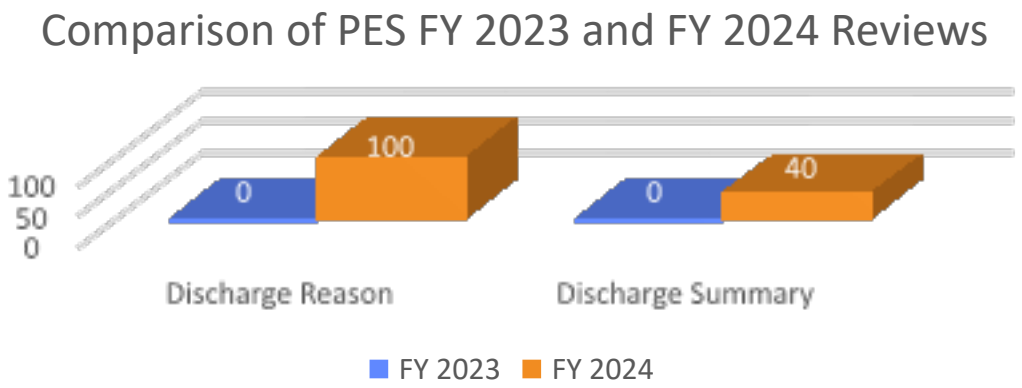
The Program did not meet or exceed standards in the following area:

- Documenting the initial wraparound plan with the needs statement.

The Program will continue its corrective action implemented on February 16, 2023.

Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred eighty (180) days.

Psychiatric Emergency Services (PES)



Threshold score= 95%

Psychiatric Emergency Services (PES) Plan of Improvement (POI) Follow-up Review

Purpose: This review was conducted to determine if the PES Program was compliant with *The Harris Center Policies and Procedures*.

The Program had an overall score of 70%.

The Program met or exceeded standards in the following area:

- 100% of documentation included reason for discharge.

The Program did not meet standards in the following area:

- 40% for documentation did not include discharge summary.

The Program will continue its corrective action implemented on March 22, 2023.

Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred-eighty 180 days.

Child & Adolescent Services (CAS)

The HARRIS CENTER for Mental Health and IDD

Child & Adolescent Services (CAS) Mental Health Program Physician Coding & Documentation Focus Review

Purpose: Compliance audited the CAS program to ensure appropriate coding & billing practices while reviewing the following standards: *Centers for Medicare and Medicaid Services (CMS) Regulations, Current Procedural Terminology (CPT) guidelines, American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines*, Texas Administrative Codes (TAC), and Agency Policy and Procedures (P&P).

The Program had an overall Physician (provider) score of 94%.

The Program met and/or exceeded standards in the following areas:

- 100% No Evidence of Overlap in Appointment Time
- 100% No Evidence of Copy & Pasting / Cloning within Documentation
- 100% Evidence of Medically Appropriate History
- 100% Evidence of Medically Appropriate Examination
- 100% Appropriate consent received for services rendered by QMHP
- 100% Appropriate secondary services billed and documented from Assessment & Plan
- 100% Evidence for authorized and approved codes for secondary services

The Program did not meet standards in the following area:

- 81% Appropriate primary coding based on Total Time and/or Medical Decision Making (MDM) of the Medication Maintenance encounters reviewed.

Action Plan**:** In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with Provider liaison/Division Head regarding their documentation. The Compliance Department will continue to complete audits to ensure the program is following above mentioned guidelines.

Adult Mental Health (AMH)

The HARRIS CENTER for Mental Health and IDD

Adult Mental Health (AMH) Physician Coding & Documentation Focused Review

Purpose: Compliance audited the AMH program to ensure appropriate coding & billing practices while reviewing the following standards: *Centers for Medicare and Medicaid Services (CMS) Regulations, Current Procedural Terminology (CPT) guidelines, American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines*, Texas Administrative Codes (TAC), and Agency Policy and Procedures (P&P).

The Program had an overall Physician (Provider) score of 92%.

The Program met and or exceeded standards in the following area:

- 100% Evidence of Overlap in Appointment Time
- 100% Evidence of Copy & Pasting / Cloning within Documentation
- 100% Evidence of Medically Appropriate History
- 100% Evidence of Medically Appropriate Examination
- 100% Appropriate consent received for services rendered by QMHP
- 100% Appropriate secondary services billed and documented from Assessment & Plan
- 100% Evidence for authorized and approved codes for secondary services

The Program did not meet and or exceed standards in the following area:

- 64% Appropriate primary coding based on Total Time and/or Medical Decision Making (MDM) of the Medication Maintenance encounters reviewed.

Action Plan: In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with Provider liaison/Division Head regarding their documentation. The Compliance Department will continue to complete audits to ensure the program is following above mentioned guideli

Homeless Outreach Team (HOT)

The Harris Center for Mental Health and IDD

Homeless Outreach Team (HOT) Comprehensive Review

Purpose: This review was conducted to determine if the HOT Program was compliant with the *Texas Administrative Code (TAC)*, *HOT Operational Guidelines*, and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%

The Program had an overall score of 85%.

The Program did not meet standards in the following areas:

- 79% Client Records
- 91% Personnel

The Program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the HOT program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Texas Home Living (TxHmL) Provider

Texas Home Living (TxHmL) Provider Program Comprehensive Review

Purpose: This review was to ensure that the TxHmL Provider program documentation, employee training, and operational guidelines comply with the *Texas Administrative Code (TAC)* and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%.

The Program had an overall score of 94%.

The Program met or exceeded standards in the following areas:

- 95% Service Compliance
- 99% Individualized Skills and Socialization (ISS) Requirements

The Program did not meet standards in the following areas:

- 89% Progress note documentation

The Program will be required to submit a Plan of Improvement (POI).

Action Plan: Compliance will review the TxHmL Provider Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

The HARRIS CENTER for Mental Health and IDD

Multisystemic Therapy (MST)

The HARRIS CENTER for Mental Health and IDD

Multisystemic Therapy (MST) Comprehensive Review

Purpose: This review was conducted to assess the MST Program for compliance with the *Code of Federal Regulations) Parts 169 and 164, Interlocal Agreement Between the Harris County Juvenile Board and the Harris Center for Mental Health and IDD, MST Goals and Guidelines, MST Overview Pamphlet, MST Job Description, MST Documentation requirements for the Harris Center and the Harris County Juvenile Probation Department and MST Referral.*

The threshold score for this review is 95%.

The Program had an overall score of 100%.

The Program met and exceeded standards in the following areas:

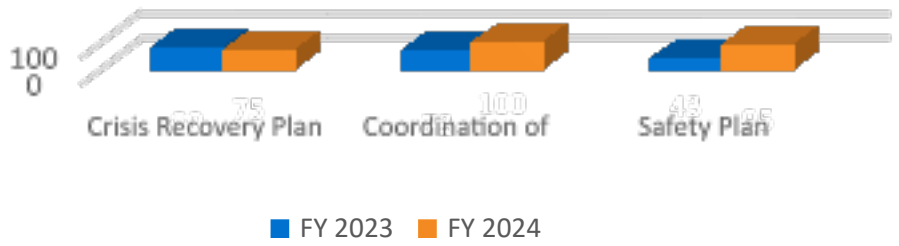
- 100% Requisites
- 100% Staff Training
- 100% No Missing Progress Notes
- 100% MST Program Overview

The program was not required to submit a Plan of Improvement (POI).

Action Plan: The Compliance Department will continue to complete audits to ensure the program is following the MST program requirements and Federal regulations.

Key Take-Aways

Comparison of MCOT FY 2023 and FY 2024 Reviews



Threshold score= 95%

Mobile Crisis Outreach Team (MCOT) POI Follow-up Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: crisis recovery planning, Coordination of crisis services, and safety planning.

The Program had an overall score of 90%.

The Program met and exceeded standards in the following areas:

- 100% Providing coordination of crisis services: Linking, Stabilizing, and Transitioning to routine care.
- 95% Completing Safety Planning.

The Program did not meet and or exceed standards in the following area:

- 75% Developing an individualized crisis recovery plan.

The Program will continue its corrective actions implemented on March 10, 2023.

Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred eighty (180) days.

The PEERS for Hope House (Hope House)

The Harris Center for Mental Health and IDD

The PEERS for Hope House (Hope House) Comprehensive Review

Purpose: This review was conducted to determine if the Hope House Program was compliant with the *Texas Administrative Code (TAC), the Heath and Human Services Commission's Information Item V*, and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%

The Program had an overall score of 91%.

The Program met or exceeded standards in the following areas:

- 100% Policy requirements
- 96% Personnel requirements
- 100% Environment and safety requirements
- 100% Medical requirements

The Program did not meet standards in the following areas:

- 59% Client Record requirements

The Program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Hope House Program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Northwest (NW) & Southeast (SE) Assertive Community Team (ACT) & Forensic Assertive Community Team (FACT)

Northwest (NW) & Southeast (SE) Assertive Community Team (ACT) & Forensic Assertive Community Team (FACT) Comprehensive Review

Purpose: The review was conducted to assess the NW and SE ACT/FACT for compliance with the *Texas Administrative Code (TAC*) and *The Harris Center Policies and Procedures.*

The threshold score for this review is 95%.

The Program had an overall score of 96%.

The Program met or exceeded standards in the following areas:

- 100% Documentation of Recovery Plan
- 100% ACT/FACT Requisite
- 100% Case Management
- 100% Case Management Employee Competency
- 97% Staff Competency Training
- 100% Progress Notes

The Program did not meet standards in the following areas:

- 85% ACT/FACT Service Compliance
- 88% ACT/FACT Operational Guidelines of Clinical Hours of Operations

The Program was required to submit a Plan of Improvement for areas that did not meet the threshold score of 95%.

Action Plan**:** Compliance will review the NW & SE ACT/FACT Program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

The HARRIS CENTER for Mental Health and IDD

Youth Diversion Center

The HARRIS CENTER for Mental Health and IDD

The Youth Diversion Center Comprehensive Review

Purpose: This review was to assess Youth Diversion for compliance with *Health and Human Services Information Item V: Crisis Respite Standards, The Harris Center Policy and Procedure Plan, and the Texas Administrative Code (TAC).*

The threshold score for this review is 95%.

The Program had an overall score of 88%.

The Program met or exceeded standards in the following areas:

- 100% Medication Management
- 95% Posting

The Program did not meet standards in the following areas:

- 91% Assessment and Intake
- 63% Infection Control
- 86% Staffing
- 94% Service Documentation

The Program is required to submit a plan of improvement for the areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Youth Diversion Center program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Psychiatric Emergency Services (PES)

The HARRIS CENTER for Mental Health and IDD

Psychiatric Emergency Services (PES) Program Physician Coding & Documentation Focus Review

Purpose: Compliance audited the PES program to ensure appropriate coding & billing practices while reviewing the following standards: *Health & Human Services (HHS) Information Item V, Centers for Medicare and Medicaid Services (CMS) Regulations, Current Procedural Terminology (CPT) guidelines, American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines*, *Texas Administrative Codes (TAC)*, and *Agency Policy and Procedures.*

The threshold score for this review is 95%.

The Program had an overall Physician (provider) score of 98%.

The Program met and/or exceeded standards in the following areas:

- 100% Evidence of Overlap in Appointment Time
- 97% Evidence of Copy & Pasting / Cloning within Documentation
- 97% Evidence of Medically Appropriate History
- 100% Evidence of Medically Appropriate Examination
- 94% Appropriate Medical Decision Making (MDM) codes for service
- 100% Appropriate codes for Face to Face/Telehealth (TH) on the date of service
- 100% Appropriate consent received for services rendered by QMHP
- 97% Appropriate secondary services billed and documented from Assessment & Plan
- 100% Evidence for authorized and approved codes for secondary services

Action Plan: The Compliance Department will continue to complete audits to ensure the program follows the above-mentioned guidelines.

Crisis Stabilization Unit (CSU)

The HARRIS CENTER for Mental Health and IDD

Crisis Stabilization Unit (CSU) Physician Coding & Documentation Focus Review

Purpose: Compliance audited the CSU program to ensure appropriate coding & billing practices while reviewing the following standards: *Health & Human Services (HHS) Information Item V, Centers for Medicare and Medicaid Services (CMS) Regulations, Current Procedural Terminology (CPT) guidelines, American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines*, *Texas Administrative Code (TAC)*, and *The Harris Center Policies and Procedures.*

The threshold score for this review is 95%.

The Program had an overall Physician (provider) score of 88%.

The Program met and/or exceeded standards in the following areas:

- 100% Evidence of Overlap in Appointment Time
- 100% Evidence of Medically Appropriate History
- 100% Evidence of Medically Appropriate Examination
- 100% Appropriate Medical Decision Making (MDM) codes for service
- 100% Appropriate codes for Face to Face/Telehealth (TH) on date of service
- 100% Appropriate consent received for services rendered by QMHP
- 100% Evidence for authorized and approved codes for secondary services

Physician coding & documentation did not meet expectations in the following areas:

- 88% Evidence for copy & pasting / cloning within documentation
- 0% Appropriate services billed and documented based on Assessment and Plan (Global Finding)

Action Plan: Compliance will review program documentation in the next one hundred eighty (180) days to ensure the program has implemented its POI.

Independent Living (IL)

The Harris Center Independent Living (IL) Comprehensive Review

Purpose: This review was conducted to determine if the IL Program was compliant with the *Texas Administrative Code (TAC), the Health and Human Services Commission's Information Item V,* and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%.

The Program had an overall score of 80%.

The Program met or exceeded standards in the following areas:

- 100% Medical requirements

The Program did not meet standards in the following areas:

- 90% Policy requirements
- 78% Environment requirements
- 90% Personnel requirements
- 42% Client Record requirements

The Program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the IL Program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

The HARRIS CENTER for Mental Health and IDD

Optum Integrated Behavioral Health Home

Optum Integrated Behavioral Health Home Care Comprehensive Review

Purpose: This review was conducted to determine if the Optum Integrated Behavioral Health Home Care Program was compliant with the *Texas Administrative Code (TAC)*, *Integrated Behavioral Health Home (IBHH) Incentive Agreement*, and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%.

The Program had an overall score of 45%.

The Program met or exceeded standards in the following areas:

- 100% Service Provision Documentation in Progress Notes

The Program did not meet standards in the following areas:

- 8% Enrollment and Assessment
- 86% Administrative Records
- 10% Health Action Plan (HAP)
- 67% Agency Required Staff training
- 0% Personal Safety Plan

The Program was required to submit a Plan of Improvement (POI) for the areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Optum Integrated Behavioral Health Home program in the next one hundred eighty (180) days to ensure implementation of its POI.

The Harris Center for Mental Health and IDD

Community Unit Probation Services (CUPS)

The HARRIS CENTER for Mental Health and IDD

Community Unit Probation Services (CUPS) Program Plan of Improvement (POI) Review

Purpose: The review was conducted to verify the program's compliance with the corrective measures implemented in the following areas: Recovery plan and progress note documentation.

The threshold score for this review is 95%.

The Program had an overall score of 98%.

The Program met and exceeded standards in the following areas:

- 100% Treatment Planning
- 95% Progress Note Documentation

The Program will not be required to submit a Plan of Improvement (POI).

Action Plan: The Compliance Department will continue to complete audits to ensure the program follows the TAC, Agency Policy and Procedures, and completes notes within two (2) business days.

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI Jr.)

The Harris Center for Mental Health and IDD

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI Jr.) Follow-up Review

Purpose: This review assessed TCOOMMI Jr. case plans/treatment plans for compliance with the *Texas Department of Criminal Justice PGP and Texas Administrative Code (TAC).*

The threshold score for this review is 95%.

The Program had an overall score of 98%.

The Program met or exceeded standards in the following areas:

- 100% Parole Treatment Plan requirements.
- 95% Probation case plan requirements.

The Program did not meet standards in the following areas:

- Reviewing and updating probation case plans within twenty-one (21) to thirty-five (35) days of the previous plan development.
- Providing the juvenile and family with a copy of the probation case plan within seven (7) calendar days.

The Program will continue its corrective action implemented on May 23, 2024.

Action Plan: Compliance will review the TCOOMMI Jr. program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Substance Use Recovery Services Detoxification (Detox)

The HARRIS CENTER for Mental Health and IDD

Substance Use Recovery Services Detoxification (Detox) Program Comprehensive Review

Purpose: This review was conducted to determine if the Detox Program was compliant with the *Texas Administrative Code (TAC)* and *The Harris Center Policies and Procedures*.

The threshold score for this review is 95%.

The Program had an overall score of 92%.

The Program met or exceeded standards in the following are:

- 100% Medical requirements
- 100% Policy requirements
- 100% Environment requirements

The Program did not meet standards in the following areas:

- 82% Personnel requirements
- 79% Client Record requirements

The Program was required to submit a Plan of Improvement (POI) for areas that did not meet the threshold score of 95%.

Action Plan: Compliance will review the Detox Program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

Northwest Community Service Center (NWCSC)

The HARRIS CENTER for Mental Health and IDD

Northwest Community Service Center (NWCSC) Routine Review Plan of Improvement (POI) Follow-Up

Purpose: This review was conducted to determine if the POI actions have been implemented from the previous review conducted on April 17, 2023, to April 20, 2023, and for compliance with *Texas Administrative Code*.

The threshold score for this review is 95%.

The Program had an overall score of 98%.

The Program met or exceeded standards in the following areas:

- 100% Plan of Care (specifically addressed co-occurring substance use)
- 100% Case Management Services Standards (identify strength, service needs, and assistance required)
- 95% Case Management Services Standards (develop a timeline for obtaining and evaluating individual's need)
- 98% Service Provision (progress notes reflect persons served issue stated in the plan of care)

The Program satisfactorily completed its Plan of Improvement (POI) from the previous review. Staff training was completed in relation to the previous POI. The Program is not required to submit a POI.

Action Plan: Compliance will continue to provide the necessary support to ensure the program maintains its high standard.

External Reviews

79 External Reviews were monitored by Compliance within this reporting period

1. Office of Budget and Finance of Houston Police Department Desk Review 11/20/2023
2. CIOX Oscar Records Request 12/02/2023
3. CIOX Oscar Records Request 12/01/2023
4. Community Health Choice Records Request 12/04/2023
5. Episource Village MD Records Request 12/05/2023
6. Change Healthcare Ambetter Records Request 12/06/2023
7. Superior Behavioral Health Provider Review Feedback Q4 2023 12/07/2023
8. ECI Child Findings Child Record Annotation Review 12/12/2023, 01/04/2024, 02/04/2024
9. United Healthcare Optum Records Request 12/13/2023
10. Aetna Episource Records Request 12/13/2023
11. CIOX Oscar Records Request 12/14/2023
12. Witt O'Brien's CCHP 2.1 Monitoring Report 12/14/2023, 12/21/2023
13. Ambetter Change Healthcare Records Request 12/20/2023
14. Wellcare CIOX Records Request 12/21/2023
15. United Healthcare Records Request 12/21/2023
16. United Healthcare EQRO Record Request 12/21/2023
17. Community Health Choice 01/03/2024
18. Harris Center WY6 QM Review Report (YES Waiver) 1/03/2024
19. The Harris Center for Mental Health and IDD Noticer of Findings 1/04/2024
20. Change Healthcare BCBS Records Request 1/08/2024
21. Change Healthcare Ambetter Records Request 1/11/2024
22. Change Healthcare BCBS Records Request 1/11/2024
23. Change Healthcare Ambetter Records Request 1/17/2024
24. CIOX Ambetter Records Request 1/24/2024
25. United Healthcare Advantmed Records Request1/30/2024
26. Molina Healthcare Records Request 1/31/2024
27. Change Healthcare Ambetter Records Request 2/02/2024
28. Episource Aetna Records Request 2/02/2024
29. BCBS Advant Med Records Request 2/08/2024
30. OIG Records Request Letter 2/08/2024
31. YES Waiver Harris Center Form 3046_CAP Not Approved 2/09/2024
32. Molina Medical Records Request 02/09/202024
33. Episource Aetna Medical Records Request 2/12/2024
34. United Health Care Records Request 2/13/2024
35. Episource Aetna Medical Records Request 2/13/2024
36. ECI MHMR of Harris County Determinations Letter 2/15/2024
37. Molina Medical Records Request 2/16/2024
38. CIOX Oscar Risk Adjustment Review 2/16/2024
39. Wellpoint Records Request 2/21/2024
40. CIOX Oscar Records Request 02/22/2024

.

External Reviews

41. Episource Aetna Records Request 3/05/2024
42. Wellpoint Amerigroup STAR PLUS MMP HEIDIS R eview 3/05/2024
43. Molina Healthcare Behavioral Health Medical Record Review Project 3/05/2024
44. CIOX Oscar Risk Adjustment Review 3/07/2024
45. Complexcare Texas Children's Health Plan HEIDIS Review 3/11/2024
46. Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement Program Record Review 3/13/2024
47. CIOX Oscar Risk Adjustment Review 3/13/2024
48. CIOX Oscar Risk Adjustment Review 3/13/2024
49. CIOX Southern Health Plan HEIDIS Review 3/13/2024
50. CIOX Oscar Risk Adjustment Review 3/14/2024
51. Be Well Texas MAT AUD (M-SUD) Entrance Conference Announcement 3/19/2024
52. Episource Optum BCBSTX Risk Adjustment Review 3/22/2024
53. Molina Risk Adjustment Review 3/22/2024
54. Blue Cross Blue Shield of TX Medical Record Request 3/22/2024
55. CIOX Ambetter Risk Adjustment Review 3/26/2024
56. Advantmed United Healthcare HEIDIS Review 4/01/2024
57. Advantmed United Healthcare HEIDIS Review 4/01/2024
58. Advantmed United Healthcare HEIDIS Review 4/03/2024
59. Episource Aetna Risk Adjustment Review 4/04/2024
60. Episource Oscar Risk Adjustment 4/08/2024
61. KDJ Consultants Community Health Choice HEIDIS Review 4/09/2024
62. Advantmed Blue Cross Blue Shield of Texas HEIDIS Review 4/09/2024
63. Texas Health and Human Services Commission (HHSC) Applewhite House ICF/IID Life Safety Code non-onsite follow-up Review 4/09/2024
64. Advantmed United Healthcare HEIDIS Review 4/15 /2024
65. Advantmed United Healthcare HEIDIS Review 4/18 /2024
66. Advantmed United Healthcare HEIDIS Review 4/19 /2024
67. Texas Health and Human Services Commission (HHSC) Westbury House Statement of Licensing Violations and Plan of Correction 4/21/2024
68. Be Well Texas MAT AUD (M-
69. Superior Health Plan HEIDIS Review 4/25/2024
70. Episource Aetna Risk Adjustment Review 5/01/2024
71. Episource Aetna Risk Adjustment Review 5/02/2024
72. Episource Aetna Risk Adjustment Review 5/02/2024
73. Datavant Oscar Risk Adjustment Review 5/09/2024
74. Datavant Oscar Risk Adjustment Review 5/09/2024
75. Superior Health Plan Risk Adjustment Review 5/10/2024
76. Optum RX Pharmacy Desk Audit Preliminary Audit Results 5/13/2024
77. Texas Health and Human Services Commission (HHSC) Westbury House ICF/IID Life Safety Code non- onsite follow-up Review 5/14/2024
78. Datavant Cigna Risk Adjustment Review 5/24/2024
79. Datavant United Healthcare Risk Adjustment Review 5/29/2024

Thank you.

EXHIBIT A-5

The HARRIS CENTER for Mental Health and IDD

The Harris Center for Mental Health and IDD (The Harris Center):
Compliance Department (Compliance) Audit Committee Report

Report Description: The aim of this report is to inform the Audit Committee of the reviews/audits conducted by, or in association with, Compliance for the review period: December 1, 2023, through May 31, 2024.

Presenter: Demetria Luckett, Compliance Director

Explanation of Reviews

The following types of reviews were conducted by Compliance during the 2nd and 3rd Quarter (Qtr.) of Fiscal Year (FY) 2024:

Focus Review – A review concentrating on specific areas such as billing and procedural coding, individual information, confidentiality, service activities, etc. A focus review may be initiated by sources other than Compliance, including, but not limited to, Directors, Program Managers, and Administrative or Direct care staff.

Fifteen (15) Focus Reviews were conducted during the reporting period to ensure regulatory compliance in the following areas:

Eleven (11) Plan of Improvement (POI) Follow-up Reviews were conducted in accordance with the Compliance Department's Audit Schedule.

- 12/05/2023 Southwest Community Service Center (SWCSC)
- 12/06/2023 Northeast Community Service Center (NECSC)
- 12/08/2023 Projects for Assistance in Transition from Homelessness (PATH)
- 12/15/2023 Southeast Community Service Center (SECSC)
- 01/29/2023 Crisis Residential Unit (CRU)
- 02/05/2024 Youth Empowerment Services (YES) Waiver
- 02/09/2024 Psychiatric Emergency Services (PES)
- 02/21/2024 Mobile Crisis Outreach Team (MCOT)
- 05/09/2024 Northwest Community Service Center (NWCSC)
- 04/23/2024 Community Unit Probation Services (CUPS)
- 04/25/2024 Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI, Jr.)

Four (4) Billing and Coding Reviews were conducted in accordance with the Compliance Department's Audit Schedule.

- 02/09/2024 Children and Adolescent Services (CAS) Physician Documentation Review
- 02/14/2024 Adult Mental Health (AMH) Physician Documentation Review
- 04/03/2024 Psychiatric Emergency Services (PES) Physician Documentation Review
- 04/03/2024 Crisis Stabilization Unit (CSU) Physician Documentation Review

Comprehensive Review – A review of The Harris Center's adherence to regulatory guidelines related to Operations, Medical, Environment, Personnel Requirements, Clinical Record Review, and others as assigned. Records are selected randomly—the size of the programs and the frequency of entries are contributing factors to the number of records reviewed.

Thirteen (13) Comprehensive Reviews were conducted to ensure the programs are compliant with Texas Administrative Codes, Agency Policy and Procedure, and programmatic guidelines.

Thirteen (13) Comprehensive Reviews were conducted in accordance with the Compliance Department's Audit Schedule.

- 12/15/202 Intellectual and Developmental Disabilities (IDD): Specialized Therapies and Rehabilitation Services (STARS) and STARS Disorders Feeding Clinic
- 01/02/2024 Intellectual and Developmental Disabilities (IDD): Outpatient Biopsychosocial Approach for IDD Services (OBI)
- 01/12/2024 Comprehensive Psychiatric Emergency Program (CPEP): Step Down State Hospital Transition Project (STEP DOWN)
- 01/18/2024 Mental Health (MH): Integrated Care
- 02/06/2024 Intellectual and Developmental Disabilities (IDD): Texas Home Living (TxHmL) Provider
- 02/19/2024 Comprehensive Psychiatric Emergency Program (CPEP): Homeless Outreach Team (HOT)
- 02/20/2024 Mental Health (MH): Multisystemic Therapy (MST)
- 02/26/2024 Comprehensive Psychiatric Emergency Program (CPEP): P.E.E.R.S for Hope House (Hope House)
- 03/07/2024 Mental Health (MH): Assertive Community Treatment (ACT) & Forensic Community Treatment (FACT)
- 03/18/2024 Forensics: Youth Diversion Center
- 04/12/2024 Comprehensive Psychiatric Emergency Program (CPEP): The Harris Center Independent Living (IL)
- 04/18/2024 Mental Health (MH): Optum Integrated Behavioral Health Home Care
- 04/29/2024 Comprehensive Psychiatric Emergency Program (CPEP): Substance Use Recovery Services Detoxification (DETOX)

The HARRIS CENTER for Mental Health and IDD

Other Compliance Activities:

Training/Meeting:

- Consent Protocols and Epic Support May 8, 2024
- Health Care Compliance Association (HCCA) Healthcare Compliance Essentials Workshop May 13 – 16, 2024

Other Responsibilities:

- Epic Deficiency Tracking (Ongoing)
- Managing The Harris Center's legacy incident reporting system
- Maintenance of The Harris Center's policy and procedure process and platform (Ongoing)

Key Takeaways

1. SWCSC POI Follow-up Focus Review: The objective of the review was to monitor the implementation of corrective measures related to obtaining medication consents and the completion of Abnormal Involuntary Movement Scale (AIMS) assessments where applicable. Compliance reviewed the following Texas Administrative Code (TEX. ADMIN. CODE) regulations: *Consent to Treatment with Psychoactive Medication* and *Documentation of Informed Consent 25 TEX. ADMIN. CODE §414.405 (a-b)(2)* and *AIMS Assessment 25 TEX. ADMIN. CODE §415.10 (e).* The program received an overall score of 92%. The Program will continue its corrective actions implemented on December 9, 2022.

   Action Plan: Compliance referred the program to Performance Improvement (PI) to assist with its processes in completing Medication Consents and AIMS assessments.

2. NECSC POI Follow-up Focus Review: The objective of the review was to monitor the implementation of corrective measures related to recover plan documentation, obtaining informed medication consents and the completion of AIMS assessments where applicable. Compliance reviewed the following regulations: *Documentation of Recovery Plan 25 TEX. ADMIN. CODE §415.5 (e), Consent to Treatment with Psychoactive Medication* and *Documentation Informed Medication Consent 25 TEX. ADMIN. CODE §414.405 (a-b) (2)* and *AIMS Assessment 25 TEX. ADMIN. CODE §415.10 (e)*. The program received an overall score of 78%. The program met and exceeded standards in the following area: Recovery Planning. The program remains non-compliant in the domains of obtaining medication consents and completing AIMS assessments where applicable. The Program will continue its corrective actions implemented on December 9, 2022.

   Action Plan: Compliance referred the program to Performance Improvement to assist with its processes in completing Medication consents and AIMS forms.

3. PATH POI Follow-up Focus Review: The objective of the review was to monitor the implementation of corrective measures related to case management activities and nursing documentation. Compliance reviewed the following regulations: *Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361, MH Case Management Services 26 TEX. ADMIN. CODE §306.263, Standards of Nursing Practice 22 TEX. ADMIN. CODE §217.11 (D)(i-iv).* The program had an overall score of 87%. The program met and exceeded standards in the following areas of Case Management Services: Identifying strengths, needs and assistance and taking the steps that were necessary to accomplish the goals required to meet the individual's identified needs by using referral, linking, advocacy, and monitoring. The program did not meet standards in the following areas: nursing documentation regarding documentation of the persons served responses to treatment, contacting other healthcare team members concerning the client's status, and documenting the client's outcomes to treatment; and case management services regarding the identification of the persons served strengths, service needs, and assistance required to address the identified needs; and assisting the individual in identifying the individual's immediate needs and in determining access to community resources that may address those needs.

   Action Plan: Compliance referred the program to Performance Improvement to assist with its processes in case management and nursing documentation and will conduct a follow-up review in the next 180 days.

4. Focus Review: SECSC POI Follow-up Review: The objective of the review was to monitor the implementation of corrective measures related to Recovery Planning documentation and Progress note documentation. Compliance reviewed the following regulations: *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §§301.353 (e)(1)(A), (e)(1)(F),* and *(e)(2)(D); Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361 (a)(11); MH Case Management Services Standards 26 TEX. ADMIN. CODE §306.263 (b)(3)(7);* and *The Harris Center Policy & Procedure HIM.EHR.B.5 Content of Patient/Individual Records*. The program had an overall score of 88% for the areas reviewed. The program met the standards in the following areas: Services were reflected in the recovery plan, and Progress notes were individualized. The program did not meet standards in the following areas: documenting the presenting problem within progress notes documentation. The plans of care did not consistently reflect the expected date of goal achievement, the plan of care did not reflect the person-served objectives as stated in the recovery plan and were not consistent with the focus of the service, and the Case Management progress notes did not identify the person-served strengths. The Program will continue its corrective actions implemented on July 5, 2023.

   Action Plan: Compliance will continue to provide essential support for program compliance with the recovery plan and progress note documentation. Compliance will not refer the program to Performance Improvement but will follow up in the next one hundred eighty (180) days.

5. Comprehensive Review Specialized Therapies and Rehabilitative Services (STARS) and STARS Feeding Disorders Clinic: A review of the STARS clinic and the STARS Feeding

Disorders Clinic Programs was completed to ensure compliance with the following regulations and Harris Center Policy and Procedures TEX. ADMIN. CODE *Conducting a Determination of Intellectual Disability 25 TEX. ADMIN. CODE §304.401; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §301.353; Determination of Ability to Pay 40 TEX. ADMIN. CODE §2.106; Health, Safety, and Rights 40 TEX. ADMIN. CODE §2.313; LIDDA's (Local Intellectual and Developmental Disability Authorities) Responsibilities 26 TEX. ADMIN. CODE §331.11;* and *The Harris Center Agency Policy and Procedures Plan of Care ACC.B.2* and *Content of Patient/Individual Records HIM.EHR. B.5.* The STARS Programs had an overall score of 99%. The program met and exceeded standards in the following areas: documentation of services provided found in the consumer's records, services provided were supported by documentation, the correct Procedure Codes used, documentation of services resulted in correct billing, time matched billed units, eligibility was documented with applicable guidelines, correct date of service, correct start/end time of service, signature and title of who provided the service, correct location of service, all the time accounted for in the body of note, services reflect what was on the POC, services listed in the chart match what is entered into Epic, notes reflected individualization, notes contained all consumer identifying information, and notes were not completed within two (2) business days. The STARS Programs program was not previously under a POI.

Action Plan: The Compliance Department will continue to complete audits to ensure the program is following the TEX. ADMIN. CODE, Agency P&P and completing notes within two business days.

6. Comprehensive Review Outpatient Biopsychosocial Approach for IDD Services (OBI): A Comprehensive Review of the OBI Program was completed to ensure compliance with the following regulations and Harris Center Policy and Procedures: *HHSC OBI Learning Collaborative Manual, 42, Condition of participation: Facility staffing Code of Federal Regulations (CFR),42 CFR §483.430 (a)(b); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §301.353; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; Health, Safety, and Rights 40 TEX. ADMIN. CODE §2.313, LIDDA's Responsibilities 26 TEX. ADMIN. CODE §331.11; Agency Policy and Procedures Plan of Care ACC.B.2* and *Content of Patient/Individual Records HIM.EHR.B.5.* The OBI Program had an overall score of 98%. The program met and exceeded standards in the following areas: documentation of services provided found in the consumer's records, services provided were supported by documentation, the correct Procedure Codes used, documentation of services resulted in correct billing, time matched billed units, correct date of service, correct start/end time of service, notes completed within two (2) business days, signature and title of who provided the service, correct location of service, all the time accounted for in the body of note, services listed in the chart match what is entered into Epic, notes reflected individualization ("Cookie Cutter" note), notes contained all consumer identifying information, eligibility was not documented with applicable guidelines and services did not reflect what was on the Plan of Care (POC).

Action Plan: The Compliance Department will continue to complete audits to ensure the program follows the TEX. ADMIN. CODE, Agency P&P, and the development of the POC.

7. Comprehensive Review Step-Down State Hospital Transition Program (Step Down): A review of the Step-Down State Hospital Transition Program (Step Down) was completed to ensure compliance with the following regulations and Harris Center Policy and Procedures: Texas Administrative Code (TEX. ADMIN. CODE) *Rights of Persons Receiving Mental Health Services 25 TEX. ADMIN. CODE Chapter 404, Subchapter E; IDD-BH Contractor Administrator Functions 26 TEX. ADMIN. CODE Chapter 301, Subchapter G; Behavioral Health Delivery System 26 TEX. ADMIN. CODE Chapter 306, Subchapter F; Standard of Care 25 TEX. ADMIN. CODE Chapter 448; the Step-Down Statement of Work (SOW); Performance Contract Attachment A-1 Supported Living Group Home Standards (SLGHS); and Agency Policies and Procedures*. The overall score for the program was 92%. The program met and exceeded standards in the following areas: agency policies and procedures, environmental and medical, and personnel (e.g., staff training and hiring practices). The program did not meet standards in the following area: records review: no participation or input in the persons served treatment planning, educating clients on communicable diseases, educating clients on the health risks of tobacco use, progress note documentation and the development of transition plans.

   Action Plan: Compliance will conduct a follow-up review in one hundred-eighty (180) days ensuring the program is following the TEX. ADMIN. CODE, Agency P&P, and completing notes within two business days.

8. Comprehensive Review Integrated Care (IC): A review was completed to ensure compliance with the following regulations and Harris Center Policy and Procedure: *Screening and Assessment 26 TEX. ADMIN. CODE 306.161 (b)(1)(A); CCBH Grant Criteria Section 2.B; Adult Integrated Collaborative Care Clinic (ICC) Policy; Evaluation and Diagnosis 25 TEX. ADMIN. CODE 415.6 (a)(1- 5); Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE 404.163(b); Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE 301.353 (h)(1-3); Population of Focus and Statement of Needs CCBHC-A.1; Proposed Implementation Approach CCBH B.1;* and *Documentation of Service Provision 26 TEX. ADMIN. CODE 301.361 (a)-(c).* The Program had an overall score of 78%. The program met and exceeded standards in the following areas: Eligibility, Timing of screening, Eligibility/Crisis, Psychiatric Evaluation, Service, Certification Criteria procedures for Collecting, reporting, and tracking encounter outcomes and quality data, sustainability Plan, Data Collection and Performance Measure, Financials, Discharge Summaries, and progress notes. The program did not meet standards in staff training: CCBHC Training plans, Orientation training, Competence of trainers and trainees, Methods for assessing skills and Competencies of Providers, in-service training and education, and List of in-service training and educational programs provided during the previous 12 months. The program was required to submit a Plan of Improvement (POI) for the following area: Staff Training.

Action Plan: Compliance will review the Integrated Care Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

9. Focus Review Crisis Residential Unit (CRU): The review's objective was to monitor the implementation of corrective measures related to physician visitation, medication education, unit orientation, and discharge planning. Compliance reviewed the following standards: *Health and Human Services Information Item V: V. Crisis Residential Services D.2.Staffing. e.v.; D.3.Assessment and Intake.vi.1.-5.; D.5.Coordination of Treatment, Continuity of Care, and Discharge.c.i.-iv.;* and *D.12.Medication Management.e.iv.* The program had an overall score of 63%. The program met and exceeded standards in the following areas: clients are seen by a physician at least weekly while enrolled, and clients are educated about their medications. The program remains non-compliant in the domains of completion of orientation within 24 hours of admission and initiating discharge planning during the enrollment process. The Program will continue its corrective action implemented on March 2, 2023.

   Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred-eighty (180) days.

10. Focus Review Youth Empowerment Services (YES) Waiver: The objective of the review was to monitor the implementation of corrective measures related to Wraparound Plan requirements of documenting needs statements for the participant and legal authorize representative (LAR). Compliance reviewed the following standard: *Health and Human Services YES Waiver Manual for Initial Wraparound Plan Development.* The program received an overall score of 45%. The Program will continue its corrective actions implemented on February 16, 2023.

    Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred-eighty (180) days.

11. Comprehensive Review TxHmL Provider: The objective of the review was to ensure that the TxHmL Provider program documentation, employee training, and operational guidelines are complying with the rules and regulations of the Texas Administrative Code (TEX. ADMIN. CODE) *Program Provider Certification Principles: Service Delivery 26 TEX. ADMIN. CODE §566.7; Certification Principles: Staff Member and Service Provider Requirements 26 TEX. ADMIN. CODE §566.9; Certification Principles: Quality Assurance 26 TEX. ADMIN. CODE §566.11; Certification Principles: Requirements Related to the Abuse, Neglect, and Exploitation of an Individual 26 TEX. ADMIN. CODE §566.15; Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §301.353; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; Conducting a Determination of Intellectual Disability 26 TEX. ADMIN. CODE §304.401; General Requirements 26 TEX. ADMIN. CODE §559.225; Program Requirements 26 TEX. ADMIN. CODE §559.227; Environment and Emergency Response 26 TEX. ADMIN. CODE*

§559.229; and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care* and *HIM.EHR.B.5 Content of Patient/Individual Record.* The TxHmL Program had an overall score of 94%. The program met and exceeded standards in the following areas: Service Compliance and Individualized Skills and Socialization (ISS) Requirements. The program did not meet standards in: Progress note documentation. The TxHmL Provider Program will be required to submit a Plan of Improvement (POI) in the following: The services provided were not supported by documentation- missing the treatment plan objective and missing statements of progress or lack of progress toward treatment plan goals, Services do not reflect what is on the PDP, Missing Consumer identifying information, Development of Transportation Plan, Development of Implementation Plan, and Participation in community activities.

Action Plan: Compliance will review the TxHmL Provider Program in the next one hundred eighty (180) days to ensure the program has implemented its POI.

12. Focus Review Psychiatric Emergency Services (PES): The review's objective was to monitor the implementation of corrective measures related to discharge documentation. Compliance reviewed the following standards*: ACC.B.8.Referral, Transfer, and Discharge.D.2.* The program had an overall score of 70%. The program met and exceeded standards in the following area: including the date and reason for discharge for clients. Although improvements have been made, the program remains non-compliant in the domain of including a summary of all services received by the person served since admission and the persons served a response to each service. The Program will continue its corrective action implemented on March 22, 2023.

    Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred-eighty (180) days.

13. Focus Review Child & Adolescent Services (CAS) Division Physician Documentation Review: A review of Adult Mental Health (AMH) Division was completed. Compliance reviewed the following standards: *Centers for Medicare and Medicaid Services (CMS) Coding Regulations and Guidance; Current Procedural Terminology (CPT) guidelines; American Medical Association (AMA) Evaluation and Management (E/M) Documentation Guidelines; Telemedicine and Telehealth Benefits and Limitations 1 TEX. ADMIN. CODE §354.1432,* and *Agency Policy and Procedures (P&P)* concerning Mental Health documentation standards. The program had an overall physician score of 94%. The program met and exceeded standards in the following areas: Evidence of Overlap in Appointment Time, Evidence of Copy & Pasting/Cloning within Documentation, Medically Appropriate History, Medically Appropriate Examination, Appropriate consent received for services rendered by Qualified Mental Health Professional (QMHP), Appropriate services billed and documented in Assessment & Plan (Missing Codes), and authorized and approved codes for secondary services (Extra Codes). The program did not meet and exceed standards in the following area: Appropriate primary coding based on Total Time-Based Code and/or Medical Decision-Making Code for services rendered.

Action Plan: The Compliance Department will continue to complete monthly audits to ensure the program is adhering to the 2024 CMS/AMA coding guidelines as well as Agency Policy and Procedures (P&P) especially those pertaining to primary codes suitable for E/M services. Compliance will work with Division Leaders/Directors and review Agency P&P in the next one hundred eighty (180) days.

14. Focus Review Adult Mental Health (AMH) Division Physician Documentation Review: A review of Adult Mental Health (AMH) Division was completed. Compliance reviewed the following standards: *Centers for Medicare and Medicaid Services (CMS) Coding Regulations and Guidance; Current Procedural Terminology (CPT) guidelines; American Medical Association (AMA) Evaluation and Management (E/M) Documentation Guidelines; Telemedicine and Telehealth Benefits and Limitations 1 TEX. ADMIN. CODE §354.1432;* and *Agency Policy and Procedures (P&P)* concerning Mental Health documentation standards. The program had an overall physician score of 92%. The program met and exceeded standards in the following areas: Evidence of Overlap in Appointment Time, Evidence of Copy & Pasting/Cloning within Documentation, Medically Appropriate History, Medically Appropriate Examination, Appropriate consent received for services rendered by Qualified Mental Health Professional (QMHP), Appropriate services billed and documented in Assessment & Plan (Missing Codes), and authorized and approved codes for secondary services (Extra Codes). The program did not meet and exceed standards in the following area: Appropriate primary coding based on Total Time-Based Code and/or Medical Decision-Making Code for services rendered.

Action Plan: The Compliance Department will continue to complete monthly audits to ensure the program is adhering to the 2024 CMS/AMA coding guidelines as well as Agency Policy and Procedures (P&P) especially those pertaining to primary codes suitable for E/M services. Compliance will work with Division Leaders/Directors and review Agency P&P in the next one hundred eighty (180) days.

15. Comprehensive Review Homeless Outreach Team (HOT): Compliance reviewed the following standards: *Texas Administrative Code (TEX. ADMIN. CODE) §301.331 (h)(1)* and *(4), §301.363 (a), HOT Program Operational Guidelines,* and *Agency Procedures HIM.EHR.B.5* and *HIM.EHR.B.9*. The program had an overall score of 85%. The program met and exceeded standards in the following areas: including the start and end times of service provision, entering outreach notes within 72 hours, writing outreach notes in narrative form, completion of background checks on employees, possession of signed job descriptions, and documenting monthly supervisory meetings with employees. The program did not meet standards in the following areas: documenting the location at which services were provided to persons served, the services offered to persons served, linking persons served to other services, documenting a subjective assessment of the person served, indicating previous experience with persons served, providing evidence employees had completed all required training courses, and employees documenting a minimum of 100 person served conTex.

Admin. Codet per month. The program was required to submit a Plan of Improvement to address these deficiencies.

Action Plan: Compliance will conduct a Plan of Improvement Follow-up Review in one hundred eighty (180) days.

16. Comprehensive Review Multisystemic Therapy (MST): Compliance reviewed the following standards*: 45 C.F.R. (Code of Federal Regulations) Parts 169* and *164, Interlocal Agreement Between the Harris County Juvenile Board and the Harris Center for Mental Health and IDD, MST Goals and Guidelines, MST Overview Pamphlet, MST Job Description, MST Documentation requirements for the Harris Center and the Harris County Juvenile Probation Department and MST Referral.* The Program had an overall score of 100%. The program met and exceeded standards in the following areas: Demographics Entered the Day of the Intake Assessment, Health Insurance Portability and Accountability Act (HIPAA) forms, Open Cases, Staff Training and No Missing Progress Notes. The program was not required to submit a Plan of Improvement (POI).

    Action Plan: The Compliance Department will continue to complete audits to ensure the program is following the MST requirements.

17. Focus Review Mobile Crisis Outreach Team (MCOT) POI Follow-up Review:
    The review objective was to monitor the implementation of corrective measures related to the Coordination of crisis services, safety planning, and crisis recovery plan documentation. Compliance reviewed the following standards: *Health and Human Information Item V: II. Mobile Crisis Outreach Team D.6.Education and Documentation.* and *D.7.Coordination of Services.a.i.-ii.*, and *Agency Policy and Procedure ACC.B.2 Plan of Care*. The program had an overall score of 90%. The program met and exceeded standards in the following areas: Coordination of services and completion of a safety plan for each individual served. The program did not meet or exceed standards in the following area: developing an individualized crisis recovery plan. The Program will continue its corrective actions implemented on March 10, 2023.

    Action Plan: Compliance referred the program to Performance Improvement to assist with its processes and will conduct a follow-up review in one hundred-eighty (180) days.

18. Comprehensive Review P.E.E.R.S for Hope House: Compliance reviewed the following standards: *Health and Human Services Commission (HHSC) Information Item V.VII Peer Run Crisis Respite Services; Texas Administrative Code (TEX. ADMIN. CODE) Eligibility to Receive Services 1 TEX. ADMIN. CODE §354.3011; Minimum Qualifications 1 TEX. ADMIN. CODE §354.3051 (d); Supervision of Peer Specialists 1 TEX. ADMIN. CODE §354.3103 (b)(1)-(2), (d); Initial Peer Specialist Certification 1 TEX. ADMIN. CODE §354.3205 (f); Competency and Credentialing 26 TEX. ADMIN. CODE §301.331 (h)(1)* and *(4); Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361; Supervision 26 TEX. ADMIN. CODE §301.363; Must I have a carbon monoxide detector-system? 26 TEX. ADMIN. CODE §748.3191; a*nd *The Harris Center for Mental Health and IDD Agency*

Policies and Procedures HIM.EHR.B.9. Patient/Individual Records Administration.5.Procedures.I.Guidelines for Patient/Individual Record Entries and *ACC.B.8.Referral, Transfer, and Discharge.5.Discharge.1-4.* The program had an overall score of 91%. The program met and exceeded standards in the following areas: policies and procedures; agency-mandated training, background checks on employees, signed job descriptions from employees, employee completion of initial and two-year certification training, environmental requirements, safety requirements, required postings, food service requirements, medication management requirements, infection control requirements, and admission requirements. The program did not meet standards in the following areas: conducting weekly and monthly supervisory meetings with peer specialists; conducting monthly observations of peer specialists providing services; providing persons served with a unit orientation within 24 hours of admission; providing persons served with wellness and recovery tools; offering persons served a Declaration for Mental Health Treatment; daily documentation of a person's served progress toward goals; identifying, linking, and providing necessary assistance to persons served to access community resources; content of progress notes; completing progress notes within two business days; individualizing progress notes; and including required information in discharge summaries. The program was required to submit a Plan of Improvement to address these deficiencies.

Action Plan: Compliance will conduct a Plan of Improvement Follow-up Review in one hundred eighty (180) days.

19. Comprehensive Review Northwest and Southeast ACT/FACT: Compliance reviewed the following standards: *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §§301.353 (a-b), (d)(1)(C), (e)(1)(A-G), (e)(1)(H)(i-iii), (e)(2)(A-E), (f)(1)(A), (f)(1)(C), (f)(1)(D),* and *(h)(1-3); General Principles 25 TEX. ADMIN. CODE 415.5 (e); Documentation of Service Provision, 26 TEX. ADMIN. CODE §301.161(b)(1)(A), Evaluation and Diagnosis 25 TEX. ADMIN. CODE §415.6(c); Documentation of Informed Consent; 25 TEX. ADMIN. CODE §414.405(a-b); ACC.B.2 Plan of Care, Determination of Ability to Pay; 25 TEX. ADMIN. CODE §412.106 (a); ACT Operational Guidelines; Authorization for Mental Health Case Management 26 TEX. ADMIN. CODE §306.261(a)(1-3); Mental Health Case Management Employee Competencies 26 TEX. ADMIN. CODE §306.273 (a)(1)(A-D); HR.A.16 Organizational Development, Staff Training in Rights of Person Receiving Mental Health Services; 25 TEX. ADMIN. CODE §404.165(1)(2);* and *Documentation of Service Provision 26 TEX. ADMIN. CODE 301.361.* The program had an overall score of 96%. The program met and exceeded standards in the following areas: Documentation of the Recovery Plan, Documentation of Eligibility Screening and Assessment, Documented Psychiatric Evaluation, Quarterly Completion of Abnormal Involuntary Movement Scale (AIMS), Documentation of Skill Training and Development, Medication Training and Support Services, Documented Oral Communication of Rights of Persons served, Financial assessments in records, ACT/FACT Staff Members on Call 24 Hours, Organizational Development Job Specific Competency Training in staff record, Mental Health Employee Competencies competed in the record, New Employee Training on Rights of Person Receiving Mental Health Services, Licensed Nursing Personnel Training completed, Documentation of service Provision in Progress

Notes. The Program did not meet standards in the following areas: Documentation of Informed Medication Consent, Personal crisis/Safety Plan in the record, Team Leader Supervision of staff documented in Performance Pro, and Documentation of Annual Training and Refreshers. The program was required to submit a Plan of Improvement to address these deficiencies.

Action Plan: Compliance will conduct a POI Follow-up in one hundred eighty (180) days.

20. Comprehensive Review Youth Diversion Center: The review objective was to assess service documentation, facility posting requirements, infection control procedures, medication management standards, and staff training. Compliance reviewed the following standards *Health and Human Services Information Item V: Crisis Respite Standards* and *The Harris Center Policy ACC.B.2 Plan of Care, Guidelines for Personal Safety Plans.*
The program had an overall score of 88%. The program met and exceeded standards in the following areas: medication management requirement and coordination of services (i.e. crisis assessments and crisis plans of care). The program did not meet or exceed standards in the following areas: personal safety planning, unit orientation, signed medical consent, co-occurring substance use counseling, tuberculosis (TB) screening and reporting requirements, annual training requirements, and progress note documentation. The Program will continue its corrective actions implemented on April 23, 2023.

Action Plan: Compliance will review the Youth Diversion Center program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

21. Focus Review Psychiatric Emergency Services (PES) Program Physician Coding & Documentation: Compliance reviewed the following standards: *2023–2024 Centers for Medicare and Medicaid Services (CMS) Coding Regulations; Current Procedural Terminology (CPT) guidelines; 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines; Texas Administrative Code (TEX. ADMIN. CODE) Telemedicine and Telehealth Benefits and Limitations 1 TEX. ADMIN. CODE §354.1432; Purpose 26 TEX. ADMIN. CODE §510.1; Definitions 26 TEX. ADMIN. CODE §306.45; HHS Information Item V, Pages 2, 4,* and *31-33;* and *Agency Policy and Procedures MED.B.6 Telehealth & Telemedicine Procedure, EM.P.4 Corporate Compliance Documentation and Claims Integrity, GA.B.6 All Contracts,* and *LD.A.13 Code of Ethics Policy.* The Program had an overall Physician (Provider) score of 98%. The program met and exceeded standards in the following areas: Evidence of Overlap in Appointment Time, Evidence of copy and pasting/cloning within documentation, Evidence of Medically Appropriate History, Evidence of Medically Appropriate Examination, Appropriate Medical Decision Making (MDM) codes for service, Appropriate codes for Face to Face/Telehealth (TH) on date of service, Appropriate consent received for services rendered by QMHP, Appropriate services billed and documented bases on Assessment and Plan, and Evidence for authorized and approved codes for secondary services.

Action Plan: The Compliance Department will continue to complete monthly audits to ensure the program is adhering to the 2024 CMS/AMA coding guidelines as well as Agency Policy and Procedures (P&P), especially those pertaining to primary codes suitable for intake

assessments, crisis services, and evaluation and management (E/M) services. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder.

22. Focus Review Crisis Stabilization Unit (CSU) Program Physician Coding & Documentation: Compliance reviewed the following standards: *2023–2024 Centers for Medicare and Medicaid Services (CMS) Coding Regulations; Current Procedural Terminology (CPT) guidelines; 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines; Texas Administrative Code (TEX. ADMIN. CODE) Telemedicine and Telehealth Benefits and Limitations 1 TEX. ADMIN. CODE §354.1432; Purpose 26 TEX. ADMIN. CODE §510.1; Definitions 26 TEX. ADMIN. CODE §306.45; HHS Information Item V.: Pages 2, 4,* and *31-33;* and *Agency Policy and Procedures MED.B.6 Telehealth & Telemedicine Procedure, EM.P.4 Corporate Compliance Documentation and Claims Integrity, GA.B.6 All Contracts,* and *LD.A.13 Code of Ethics Policy.* The Program had an overall Physician (Provider) score of 88%. The program met and exceeded standards in the following areas: Evidence of Overlap in Appointment Time, Evidence of Medically Appropriate History, Evidence of Medically Appropriate Examination, Appropriate Medical Decision Making (MDM) codes for services, Appropriate codes for Face to Face/Telehealth (TH) on date of service, Appropriate consent received for services rendered by QMHP, and Evidence for authorized and approved codes for secondary services. Physician documentation did not meet expectations in the following areas: Evidence for copying and pasting/cloning within documentation and Appropriate services billed and documented based on Assessment and Plan.

    Action Plan: The Compliance Department will continue to complete monthly audits to ensure the program is adhering to the 2024 CMS/AMA coding guidelines as well as Agency Policy and Procedures (P&P), especially those pertaining to primary codes suitable for intake assessments, crisis services, and evaluation and management (E/M) services. Compliance will review documentation and Agency P&P in the next one hundred (180) days to ensure the program has implemented its POI. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder.

23. Comprehensive Review Harris Center Independent Living (IL): Compliance reviewed the following standards: Texas Administrative Code (TEX. ADMIN. CODE) *Protection of Clients and Staff—Mental Health Services 25 TEX. ADMIN. CODE Chapter 404, Standard of Care 25 TEX. ADMIN. CODE Chapter 448*, *IDD-BH Contractor Administrative Functions 26 TEX. ADMIN. CODE Chapter 301, Behavioral Health Delivery System 26 TEX. ADMIN. CODE Chapter 306*, the *Texas Health and Human Services Commission's Information Item V*, and Harris Center procedures *ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration of Mental Health Treatment; HIM.EHR. B.5 Content of Patient/Individual Record,* and *HIM.EHR.B.9 Patient/Individual Records Administration*. The program had an overall score of 80%. The program met and exceeded standards in the following area: Medical requirements. The program did not meet standards in the following

areas: Policy requirements, environment requirements, personnel requirements, and client record requirements. The program was required to submit a Plan of Improvement (POI) to address these deficiencies.

Action Plan: Compliance will conduct a POI Follow-up Review in one hundred eighty (180) days.

24. Comprehensive Review Optum Integrated Behavioral Health Home Care: Compliance reviewed the following standards*: Integrated Behavioral Health Home (IBHH) Incentive Agreement; Agency Procedures ACC.B.8 Referral, Transfer and Discharge* and *ACC.B.2 Plan of Care; Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361;* and *Organizational Development Required Employee Training HR.A.16*. The program had an overall score of 45%. The program met and exceeded standards in the following areas: Service Provision Documentation in Progress Notes. The Program did not meet standards in the following areas: Enrollment and Assessment, Administrative Review of staff records, Health Action Plan (HAP), Staff Training, and Personal Safety Plan. A Plan of Improvement is required to address the deficiencies noted.

    Action Plan: Compliance will conduct a POI Follow up review in one hundred eighty (180) days.

25. Focus Review Plan of Improvement (POI) Community Unit Probation Services (CUPS) Follow-up Review: The objective of the review was to ensure that the CUPS was implementing the corrective action steps identified from the POI review and were complying with the rules and regulations from the Texas Administrative Code (TEX. ADMIN. CODE) *Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §§301.353 (e)(1) (A,B,D)* and *(f)(1)(A); Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361(b);* and Agency P&P *ACC.B.2 Plan of Care*. The program had an overall score of 98%. The program met and exceeded standards in the following areas: Treatment Planning and Progress Note Documentation. The CUPS Program will not be required to submit a Plan of Improvement (POI).

    Action Plan: The Compliance Department will continue to complete audits to ensure the program is following the TEX. ADMIN. CODE, Agency P&P, and completing notes within two (2) business days.

26. Focus Review Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI Jr.) Follow-up Review: The review objective was to assess case plans/treatment plans. Compliance reviewed the following standards *Texas Department of Criminal Justice PGP 01.05 Revision 2: Program Guidelines and Processes for Juvenile Case Management* and *Texas Administrative Code (TEX. ADMIN. CODE) Provider Responsibilities for Treatment Planning and Service Administration 26 TEX. ADMIN. CODE §301.353 (e)(1) (A-H)* and *(e)(2) (A-E).* The program had an overall score of 98%. The program met and exceeded standards in the following areas: meeting all parole treatment plan requirements

and completing the initial case plan within seventy-two (72) hours of the person served enrollment. The program did not meet or exceed standards in the following areas: reviewing and updating probation case plans within twenty-one (21) to thirty-five (35) days of the previous plan development and providing the juvenile and family with a copy of the probation case plan within seven (7) business days. The Program will continue its corrective actions implemented on May 23, 2023.

Action Plan: Compliance will review the TCOOMMI Jr. program in the next one hundred eighty (180) days to ensure implementation of the Program's POI.

27. Comprehensive Review Substance Use Recovery Services Detoxification (DETOX): Compliance reviewed the following standards: *Admission Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TEX. ADMIN. CODE §§3.8007, Continued Stay Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TEX. ADMIN. CODE §§3.8008, Admission Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TEX. ADMIN. CODE §§3.8011, Continued Stay Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TEX. ADMIN. CODE §§3.8012, Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TEX. ADMIN. CODE §§ 404.161 (e)-(f), Communication of Rights to Individuals Receiving Mental Health Services 25 TEX. ADMIN. CODE §§ 404.163 (a)-(d),* and *Staff Training in Rights of Persons Receiving Mental Health Services 25 TEX. ADMIN. CODE § 404.165; Provider Responsibilities for Treatment Planning and Service Authorization 26 TEX. ADMIN. CODE §§ 301.353 (a)(e)(h), Documentation of Service Provision 26 TEX. ADMIN. CODE §§ 301.361 (a)-(b),* and *Supervision 26 TEX. ADMIN. CODE § 301.363 (a)(1); MH Case Management Services Standards 26 TEX. ADMIN. CODE § 306.263 (b),* and *Documenting MH Case Management Services 26 TEX. ADMIN. CODE § 306.275 (c); Chemical Dependency Treatment Facilities 26 TEX. ADMIN. CODE Chapter 564;* and *The Harris Center Policies and Procedures ACC.B.2 Plan of Care; ACC.B.8 Referral, Transfer, and Discharge; ACC.B.14 Declaration of Mental Health Treatment; HIM.EHR.B.5 Content of Patient/Individual Record; HIM.EHR.9 Patient/Individual Records Administration; MED.NUR.B.10 Supervision of Self Administration of Medication (SSAM);* and *required employee training courses*. The program had an overall score of 92%. The program met and exceeded standards in the following areas: policy requirements, medical requirements, and environment requirements. The program did not meet standards in the following areas: Personnel requirements and client record requirements. The program was required to submit a Plan of Improvement (POI) to address these deficiencies.

Action Plan: Compliance will conduct a POI Follow-up Review in one hundred eighty (180) days.

28. Focus Review Northwest Community Service Center (NWCSC): Compliance reviewed the following standards: *Provider Responsibilities for Treatment Planning and Service*

Authorization 26 TEX. ADMIN. CODE §301.353 (e)(2)(B), Case Management Services Standards 26 TEX. ADMIN. CODE §§306.263(b)(3) and *(b)(6)(15),* and *Documentation of Service Provision 26 TEX. ADMIN. CODE §301.361 (a)(14).* The Program had an overall score of 98%. The program met and exceeded the standards in the following areas: Plan of Care (specially addressed co-occurring Substance use), Case Management Services standards (Identify the strength, Service needs, and Assistance Required), and Documentation of Service Provision (Progress Notes reflect Persons served issues stated in the plan of Care). A POI is not required.

Action Plan: Compliance will continue to provide the necessary support to ensure the program maintains its high standard.

The following is a list of the external reviews (i.e., Governing Bodies, Managed Care Organizations (MCO), etc.) completed during the review period with involvement or oversight from Compliance:

1. The Office of Budget & Finances of the Houston Police Department conducted a desk review of The Harris Center's American Rescue Plan Act (ARPA) grants associated with Mobile Crisis Outreach Team (MCOT), Clinician and Officer Remote Evaluation (CORE), Crisis Intervention Response Team (CIRT) and Crisis Call Diversion (CCD) in FY 24 Qtr. 1
   Outcome: The Harris Center received the findings of this desk review on 11/20/2023. No programmatic or administrative matters requiring formal resolution were identified during the desk review.

2. Amerigroup CIOX Records Request 12/1/2023: CIOX was hired to complete a record Review of clients who received services from the Harris Center on behalf of Amerigroup. CIOX requested one (1) chart from MH clinic requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries.
   Outcome: Health and Information Management Release of Information (HIM ROI) submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

3. OSCAR CIOX Records Request 12/01/2023: CIOX, on behalf of OSCAR, conducted a Risk Adjustment review on 12/01/2023. Six (6) medical records for services rendered from January 1, 2023, through December 31, 2023, were requested. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; Pathology Reports; Progress Notes; Health Assessment Forms, Office notes, Emergency Department notes, Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where

applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

4. Community Health Choice 12/01/2024: Community Health Choice requested medical records of twelve (12) persons served receiving services from January 1, 2023, through December 31, 2023. The documentation requested for this chart review: Progress notes, History and physical, Consultation/specialist notes or letters, Operative and pathology notes, Procedure notes/reports, Physical, speech, and/or occupational therapist reports, Emergency department records, and Discharge summary. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

5. EPISOURCE Village/MD 12/05/2024: On behalf of Village MD, EPISOURCE completed a Medicare Risk Adjustment Review of a client receiving services from the Harris Center. EPISOURCE requested one (1) chart from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

6. Change Healthcare AMBETTER 12/06/2023: Risk Adjustment Records Request on behalf of Ambetter, Change HealthCare was hired to complete a Record Review of a client receiving services from the Harris Center. Change Health Care requested one (1) chart from the Mental Health (MH) clinic requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

7. Superior Behavioral Health Review of Mental Health Rehabilitation (MHR) and Mental Health Targeted Care Management (MHTCM) Q4 2023. The Harris Center Feedback 12/7/2023: Four (4) charts were reviewed in the following areas Assessment, Recovery Plan, Service Documentation, Adult, Child, and Adolescent. **Outcome:** Overall chart compliance was 99.17%, and overall claims compliance was 100%.

8. The Texas Health and Human Services Commission (HHSC) conducted a Quality Assurance complete review of the Early Childhood Intervention (ECI) on 12/12/2023.
   Outcome:

- **Requirements not Met:**
  - A review of the Individualized Family Service Plan (IFSP) occurs every six months or more frequently, if conditions warranted or if the family requested it. [34 CFR §303.342; 26 TAC §350.1004(f); 26 TAC §350.1017]
  - Annual meeting to evaluate the IFSP must be conducted on at least an annual basis to evaluate and revise, as appropriate, the IFSP for a child and the child's family, and documentation meets the requirements for complete review. [CFR 303.342(c), 26 TAC 350.1019, 26 TAC §350.1307]
  - Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]
  - TKIDS Data Entry was not current.
  - The Eligibility Statement documents the child eligibility decisions of the IDT and reflects supporting documentation. [34 CFR §303.321; 26 TAC §350.811; 26 TAC §350.817]
  - Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]
  - Services are delivered within 28 days of the parental signature on the IFSP. [ECI Contract Section 6.5.4 Federal Indicators]
  - Case management services provided include assisting the family in identifying available services and making referrals to address identified needs and achieve goals specified in the IFSP. [34 CFR §303.34 (b)(2)(5); 26 TAC §350.405(a)(3)]
  - Case management services include following up with the family to assist the child with timely access to services and to determine if services have met the child's identified needs. [34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9)]
  - Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]
  - Services are delivered within 28 days of the parental signature on the IFSP. [ECI Contract Section 6.5.4 Federal Indicators]
  - Case management services provided include assisting the family in identifying available services and making referrals to address identified needs and achieve goals specified in the IFSP. [34 CFR §303.34 (b)(2)(5); 26 TAC §350.405(a)(3)]

- Case management services include following up with the family to assist the child with timely access to services and to determine if services have met the child's identified needs. [34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9)]

- Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]

9. United Healthcare Optum 12/13/2023: Optum HEDIS requested Six (6) medical records of members who may have had a follow-up visit post hospitalization for mental illness. The documentation requested for the review: Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Cervical Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1C Control for Patients with Diabetes, Prenatal and Postpartum Care, Childhood and Immunization Status, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children\ Adolescents, Care for Older Adults and Transitions of Care where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received..

10. AETNA EPISOURCE 12/13/2024: On behalf of Aetna, EPISOURCE was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. EPISOURCE requested two (2) charts from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

11. OSCAR CIOX Request 12/14/2023: CIOX, on behalf of OSCAR, conducted a Risk Adjustment review. CIOX requested seventy-one (71) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

12. Witt O'Brien's Monitoring Summary including any Quality Improvement Plan Recommendations for the American Rescue Plan Expenditures for Harris County Office of County Administration, Community COVID Housing Program (CCHP) 2.1 –Permanent Supportive Housing Phase 2. 12/14/2023. For programmatic review, the Witt O' Brien's monitoring team was assigned fifty-one (51) beneficiary records to review in the Homeless Management Information System (HMIS) for Harris Center for Mental Health and IDD.

    Outcome:
    Witt O' Brien's recommended the following actions and recommendations. *Programmatic Accuracy/ Beneficiary Review*

    - The executed agreement between Harris County, Office of County Administration (for the CCHP 2.0 Supportive Housing Project), and Harris Center for Mental Health and IDD states, among other things, that demographics should be tracked for program beneficiaries, referrals should go through the Continuum of Care process, participants should meet definition of homelessness as defined in 24 CFR 576.24, and participants should be impacted by COVID.

    - Harris Center's scope of services is to provide mental health services to at least 300 individuals to help them preserve their housing. They have far exceeded their services goal based on their KPI reporting. Witt O'Brien's recommends that the Community Services Department and the Harris Center examine the 595 beneficiaries that have been served to date and identify how many have maintained their housing since receiving mental health services.

13. AMBETTER Change Healthcare 12/20/2023: On behalf of Ambetter, Change HealthCare was hired to complete a Record Review of a client receiving services from the Harris Center. Change Health Care requested one hundred twenty-one (121) records from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

14. WellCare CIOX 12/21/2023: On behalf of WellCare, CIOX was hired to complete a Record Review of a client receiving services from the Harris Center. CIOX requested one (1) chart from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was

received upon completion of the medical records. No further communication has been received.

15. United Healthcare 12/21/2023: Record requests for clients receiving services from the Harris Center. One (1) chart from MH clinics requesting specific member medical records for all applicable records that support services rendered. The documentation requested for the review: Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Cervical Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1C Control for Patients with Diabetes, Prenatal and Postpartum Care, Childhood and Immunization Status, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children\ Adolescents, Care for Older Adults and Transitions of Care where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

16. United Healthcare 12/21/2023: The Texas Medicaid and CHIP External Quality Review Organization (EQRO) performed a biennial comparison of encounter data to member medical records. The EQRO requested the record for one (1) person to match 2022 medical records to encounters. **Outcome: HIM** ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

17. Community Health Choice 1/03/2024: Community Health Choice conducted a medical chart review for one (1) requested member's medical records for services rendered. The documentation requested for this chart review: Progress notes/office notes; history and Physical and Exams; consultation reports; Operative and pathology notes; procedure notes/reports; physical, speech, and/or occupational therapist reports; emergency department records; and Discharge summary where applicable. **Outcome: HIM** ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

18. YES Waiver: The Centers for Medicare and Medicaid Services, the Health and Human Services Commission (HHSC) completed the annual review of the Youth Empowerment Services (YES) Waiver program of The Harris Center for Mental Health and IDD on 12/5/2023.

    Outcome: HHSC staff reviewed clinical and administrative records and provided technical assistance regarding the YES program.

    Positives:

    - Improvement in these areas:
        - Wraparound Plans include at least one needs statement for the youth and one for the family member. Improvement in this area increased by 10%.

- Wraparound Plan includes outcome statements, strategies and/or tasks addressing the actionable items (score of 2 or 3) identified on the CANS/Clinical Eligibility. Improvement in this area increased by 10%.
- Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Child and Family Team Meeting to reflect progress or lack or progress in all areas. Improvement in this area increased by 10%.
- Waiver participants whose services are delivered according to the duration specified in their Wraparound Plans. Improvement in this area increased by 40%.
- Waiver participants whose services are delivered according to the location specified in their Wraparound Plans. Improvement in this area increased by 40%.

- All provider qualifications and trainings were current.

Concerns and Areas for Improvement:

- Ensure individual receives a face-to-face intake assessment/Clinical Eligibility within 7 business days of the initial demographic eligibility determination contact. Applicants on the YES waiver inquiry list are offered an assessment for eligibility on a first-come first-served basis by LMHAs or LBHAs.
- Ensure Waiver participant and LAR has a face-to-face meeting with Facilitator within 7 business days of CE approval.
- Ensure Waiver participant receives services according to the type, scope, and amount specified in their Wraparound Plans.
- Ensure Waiver participants whose services are delivered according to the frequency specified in their Wraparound Plans.
- Ensure Waiver participants whose services are delivered according to the duration specified in their Wraparound Plans.
- Ensure Waiver participants whose services are delivered according to the location specified in their Wraparound Plans.
- Corrective Action Plan (CAP) addressing concerns was due February 5, 2024

19. The Harris Center for Mental Health and IDD HQ License No. 45554 Satellite Dacoma Closure Letter 1/04/2024: Health and Human Services Commission (HHSC) Corrective Action response to the Notice of Findings regarding August 11, 2023, inspection of the licensed facility in Houston (HQ license no. 4554 satellite-Dacoma). **Outcome:** The deficiencies noted in the Notice of Findings have been corrected, and no further documentation of this inspection is required.

20. Change Healthcare Blue Cross Blue Shield of Texas (BCBSTX) Medical Records Request 1/08/2024: BCBSTX performed a Risk Adjustment Review. The medical records for forty-four (44) individuals were requested for services rendered. The documents requested include Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Summaries, Consult, and Pathology Summaries and Reports Transfers, Emergency and Urgent Care Reports, Consultation Reports, and Post-operative

Notes, Anesthesia Notes/Reports and Cadia Cath. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

21. Change Healthcare Ambetter Health Care Medical Record Request 1/11/2024 performed a Risk Adjustment Review. The medical records for one (1) individual were requested for services rendered. The documents requested include Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Records, Consult and Pathology Summaries and Reports, Surgical Procedures and operating summaries, Subjective and objective Assessments, Plus Plan Notes, Diagnostic Testing, including, but not limited to Diagnostic Testing Reports (EKG, Stress Test, Holter Monitors, Doppler Studies), Interventional Radiation (MRI, Catheter, Angiography, Etc.), and Neurology (EEG, EMG, Nerve Conduction Studies, Sleep Studies), Emergency and Urgent Care Reports, Consultation Reports, Special Notes, Procedure Notes/Reports and Valid Signature with Credentials where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

22. Change Healthcare Blue Cross Blue Shield of Texas (BCBSTX)1/11/2024: Change Healthcare performed a Risk Adjustment Review. The medical records for twenty (20) individuals were requested for services rendered. The documents requested include Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Summaries, Consult, and Pathology Summaries and Reports Transfers, Emergency and Urgent Care Reports, Consultation Reports, and Post-operative Notes, Anesthesia Notes/Reports and Cadia Cath where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

23. Change Healthcare Ambetter Health Care Medical Records Request 1/17/2024: Change Healthcare performed a Risk Adjustment Review. The medical records for nineteen (19) individuals were requested for services rendered. The documents requested included Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Records, Consult and Pathology Summaries and Reports, Surgical Procedures and operating summaries, Subjective and objective Assessments, Plus Plan Notes, Diagnostic Testing, including, but not limited to Diagnostic Testing Reports (EKG, Stress Test, Holter Monitors, Doppler Studies), Interventional Radiation (MRI, Catheter, Angiography, Etc.), and Neurology (EEG, EMG, Nerve Conduction Studies, Sleep Studies), Emergency and Urgent Care Reports, Consultation Reports, Special Notes, Procedure Notes/Reports and Valid Signature with Credentials where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

24. CIOX Ambetter Health Care Medical Records Request 1/24/2024: CIOX conducted a Risk Assessment Review. The medical records for two (2) members were requested for services rendered. Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Records, Consult and Pathology Summaries and Reports, Surgical Procedures and operating summaries, Subjective and objective Assessments, Plus Plan Notes, and Diagnostic Testing, including, but not limited to Diagnostic Testing Reports (EKG, Stress Test, Holter Monitors, Doppler Studies), Interventional Radiation (MRI, Catheter, Angiography, Etc.), and Neurology (EEG, EMG, Nerve Conduction Studies, Sleep Studies), Emergency and Urgent Care Reports, Consultation Reports, Special Notes, Procedure Notes/Reports and Valid Signature with Credentials where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

25. United Healthcare/Advantmed Urgent Request for Medical Records 1/30/2024: United Healthcare conducted a HEDIS Review. The medical records for two (2) members were requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

26. Molina Healthcare Medical Records Request 1/31/2024: Molina Healthcare performed a Risk adjustment and CMS Validation and Quality Reporting Review. The Medical records for twenty-seven (27) individuals were requested for services rendered. The documents requested include medical records. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

27. Change Healthcare Ambetter Healthcare Medical Records Request 2/02/2024: Change Healthcare performed a Risk Adjustment Review. The medical records for one (1) individual were requested for services rendered. The documents requested include Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Records, Consult and Pathology Summaries and Reports, Surgical Procedures and operating summaries, Subjective and objective Assessments, Plus Plan Notes, Diagnostic Testing, including, but not limited to Diagnostic Testing Reports (EKG, Stress Test, Holter Monitors,

Doppler Studies), Interventional Radiation (MRI, Catheter, Angiography, Etc.), and Neurology (EEG, EMG, Nerve Conduction Studies, Sleep Studies), Emergency and Urgent Care Reports, Consultation Reports, Special Notes, Procedure Notes/Reports and Valid Signature with Credentials where applicable . **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

28. Episource Aetna Medical Record Request 2/02/2024. Aetna performed a Commercial Risk Adjustment Review. The medical records for one (1) individual were requested for services rendered. The documentation requested are Demographic/Face sheet, Progress Notes, Consult Notes, Hospital records, History & Physical Reports, Pathology Reports, Diagnostics, Medication & Problem List and Past Medical History where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

29. ECI: Contract # HHS000640200031 was reviewed for compliance with federal, state, and Health and Human Services Commission Early Childhood Intervention (HHS/ECI) regulations. The review included: 1)The effectiveness of the organization's programs, activities, or functions; 2) Whether the organization has complied with laws and regulations applicable to the program; 3)Whether the organization corrected all the individual child findings from the comprehensive review conducted in January 2023; 4) Verification of the implementation of ECI's corrective action; and 5)Review of child and administrative records to clear systemic level findings from the January 2023 comprehensive monitoring review.

    Outcome: The following items were not compliant with all applicable rules and regulations: Program Review Of the 20 client records reviewed, compliance requirements were not met for the area(s) identified below:

    - Finding #1: Pre-Enrollment and Procedural Safeguards: Evaluation, Eligibility and Assessment: Eligibility Determinations Records were reviewed to determine if eligibility determination was appropriate and consistent. Five requirements were reviewed for each record with 1% of procedures noted as out of compliance.

    - Finding #2: IFSP: Reviews and Revisions: Records were reviewed to determine if the IFSP was reviewed periodically to determine progress toward achieving outcomes and changes needed to service in the IFSP. Four requirements were reviewed for each record with 4% of procedures noted as out of compliance.

    - Finding #3: Services and Case Management: Services Provided Records were reviewed to determine if services provided met requirements and were delivered in accordance with the IFSP. Six requirements were reviewed for each record with 12% of procedures noted as out of compliance.

- Finding #4: Verification of TKIDS Data Accuracy Records were reviewed to verify that data entered in TKIDS accurately reflected data in the child's record. Data reviewed consisted of demographic data, child outcomes data, IFSP data and transition data. A total of 244 TKIDS data entry items were reviewed from all client records with 1% noted as out of compliance.

- Corrective Action: Noncompliance was less than 10%. Since noncompliance is less than 10%, it is not systemic; therefore, no written corrective action plan is required. All individual child findings must be corrected and/or cleared.

30. BlueCross BlueShield Request for Medical Records 2/08/2024: Blue Cross and Blue Shield of Texas requested one (1) individual medical record. The documentation required for this review included colorectal screening, consultations, Cologuard, FOBT, Colonoscopy, CT colonography, and Flexible Sigmoidoscopy where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

31. OIG Record Request Letter 2/07/2024: The Investigations and Utilization Reviews (I&UR) section of the Office of Inspector General (OIG), a division of the Texas Health and Human Services (Texas HHS), is conducted an investigation of certain claims paid by the Medicaid program and submitted by or on behalf of The Harris Center for Mental Health and IDD. The medical records for eight (8) individuals were requested for services rendered. The documentation requested for this review were complete Complaint Logs, Incident reports, a Complete roster of all owners and employees (current and former), their credentials, job titles, functions/duties, date of hire and/or termination, professional license, home address, home phone number, salary, and bonus or incentives and any owner or employees received for dates of service: June 1, 2019, through May 31, 2023023, The Audit also consisted of Staff interviews **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

32. YES Waiver Harris CAP Follow-up: **Outcome: HHSC** received the Corrective Action Plan (CAP) to address areas of non-compliance discovered during the Quality Management Review on December 15, 2023. HHSC determined that the CAP sufficiently addresses all required elements. As outlined in the plan, you will implement the corrective action on or before February 12, 2024.

33. Molina Medical Record Review Request 2/09/2024: Molina performed a Risk Adjustment Review. The medical charts for fourteen (14) individuals were requested for services rendered. The documentation requested for this review includes Controlling High Blood Pressure, Care of Older Adults, Colorectal Cancer Screening, Immunizations for Adolescents, Lead Screening in Children, and Transition of Care where applicable.

Outcome: HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

34. Episource: Aetna Medical Records Request 2/12/2024: Aetna conducted a Risk Adjustment review. Medical records for eleven (11) individuals were requested. The documentation requested for this review is Demographic/Face Sheet, Progress Notes, Consult Notes, Hospital Records, History & Physical Reports, Pathology Reports, Diagnostics, Medication and Problem List, and Past Medical History where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

35. United Health Care CIOX Records Request 02/13/2024: CIOX, on behalf of United Health Care, will conduct a Risk Adjustment review. The medical record for one (1) requested individual's medical records for services rendered. The documentation requested for this chart review: Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes/Reports, Physical, Speech and/or Occupational Therapist Reports, Emergency Department Reports and Discharge Summary where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

36. Episource: Aetna Medical Record Request 2/13/2024: Aetna performed a commercial Risk Adjustment Review. The medical records for sixty-six (66) individuals were requested for services rendered. The documentation requested for this review were Demographic/Face Sheet, Progress Notes, Consult Notes, Hospital Records, History & Physical Reports, Pathology Reports, Diagnostics, Medication and Problem List and Past Medical History where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

37. MHMR of Harris County Determination Letter 2/15/2024: The Texas Health and Human Services (HHS) Early Childhood Intervention (ECI) program is required under Section 616 of the Individuals with Disabilities Education Act to make annual determinations on the performance of local ECI programs. States must assign one of the following three determinations; 1) Meets the Requirements of Part C; 2) Needs Assistance to Meet the Requirements of Part C; or 3) Needs Intervention to Meet the Requirements of Part C.

    Outcome: The Texas Health and Human Services (HHS) Early Childhood Intervention (ECI) has determined that the Harris Center for Mental Health and IDD needs assistance to meet the requirements of part C. This means that ECI performance is below the statewide average, considering all indicators across the network of Texas ECI providers. Based on this determination, ECI will be asked to provide an update during your quarterly calls on the indicators.

38. Molina Medical Record Request 2/16/2024: Molina conducted a Risk Adjustment Review. The medical records for two (2) individuals were requested for services rendered. The Document requested for this chart review is Controlling High Blood Pressure and Colorectal Cancer Screening where applicable. **Outcome:** The requested documentation was submitted by HIM ROI, and a confirmation receipt upon completion. No further communication has been received The Harris Center received an 85% on this review.

39. CIOX Oscar Risk Adjustment Review 2/16/2024: CIOX conducted a Risk Assessment Review. Patient demographic Sheets, History and Physical Records, Progress Notes and Consultations, Discharge Records, Consult and Pathology Summaries and Reports, Surgical Procedures and operating summaries, Subjective and objective Assessments, Plus Plan Notes, and Diagnostic Testing, including, but not limited to Diagnostic Testing Reports (EKG, Stress Test, Holter Monitors, Doppler Studies), Interventional Radiation (MRI, Catheter, Angiography, Etc.), and Neurology (EEG, EMG, Nerve Conduction Studies, Sleep Studies), Emergency and Urgent Care Reports, Consultation Reports, Special Notes, Procedure Notes/Reports and Valid Signature with Credentials where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

40. Wellpoint Record Request 2/21/2024: The medical record for one (1) member was requested for services rendered. The documentation requested for the review: Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Cervical Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1C Control for Patients with Diabetes, Prenatal and Postpartum Care, Childhood and Immunization Status, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children\ Adolescents, Care for Older Adults and Transitions of Care where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

41. Oscar CIOX Records Request 02/22/2024: CIOX, on behalf of OSCAR, conducted a Risk Adjustment review. The medical charts for nineteen (19) requested members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy, History & Physical notes, Consult Notes, Pathology Reports, Progress Notes. Health Assessment Forms, Office notes, Emergency Department notes, Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

42. Episource Aetna 3/05/2024: On behalf of Aetna, Episource was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. Episource requested one (1) chart from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

43. Wellpoint Amerigroup STAR PLUS MMP 3/05/20243: Wellpoint on behalf of Amerigroup conducted annual HEDIS review requested two (2) medical records of members who may have had a follow-up visit post hospitalization for mental illness. The documentation requested for the review: Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Cervical Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1C Control for Patients with Diabetes, Prenatal and Postpartum Care, Childhood and Immunization Status, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children\ Adolescents, Care for Older Adults and Transitions of Care where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

44. Molina Healthcare 3/05/2024 conducted a Behavioral Health Medical Record Review Project requested thirty (30) records. Molina Healthcare requested specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

45. CIOX Oscar Medical Records Request 3/07/2024: CIOX, on behalf of Oscar, conducted a Risk Adjustment review. CIOX requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

46. COMPLEXCARE Texas Children Health Plan 3/11/2024 1/30/2024: conducted a HEDIS Review. The medical records for two (2) members were requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

47. Center for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement Program (PERM) 3/13/2024 One (1) record requested. CMS performed a medical records compliance review for the patient date of service outlined in the attached letter. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

48. CIOX Oscar Medical Records Request 3/13/2024: CIOX, on behalf of Oscar, conducted a Risk Adjustment review. CIOX requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

49. CIOX Oscar Medical Records Request 3/13/2024: CIOX, on behalf of Oscar, conducted a Risk Adjustment review. CIOX requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency

Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

50. CIOX Superior Health Plan Medical Records Request 3/14/2024: CIOX, on behalf of Superior Health Plan, conducted a Risk Adjustment review. CIOX requested one (1) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

51. CIOX Oscar Risk Adjustment Medical Records Request 3/14/2024: CIOX, on behalf of Oscar, conducted a Risk Adjustment review. CIOX requested one (1) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

52. Be Well Texas MAT AUD (M-SUD) Entrance Conference Announcement 3/19/2024. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

53. Episource Optum Blue Cross Blue Shield of Texas Medical Records request 3/22/2024 one (1) record was requested for medical record review of the following documentation

Demographic/Face Sheet, Operative Reports, History & Physical, Procedure Reports, Consult Notes, Problem List, Progress Notes, and Signature Log where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

54. Molina 2nd Medical Record Request 3/22/2024: Molina conducted a Risk Adjustment Review. The medical records for two (2) individuals were requested for services rendered. The Documents requested for this chart review requested specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

55. Blue Cross Blue Shield of Texas Medical Records request 3/22/2024 one (1) record was requested for medical record review of the following documentation Demographic/Face Sheet, Operative Reports, History & Physical, Procedure Reports, Consult Notes, Problem List, Progress Notes, and Signature Log where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

56. CIOX Ambetter Health Medical Records Request 3/26/2024 The medical record for one (1) individual was requested for services rendered. The Documents requested for this chart review included specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech, and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

57. Advantmed United Healthcare 4/01/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested included the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results

where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

58. Advantmed United Healthcare 4/01/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable . **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

59. Advantmed United Healthcare 4/03/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

60. Episource Aetna 4/04/2024: On behalf of Aetna, Episource was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. Episource requested one (1) chart from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested

documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

61. CIOX Oscar Medical Records Request 4/08/2024: CIOX, on behalf of Oscar, conducted a Risk Adjustment review. CIOX requested ten (10) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

62. KDJ Consultant Community Health Choice 4/09/2024 KDJ on behalf of Community Health Choice HEDIS requested one (1) medical record of member who may have had a follow-up visit post hospitalization for mental illness. The documentation requested for the review: Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Cervical Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1C Control for Patients with Diabetes, Prenatal and Postpartum Care, Childhood and Immunization Status, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children\ Adolescents, Care for Older Adults and Transitions of Care where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

63. Advantmed Blue Cross Blue Shield of Texas 4/09/2024 Advantmed on behalf of Blue Cross Blue Shield conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested included the Member Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, consults, vitals flowchart, Telehealth visit notes, Referrals, Demographic Sheet, Progress notes, Health Maintenance and Telephone logs. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

64. Texas Health and Human Services Commission (HHSC) Applewhite 4/09/2024 conducted a Life Safety Code non-onsite follow-up to determine if your facility complied with state licensure requirements and federal participation requirements for ICF-IID facilities in the Medicare or Medicaid programs. The survey found that that your facility met state licensure requirements and is in substantial compliance with federal participation requirements.

65. Advantmed United Healthcare 4/15/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings from 1/1/2023 to 12/31/2023, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

66. Advantmed United Healthcare 4/18/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested included the Member Hemoglobin A1C (HbA1c), Labs, Demographic, Consults, Diabetic Flow Records, Referrals, and Progress notes where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

67. Advantmed United Healthcare 4/19/2024 United Healthcare conducted a HEDIS Review. The medical record for one (1) member was requested for services rendered. The documents requested included the Colorectal Cancer Screening, Consults, Demographic Sheet, Consultations, FIT-DNA, Colectomy, Health Maintenance, FOST, Colonoscopy, CT Colonography, Flexible Sigmoidoscopy where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

68. Texas Health and Human Services Commission (HHSC) Statement of Licensing Violations and Plan of Correction. Westbury House ICF/IID Plan of Correction 4/21/2024 A Plan of Correction was submitted in response to deficiencies identified during a survey conducted on 3/28/2024.

69. Be Well Texas MAT AUD (M-SUD) Exit Conference Announcement 4/23/2024 **Outcome:** June 2023 (FY23): Spend down not properly managed. Repeat Finding – Out of compliance as of FY2024

70. Superior Health Plan HEIDIS Medical Records Request 4/25/2024. Superior Health Plan conducted a HEDIS Review. The medical record for one (1) member was requested for

services rendered from 1/1/2023 to 12/31/2023 The documents requested include the Member Demographic Sheet: Name and Date of Birth, all Blood Pressure Readings, Cervical Cancer Screening, Child Immunization status, Medication List, Colorectal Cancer Screening, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HbA1c), Developmental Screening (First three years of Life, second and third Years of Life), Eye Exam for People with Diabetes, Immunization for Adolescents, Lead Screening in children, Perinatal depression screening, Prenatal Screening for Smoking and Treatment Discussion during Prenatal visit, Prenatal, Prenatal and Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Progress Notes, History and Physical, Consult/Specialist Notes or Letters, Operative Notes, Procedures Notes, Reports, Vital Signs and Lab results where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

71. Episource Aetna 5/01/2024: On behalf of Aetna, Episource was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. Episource requested one (1) chart from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

72. Episource Aetna 5/02/2024: On behalf of Aetna, Episource was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. Episource requested thirty-two (32) charts from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

73. Episource Aetna 5/02/2024: On behalf of Aetna, Episource was hired to complete a Medical Record Request Commercial Risk Adjustment Review of a client receiving services from the Harris Center. Episource requested twenty-six (26) charts from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

74. Datavant Oscar Notice of Outstanding Medical Records Request 5/09/2024: Datavant, on behalf of OSCAR, conducted a Risk Adjustment review. Datavant requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

75. Datavant Oscar Notice of Outstanding Medical Records Request 5/09/2024: Datavant, on behalf of OSCAR, conducted a Risk Adjustment review. Datavant requested one (1) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

76. Superior Health Plan Ambetter Medical Records Request 5/10/2024: Superior Health Plan, on behalf of Ambetter, conducted a Risk Adjustment review. Superior Health Plan requested two (2) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

77. SE Optum RX Preliminary Audit 5/13/2024 Conducted an overall fraud, waste, and abuse audit of the SE Clinic Pharmacy of The Harris Center for Mental Health and IDD. **Outcome:** no overpayment detected.

78. Texas Health and Human Services Commission (HHSC) Westbury House 5/14/2024 conducted a Life Safety Code non-onsite follow-up to determine if your facility complies with state licensure requirements and federal participation requirements for ICF-IID facilities in the Medicare or Medicaid programs. **Outcome:** The survey found that that The Harris Center's Westbury House met state licensure requirements and is in substantial compliance with federal participation requirements.

79. Datavant Cigna Medical Records Request 5/24/2024: Datavant, on behalf of Cigna, conducted a Risk Adjustment review. Datavant requested twelve (12) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

80. Datavant United Health Medical Records Request 5/29/2024: Datavant, on behalf of United Health, conducted a Risk Adjustment review. Datavant requested one (1) records of members' medical records for services rendered. The documentation requested for this chart review: Demographic/Face Sheet, Physical, Occupational, and other Therapy; history & Physical notes; consult Notes; pathology Reports; Progress Notes; Health Assessment Forms; Office notes; Emergency Department notes; Operative Reports/ Procedure Notes, Radiology Reports/ Mammogram Reports, Signature Log, Skilled Nursing Facility (SNF) encounters, Problem list/ Medication List, Labs/Laboratory Reports, Chemo/Radiation Reports and Consultation Correspondence (Inpatient and Encounters Outpatient), Admission/Discharge Summaries for Hospital and SNF facilities where applicable. **Outcome:** HIM ROI submitted the requested documentation, and a confirmation receipt was received upon completion of the medical records. No further communication has been received.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of MH Division

X Melissa M. Hill PM 5/5/24

Program Director/Manager

X Demetria Luckett

Director of Compliance

The HARRIS CENTER for Mental Health and IDD

Compliance recommends that the SWCSC program review the findings and continue to assess its processes with TAC. The program should continue to implement its corrective action steps from the previous POI and collaborate with Performance Improvement (PI) to assist with completing Psychoactive Medication documentation. A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven business (7) days by the close of business, January 8, 2023.

Management Response

The HARRIS CENTER for Mental Health and IDD

Compliance Department Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Southwest Community Service Center (SWCSC) Psychoactive Medication Documentation
Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Emmanuel Golakai

Review Period: December 5, 2023, to December 6, 2023

Purpose

Compliance conducted a POI follow-up review to determine if the program has implemented its corrective action steps for completing Psychoactive Medication Documentation pertaining to the issues cited in the November 9-14, 2022, Compliance review.

Method

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) service entries using the MH Medication Consent Review Tool, focusing on the previous POI.

Findings

Detailed findings are presented below.

Item (Reference)	Score
• Medication Consent ***TAC (414.405(a-b) (2))***	92%
• Abnormal Involuntary Movement Scale (AIMS) ***TAC (415.10(e)***	92%

Observations

- SWCSC made improvements in the quarterly update of the AIMS.
- SWCSC findings remain the same as the previous review conducted November 9-14, 2022.

History

The Compliance Department conducted a Medication Consent review of the Southwest CSC program during the 1st quarter (Qtr.) of the fiscal year (FY) 2022 for services completed during 1st quarter from (November 9, 2022- 30, 2022), sampling thirty (30) records.

Recommendations

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Northeast Community Service Center (NECSC) Psychoactive Medication Documentation
Plan of Improvement (POI) Follow-up Review
Review Date: December 6, 2023, to December 7, 2023

I. Audit Type:
POI Follow-up Review

II. Purpose:
Compliance conducted a POI follow-up review to determine if the program has implemented its corrective action steps for completing Psychoactive Medication Documentation pertaining to the issues cited in the November 10-15, 2022, Compliance review.

III. Audit Method:
Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) service entries using the MH Psychoactive Medication Consent Review Tool, focusing on the previous POI.

IV. Audit Findings and History:
The NECSC program scored 100% on the Recovery Plan,67% on the Abnormal Involuntary Movement Scale (AIMS), and 67% on Medication Consent. The NECSC program made improvements in updating the Recovery Plan since the review on November 10-15, 2022. The NECSC program had medication Consent in the Electronic Health Record (EHR) that was not signed. A signed Medication Consent form would have cleared all the findings. The Compliance Department conducted a review of the NECSC program in the first (1st) of Fiscal Year (FY) 2023 for services completed during 1st quarter FFY2023 (September 1, 2022- November 9, 2023, sampling 30 records.

V. Recommendations:
Compliance recommends that the NECSC program review the findings and continue to assess its processes with TAC guidelines. The program should implement its POI and continue to collaborate with Performance Improvement (PI) to assist with completing psychoactive medication documentation. A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report. The signed report and Management response must be returned to Compliance within seven (7) days by the close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Northeast Community Service Center (NECSC) Psychoactive Medication Documentation
Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Emmanuel Golakai

Review Period: December 6, 2023, to December 7, 2023

Purpose

Compliance conducted a POI follow-up review to determine if the program has implemented its corrective action steps for completing Psychoactive Medication Documentation pertaining to the issues cited in the November 10-15, 2022, Compliance review.

Method

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) service entries using the MH Psychoactive Medication Consent Review Tool, focusing on the previous POI.

Findings

Detailed findings are presented below.

Item (Reference)	Score
• Recovery Plan ***TAC 415.5(e)***	100%
• Abnormal Involuntary Movement Scale (AIMS) ***TAC (415.10(e)***	67%
• Medication Consent **TAC 414.405(a-b) (2)**	67%

Observations

- NECSC made improvements in updating the recovery plan since the previous review on November 10-15, 2022.
- NECSC had Medication Consents in the Electronic Health Record (EHR), that were not signed. A signed Medication consent form would have cleared all the findings.

History

The Compliance Department conducted a Medication Consent review of the NECSC program during the 1st quarter (Qtr.) of the fiscal year (FY) 2023 for services completed during 1st quarter from FY 2023 (September 1, 2022- November 9, 2022), sampling thirty (30) records.

Recommendations

Compliance recommends that the NECSC program review the findings and continue to assess its processes with TAC. The program should continue to implement its corrective action steps from the previous POI and collaborate with Performance Improvement (PI) to assist with completing Psychoactive Medication documentation. A management response and a signature are required by the Vice President of the MH Division and Program Director/Manager. The signed report with management response and POI should be returned to Compliance within seven (7) business days by the close of business, January 8, 2024.

Management Response

NE Clinic Practice Manager has reviewed and agrees with the findings of this program review. While the results indicate progress from past reviews, it also is clear that additional improvement should be worked towards. To this end the unit will continue to implement the previous plan of improvement as it has produced improved results. Additionally the PI department has been consulted and is working on multiple options to support continued improvement, including improved collaboration between nursing and psychiatry and implementation of additional technology. Specifically IT has been consulted by PI and is implementing multiple computer solutions to support better ability to complete consents. Results will continue to be monitored by PM.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

Recoverable Signature

X Jeff Lovell

Program Director/Manager
Signed by: Jeff Lovell

X

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Projects for Assistance in Transition from Homelessness Plan of Improvement (POI) Follow-up Review
Review Dates: December 8, 2023-December 15, 2023

I. Audit Type:
POI Follow-up Review

II. Purpose:
The review was conducted to determine if the PATH program was compliant with the POI submitted during the 3rd Qtr. FY 2023 concerning Texas Administrative Code (TAC) requirements for case management (TAC §301.361 (b), §306.263 (b)(1-13), and agency policy and procedure) and nursing documentation (TAC §217.11 (D) (i-vi), Health and Human Services (HHS) Nurse Standards, and agency policy and procedure.)

III. Audit Method:
A random sample of 23 client records was selected using an Excel formula to identify records randomly to review case management documentation and nursing documentation. The review examined documentation entered into the electronic health record (EHR) during the first quarter of fiscal year 2024 (September 1, 2023-November 30, 2023). The review utilized a modified version of the Compliance Department's Documentation Audit Tool so that only relevant sections were present.

IV. Audit Findings/History:
Compliance noted that the program was not documenting client responses to nursing services, was not contacting other healthcare team members concerning significant events regarding the client's status, and was not documenting client outcomes. Compliance previously conducted a review of the PATH Program during the 2nd Qtr. of FY 2023.

V. Recommendations:
The Program should continue to review documentation for compliance with TAC and HHS Nursing Standards requirements. The program is not required to submit a POI but should contact Performance Improvement to assist with program processes and program leadership should ensure regular training is provided to staff so that documentation meets the standards outlined in TAC, HHS Standards, and agency policies and procedures.

HARRIS CENTER
Mental Health and IDD

Compliance Department Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP)
Projects for Assistance in Transition from Homelessness (PATH) Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Dates: December 8, 2023-December 15, 2023

Purpose

This review was conducted to determine if the PATH program was compliant with the POI submitted during the 3rd Qtr. FY 2023 concerning Texas Administrative Code (TAC) requirements for case management (TAC §301.361 (b), §306.263 (b)(1-13), and agency policy and procedure) and nursing documentation (TAC §217.11 (D) (i-vi), Health and Human Services (HHS) Nurse Standards, and agency policy and procedure.)

Method

A random sample of 23 client records was selected using an Excel formula to identify records randomly to review case management documentation and nursing documentation. The review examined documentation entered into the electronic health record (EHR) during the first quarter of fiscal year 2024 (September 1, 2023-November 30, 2023). The review utilized a modified version of the Compliance Department's Documentation Audit Tool so that only relevant sections were present.

Findings

Case Management Overall Score: 98%
Nursing Documentation Overall Score: 75%
Detailed findings are presented below.

Item (Reference)	Score
• Assist the individual in identifying the individual's immediate needs and in determining access to community resources that may address those needs (TAC §306.263 (b) (2)	93%
• Identify the strengths, service needs, and assistance required to address the identified needs (TAC §306.263 (b) (4)	93%
• Client response(s) to treatment (TAC §217.11 (D) (v)	0%
• Contact with other healthcare team members concerning specific events regarding client's status (TAC §217.11)	0%
• Client outcomes (HHS Nurse Standards)	0%

Observations

- The program made substantial improvements in case management documentation
- Five (5) clients enrolled in the PATH Program did not receive services during the review period

HARRIS CENTER
Mental Health and IDD

- One (1) client received three (3) case management services during September but did not receive services for the remainder of the review period (i.e., October and November 2023)

History

Compliance conducted a documentation review of the PATH program during the 2nd Qtr. of FY 2023.

Recommendations

The Program should continue to review documentation for compliance with TAC and HHS Nursing Standards requirements. The program is not required to submit a POI but should contact Performance Improvement to assist with program processes and program leadership should ensure regular training is provided to staff so that documentation meets the standards outlined in TAC, HHS Standards, and agency policies and procedures. The Vice President of the CPEP Division and the PATH Program Director must sign and return this report to Compliance within seven (7) business days (January 29, 2024).

Management Response

PATH Management will continue to review and monitor Care Coordinators' documentation to ensure compliance with TAC and HHSC standards. Based on the audit finding, the Senior Director of Nursing is educating the LVN on proper note content. Senior Director of Nursing is also consulting with our Harris Center Epic Representative regarding a standardized nursing note that will be created to assist the LVN with compliance with TAC and HHSC Nursing Standards requirements.

The Harris Center
Mental Health and IDD

Signature Page

X _____

Vice President of Division

X _____

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH)
Southeast Community Service Center (SECSC)
Routine
Review Date: December 15, 2023, to December 29, 2023

I. Audit Type:
POI Follow-up

II. Purpose:
The purpose of this review was to assess SECSC Plans of Care (POC) and progress note documentation to determine if the Plan of Improvement (POI) corrective actions have been implemented and ensure compliance with the Texas Administrative Code (TAC) §301.353 (e) (1) (A), 301.361 (a) (11), 306.263 (b) (3) (7), 301.353 (e) (2) (D), 301.353 (e) (1) (F) and Agency Policy & Procedure HIM.EHR.B.5.

III. Audit Method:
Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the SECSC Programs, conducting a POI Follow-up Review utilizing a tool created by Compliance.

IV. Audit Findings and History:
Detailed findings are presented below.
The overall Score: 88%
The progress notes reflected the person-served objectives as stated in the PPOC and were consistent with the focus of the services. 301.361 (a) (11). The Case Management progress notes did identify the persons served strengths. 306.263 (b) (3) (7) and HIM.EHR. B.8. The behavioral health presenting problems were regularly documented in the POCs. 301.353 (e) (1) (A). The objectives documented in the POCs were consistently measurable. 301.353 (e) (2) (D). The expected date by which the recovery goals will be achieved was regularly documented in the POCs. 301.353 (e) (1) (F). The Progress notes were individualized; there was no evidence of copying and pasting.
No audits of this type have been previously conducted.

V. Recommendations:
The SECSC program should review the findings and continue to assess its processes for completing the plan of care and progress note documentation to ensure adherence to TAC standards, agency training guidelines, and agency policy and procedure. The SECSC program is not required to submit a Plan of Improvement. The Vice President (VP) of the MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days.
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HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Adult Mental Health (AMH) Division
Southeast Community Service Center (SECSC)
Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Webb

Review Dates: December 15, 2023- December 29, 2023

Purpose

The purpose of this review was to assess SECSC Plans of Care (POC) and progress note documentation to determine if POI corrections have been implemented for compliance with the Texas Administrative Code (TAC) §301.353, 301.361, 306.263, 306.275, 306.315, 415.5 and Agency Policy & Procedure HIM8B.

Method

Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the SECSC Programs, conducting a POI Follow up Review utilizing a tool created by Compliance.

Findings

Detailed findings are presented below.

Item Reference	Overall Score: **88%**
• Progress notes did reflect the person-served objectives as stated in the POC and were consistent with the focus of the service. 301.361 (a) (11)	92%
• Case Management progress notes did identify the persons served strengths. 306.263 (b) (3) (7) and HIM8B	77%
• The behavioral health presenting problems were regularly documented in the POCs. 301.353 (e) (1) (A)	85%
• The objectives documented in the POCs were consistently measurable. 301.353 (e) (2) (D)	77%
• The expected date by which the recovery goals will be achieved was regularly documented in the POCs. 301.353 (e) (1) (F)	100%
• The Progress notes were individualized; there was no evidence of copying and pasting.	100%

HARRIS CENTER
Mental Health and IDD

Observations

There are no observations to be noted for this review.

History

A previous review was conducted June 8th – June 11th, 2023.

Recommendations

The SECSC program should review the findings and continue to assess its processes for completing the plan of care and progress note documentation to ensure adherence to TAC standards, agency training guidelines, and agency policy and procedure. The SECSC program is not required to submit a Plan of Improvement. The Vice President (VP) of the MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days, by close of business on February 19th, 2024

Management Response:

PM will share the findings with the staff audited as well as the educational communications from the previous audit with CTLs to share with their staff. Both efforts should continue to support improvement with POCs and PNs.

HARRIS CENTER
Mental Health and IDD

Signature Page

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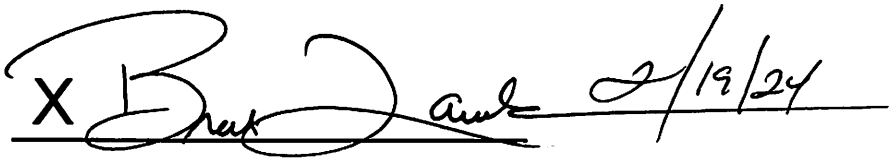
Vice President of MH Division

X 

Program Director/Manager

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Comprehensive Review:
Specialized Therapies and Rehabilitative Services (STARS)
STARS Feeding Disorders Clinic
Intellectual and Development Disability (IDD) Division
Review Dates: December 15, 2023- December 29, 2023

I. **Audit Type:**
Comprehensive Review

II. **Purpose:**
The purpose of this review was to ensure the STARS program documentation, employee credentials, and operational guidelines are complying with the rules and regulations of the Texas Administrative Code (TAC) *§301.353, §301.361, §304.401*, *§2.106, §2.313*, *§2.556* and Agency Policy and Procedures- *ACC.B.2* and *HIM.EHR. B.5*.

III. **Audit Method:**
Active records were randomly selected by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the STARS Programs, conducting a Comprehensive Review utilizing a tool created by Compliance.

IV. **Audit Findings and History:**
Of the records reviewed for STARS and STARS Feeding Disorders Clinic, the program had an overall score of 99%. The program met and exceeded standards in the following areas: no missing notes (100%), no services provided not supported by documentation (100%), no incorrect Procedure Codes used (100%), no duplicative notes (100%), time matched billed units (100%), eligibility was documented with applicable guidelines (100%), correct date of service (100%), no duplicative notes (100%), correct date of service (100%), correct start/end time of service (100%), notes completed within (two (2) business days) (99%), signature and title of who provided the service (100%), correct location of service (100%), all the time accounted for in the body of note (100%), services reflect what was on the POC (100%), services listed in the chart match what is entered into Epic (100%), notes did reflect individualization (“Cookie Cutter” note) (100%), and no missing consumer identifying information (100%).

There are no previous Comprehensive reviews.

V. **Recommendations:**
The STARS and STARS Feeding Disorders Clinic Programs should continue to assess service documentation to ensure it is in accordance with TAC and Agency P&P. The STARS Programs are not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business.

Mental Health and IDD

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Intellectual and Developmental Disability (IDD) Division
Specialized Therapies and Rehabilitative Services (STARS)
STARS Feeding Disorders Clinic
Comprehensive Review

Compliance Auditor(s): Coneka Caleb

Review Dates: December 15, 2023- December 29, 2023

Purpose

The purpose of this review was to ensure the STARS and STARS Feeding Disorders Clinic programs documentation, employee credentials, and operational guidelines are complying with the rules and regulations of the Texas Administrative Code (TAC) *§301.353, §301.361, §304.401, §2.106, §2.313, §2.556* and Agency Policy and Procedures- *ACC.B.2, HIM.EHR.B.5.*

Method

Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the STARS Programs, conducting a Comprehensive Review utilizing a tool created by Compliance.

Findings

Detailed findings are presented below.

Item Reference	Overall Score: 99%
No missing notes. *HIM.EHR.B.5*	100%
The services provided are supported by documentation. *ACC.B.2, HIM.EHR.B.5*; *§301.361*	100%
No incorrect Procedure Code was used. *HIM.EHR.B.5*	100%
There were no duplicate notes. *HIM.EHR.B.5*	100%
Time does not match billed units. *HIM.EHR.B.5*	100%
Eligibility was not documented with applicable guidelines. *ACC.B.2, HIM.EHR.B.5*; *§301.353*	100%
The correct date of service was documented. *HIM.EHR.B.5, §301.361(a)(3)*	100%
The correct start/end time of service was documented. *HIM.EHR.B.5, §301.361(a)(4)*	100%
There were progress notes not completed within (two (2) business days). *HIM.EHR.B.5, §301.361(a)(b)*	99%

HARRIS CENTER
Mental Health and IDD

The signature and title of the person who provided the service were documented. *HIM.EHR.B.5, §301.361(a)(13)*	100%
Correct location of service. *HIM.EHR.B.5, §301.361(a)(5)*	100%
All the time accounted for in the body of note. *HIM.EHR.B.5*	100%
There were services that did not reflect what was in the POC. *§301.361(a) (7-8, 11-14); ACC.B.2*	100%
Services listed in the chart match what is entered into Epic. *HIM.EHR.B.5*	100%
The note does not reflect individualization ("Cookie Cutter" note).	100%
No missing consumer identifying information. *HIM.EHR.B.5*	100%

Observations

There are no observations to be noted for this review.

History

No previous review of this type has been completed.

Recommendations

The STARS Program should continue to assess service documentation to ensure it is in accordance with TAC and Agency P&P. The STARS and STARS Feeding Disorders Clinic Programs are not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business, February 19, 2024.

Management Response:

We are in agreement with the findings of this Comprehensive Review.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Evanthe Collins

Vice President of IDD Division

X Amanda K Willis

Program Director/Manager

X

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Comprehensive Review:
Outpatient Biopsychosocial Approach for IDD Services (OBI)
Intellectual and Development Disability (IDD) Division
Review Dates: January 2, 2024- January 11, 2024

I. **Audit Type:**
Comprehensive Review

II. **Purpose:**
The purpose of this review was to ensure the OBI program documentation, employee credentials, and operational guidelines are complying with the rules and regulations of the *HHSC OBI Learning Collaborative*, Code of Federal Regulations (CFR), §483.430, Texas Administrative Code (TAC) *§301.353, §301.361, §2.313, §2.556*, and Agency Policy and Procedures- *ACC.B.2* and *HIM.EHR.B.5.*

III. **Audit Method:**
Active records were randomly selected by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the OBI Program, conducting a Comprehensive Review utilizing a tool created by Compliance.

IV. **Audit Findings and History:**
Of the records reviewed for OBI, the program had an overall score of 98%. The program met and exceeded standards in the following areas: no missing notes (100%), no services provided not supported by documentation (100%), no incorrect Procedure Codes used (100%), no duplicative notes (100%), time matched billed units (100%), eligibility was not documented with applicable guidelines (98%), correct date of service (100%), no duplicative notes (100%), correct date of service (100%), correct start/end time of service (100%), notes completed within (two (2) business days) (100%), signature and title of who provided the service (100%), correct location of service (100%), all the time accounted for in the body of note (100%), services did not reflect what was on the POC (98%), services listed in the chart match what is entered into Epic (100%), notes did reflect individualization (“Cookie Cutter” note) (100%), and no missing consumer identifying information (100%).

There are no previous Comprehensive reviews.

V. **Recommendations:**
The OBI Program should continue to assess service documentation to ensure it is in accordance with HHSC OBI Learning Collaborative, TAC and Agency P&P. The OBI is not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business.

Mental Health and IDD

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Intellectual and Developmental Disability (IDD) Division
Outpatient Biopsychosocial Approach for IDD Services (OBI)
Comprehensive Review

Compliance Auditor(s): Coneka Caleb

Review Dates: January 2, 2024- January 11, 2024

Purpose

The purpose of this review was to ensure the OBI program documentation, employee credentials, and operational guidelines are complying with the rules and regulations of the HHSC OBI Learning Collaborative, Code of Federal Regulations (CFR), *§483.430,* Texas Administrative Code (TAC) *§301.353, §301.361, §2.313, §2.556,* and Agency Policy and Procedures- *ACC.B.2, HIM.EHR.B.5.*

Method

Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023- November 30, 2023). Compliance selected a sample of ten (10) records for the OBI Program, conducting a Comprehensive Review utilizing a tool created by Compliance.

Findings

Detailed findings are presented below.

Item Reference	Overall Score: 98%
No missing notes. *HIM.EHR.B.5*	100%
The services provided are supported by documentation. *ACC.B.2, HIM.EHR.B.5, §301.361*	100%
No incorrect Procedure Code was used. *HIM.EHR.B.5*	100%
There were no duplicate notes. *HIM.EHR.B.5*	100%
Time does not match billed units. *HIM.EHR.B.5*	100%
Eligibility was not documented with applicable guidelines. *ACC.B.2, HIM.EHR.B.5, §301.353*	98%
The correct date of service was documented. *HIM.EHR.B.5, §301.361(a)(3)*	100%
The correct start/end time of service was documented. *HIM.EHR.B.5, §301.361(a)(4)*	100%
There were progress notes not completed within (two (2) business days). *HIM.EHR.B.5, §301.361(a)(b)*	100%

The signature and title of the person who provided the service were documented. *HIM.EHR.B.5, §301.361(a)(13)*	100%
Correct location of service. *HIM.EHR.B.5, §301.361(a)(5)*	100%
All the time accounted for in the body of note. *HIM.EHR.B.5*	100%
There were services that did not reflect what was in the POC. *§301.361(a) (7-8, 11-14); ACC.B.2*	98%
Services listed in the chart match what is entered into Epic. *HIM.EHR.B.5*	100%
The note does not reflect individualization ("Cookie Cutter" note).	100%
No missing consumer identifying information. *HIM.EHR.B.5*	100%

Observations

There are no observations to be noted for this review.

History

No previous review of this type has been completed.

Recommendations

The OBI Program should continue to assess service documentation to ensure it is in accordance with HHSC OBI Learning Collaborative, TAC and Agency P&P. The OBI is not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business, February 19, 2024.

Management Response:

We are in agreement with the findings of this Comprehensive Review.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Evanthe Collins

Vice President of IDD Division

X Amanda L. Willis

Program Director/Manager

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD
Executive Summary Cover Sheet
for the
Projects for Assistance in Transition from Homelessness Plan of Improvement (POI) Follow-up Review
Comprehensive Psychiatric Emergency Program (CPEP)
Review Dates: December 8, 2023-December 15, 2023

I. Audit Type:
POI Follow-up Review

II. Purpose:
The review was conducted to determine if PATH Program staff, and service provision to clients by the Step Down Program complied with the Texas Administrative Code (TAC), Step Down statement of work (SOW) requirements, and agency policies and procedures.

III. Audit Method:
Nineteen (19) client records were randomly selected to review case management documentation. The review examined documentation entered into the electronic health record (EHR) during the first quarter of fiscal year 2024 (September 1, 2023-November 30, 2023). The review utilized an audit tool developed by Compliance. The program director was provided with detailed information post-review. The audit review and completed debriefing tools were uploaded into the Compliance Shared Folder (SharePoint).

IV. Audit Findings/History:
Compliance noted that the program was not documenting client responses to nursing services, was not contacting other healthcare team members concerning significant events regarding the client's status and was not documenting client outcomes. Compliance previously conducted a review of the PATH Program during the 2nd Qtr. of FY 2023.

V. Recommendations:
The Program should continue to review documentation for compliance with TAC and HHS Nursing Standards requirements. The program is not required to submit a POI but should contact Performance Improvement to assist with program processes and program leadership should ensure regular training is provided to staff so that documentation meets the standards outlined in TAC, HHS Standards, and agency policies and procedures. The Vice President of the CPEP Division and the PATH Program Director signed and returned this report to Compliance within seven (7) business days (January 29, 2024).

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Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Step Down State Hospital Transition Program (Step Down) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Date: January 12, 2024-January 22, 2024

Purpose

This review was conducted to determine if client and employee records, and service provision to persons served by the Step Down Program complied with Texas Administrative Code (TAC) Chapter 404, Subchapter E; Chapter 301, Subchapter G; Chapter 306, Subchapter F; Chapter 448; the Step Down Statement of Work (SOW); Performance Contract Attachment A-1 Supported Living Group Home Standards (SLGHS); and agency policies and procedures.

Method

An active client roster was requested from and provided by program leadership, and all client records entered during the first quarter of fiscal year 2024 (September 1, 2023-November 30, 2023) were reviewed. An Excel formula was used to randomly identify four employee records. The review utilized an audit tool designed by Compliance to conduct a comprehensive review of the program.

Findings

Overall Program Score: 92%
Detailed findings are presented below.

Item (Reference)	Score
• Policy and Procedures (§392.511, Chapter 448, Attachment A-1 SLGHS, Agency policies and procedures)	97%
• Environment and Medical (§301.323, Chapter 448, Attachment A-1 SLGHS)	100%
• Personnel (§301.363, §404.165, Chapter 448, Attachment A-1 SLGHS)	99%
• Record Review (§404.154, §404.161-163, Chapter 301, Chapter 306, Chapter 448, Attachment A-1 SLGHS	72%

Observations

- Five (5) clients did not have housing as an identified goal on their treatment plan.
- One (1) treatment plan could not be viewed due to a "Blob server error."
- Several clients had a history of violent behavior (e.g., murder) within the previous seven (7) years. The Step Down Operational Guidelines state eligibility criteria include "no history of violent criminal behavior in the past seven years."
- Case management services were not provided to any clients during the review period.

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History

Compliance has not previously reviewed the Step Down Program.

Recommendations

The program should continue to review documentation for compliance with TAC requirements, the Step Down SOW requirements, and agency policy and procedure to ensure employee documentation, staff training and supervision, and program documents comply with these standards. A plan of improvement (POI) is required to ensure corrective actions are implemented to resolve the deficiencies identified during this review. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the Step Down Program Manager must sign and return this report to Compliance within seven (7) business days (February 13, 2024).

Management Response

This is to state the Plan of Improvement for the State Hospital Step Down Program. Both the Step Down Co-Managers will schedule meeting with Director of Emergency Services and Residential Programs to update program Operational Guidelines standards to coincide with agency policy and procedures as well as the SOW and Tac requirements before 180 day follow-up with agency compliance department. As of 1/30 & 1/31/2024, the H2H/Step Down Program Manager had Inservice Progress Notes Training with Peer Navigators & LCDC which provided verbal and demonstration of how to thoroughly write progress notes, both Individual and Group, to include consumer name, location, and progress/lack of progress of Plan of Care goals in EPIC. The Step Down LCDC requested to facilitate a Communicable Disease group and provide educational materials with all consumers of the program with documentation in EPIC once a month. The Step Down Co-Managers will formulate consumer own unit Plan of Care with person-centered goals and Transition Plan for all new admits within 1 or 2 days of admittance into the program. This all is to implemented start of 02/2024.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of CPEP Division

X LaCharlotte A. Smith

Program Director/Manager

X Demetria Luckett

Director of Compliance

The HARRIS CENTER for Mental Health and IDD

Program Name: Step Down Comprehensive Review Qtr. 2 FY 2024; January 12, 2024-January 22, 2024

Review Criteria	Finding(s)	Name and Title of Responsible Person(s)	Corrective Action To Be Taken	Estimated Completion Date	Comments
Here is where the criteria of the review is presented. Where possible, this should come directly from the TAC, PnP, Operational Guidelines, Instruction, etc.	Insert and number all findings being addressed: 1. 2. 3.	Provide the name and title of the individual or group responsible for the corrective action for each finding identified: 1. 2. 3.	Response to Findings:	When (date) the corrective action will be completed (for each finding):	Insert comments, if necessary, here with initials and date
§301.361 (a)	1. Some progress notes did not include all required elements, such as the type of service, location of service provision, method and modality of service provision, treatment plan goals addressed and the progress/lack of progress in achieving treatment plan goals.	1. LaCharlotte A. Smith, Program Manager 2. Joy Deaver-Lazard, Program Mnager	As of 1/30 & 1/31/2024, the H2H/Step Down Program Manager had Inservice Progress Notes Training with Peer Navigators & LCDC which provided verbal and demonstration of how to thoroughly write progress notes, both Individual and Group, to include consumer	To be implemented 02/2024	LAS 02/05/2024
§448.901 (d)	1. Records did not indicate clients were being provided education on communicable diseases (e.g., TB, HIV, hepatitis B and C, and STDs).	1. LaCharlotte A. Smith, Program Manager 2. Joy Deaver-Lazard, Program	The Step Down LCDC requested to facilitate a Communicable Disease group and provide educational materials with all consumers of	To be implemented 02/2024	LAS 02/05/2024
§301.353 (e)(1)	1. Step Down staff did not participate in the development of the client's treatment plan.	1. LaCharlotte A. Smith, Program Manager	The Step Down Co-Managers will formulate consumer own unit Plan of Care with person-	To be implemented 02/2024	LAS 02/05/2024
Attachment A-1SLGHS, F.c.iv.	1. Transition plans were not present in the client's electronic health record .	1. LaCharlotte A. Smith, Program Manager	The Step Down Co-Managers will formulate a Transition Plan for all new admits within 1 or 2	To be implemented 02/2024	LAS 02/05/2024

The HARRIS CENTER for Mental Health and IDD

Compliance Department Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Integrated Care Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: January 18, 2024, to January 29, 2024

Purpose

The purpose of this review was to assess the Integrated Care program for Compliance with Texas Administrative Code (TAC) §301.353(d)(1)(C), TAC §301.353(e)(1)(A-G), TAC §301.353(e)(1)(H)(i-iii), TAC §301.353(e)(2)(A-E), TAC §415.5(e), TAC §301.353(f)(1)(A)(C)(D), TAC §412.161(b)(1)(A), TAC §301.353(a)(1, 3-5, 8, 9, 10), Tac §415.6(a)(1-5), TAC §415.5(f), TAC §415.6(c), Tac §414.405(a-b), FY2023 Certified Community Behavioral Health Clinic Improvement and Advancement Grant (CCBHC-IA).

Method

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the Comprehensive Review Tool developed by Compliance.

Findings

Overall Score: 78%
Detailed findings are presented below.

Item (Reference)	Score
• Service Compliance ***§412.161(b)(1)(A), Grant Criteria 2.B, §301.353(a)(1, 3-5, 8)(9-11), Adult Integrated Collaborative Care Clinic (ICC) Policy), §415.6(a)(1-5)***	100%
• Requisites ***§404.163(b), §301.353(h)(1-3)***	100%
• Staff Training ***(CCBHC-IA)***	25%
• Progress Notes ***301.361(a)(7-8, 11-14); 306.275(c)(1-5)***	100%

Observations

- There were no safety plans found in the record for ten (10) records reviewed.
- Two (2) Client Rights forms were not updated.
- Compliance followed up with the clinics that referred the clients to Integrated Care. During the follow-up, Compliance discovered that the clinics are completing safety plans only for individuals with moderate risk and the few highs that do not go to the Neuropsychiatric Center (NPC). The Agency Procedure (ACC.B.2) states that a safety

plan is to be completed for each individual served at the time of the first service following intake and reviewed/updated following each crisis episode or annually at a minimum.

History

No previous review of this type has been completed.

Recommendations

Compliance recommends that the Integrated Care program review the findings and continue to assess its processes with TAC and CCBHC-IA. The Integrated Care program is required to submit a Plan of Improvement (POI). Compliance will review the Integrated Care program in the next one hundred eighty (180) days. A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to compliance within seven (7) business days by the close of business, February 20, 2024.

Management Response

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

X Dr. Stanley Williams, PhD

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Crisis Residential Units Plan of Improvement (POI) Follow-up Review
Review Dates: January 29,2024-February 2, 2024

I. Audit Type:
POI Follow-up Review

II. Purpose:
This review was conducted to determine if the CRU program complied with the POI submitted during the 2nd Qtr. FY 2023 concerning Health and Human Services Information Item V requirements V.D.2.e.v.1; V.D.3. Vi. (1-5); V.D.5. C. (i-iv); and V.D.12.e.iv.

III. Audit Method:
An active client roster was requested from and provided by program leadership. Ten (10) clients were selected by entering an Excel formula to identify them randomly. Client records from January 9, 2024, through January 23, 2024, were reviewed. The review utilized a modified audit tool developed by Compliance so that only relevant sections were present.

IV. Audit Findings/History
Compliance noted the program was not completing orientation within 24 hours of the persons served admission and were not initiating discharge planning during the enrollment process. Compliance previously conducted a review of the CRU Program during the 2nd Qtr. of FY 2023.

V. Recommendations:
The program should continue to review documentation for compliance with Information Item V requirements and ensure implementation of the POI corrections developed in response to the FY 2023 Audit findings. A POI for this review is not required; however, Compliance will conduct an additional POI Follow-up Review in 180 days.

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Crisis Residential Unit (CRU) Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Date: January 29, 2024-February 2, 2024

Purpose

This review was conducted to determine if the CRU program complied with the POI submitted during the 2nd Qtr. FY 2023 concerning Health and Human Services Information Item V requirements V.D.2.e.v.1; V.D.3. Vi. (1-5); V.D.5. C. (i-iv); and V.D.12.e.iv.

Method

An active client roster was requested from and provided by program leadership. Ten (10) clients were selected by entering an Excel formula to identify them randomly. Client records from January 9, 2024, through January 23, 2024, were reviewed. The review utilized a modified audit tool developed by Compliance so that only relevant sections were present.

Findings

Overall Program Score: 63%
Detailed findings are presented below.

Item (Reference)	Score
• Clients are seen by a physician at least weekly while enrolled. *V V.D.2. e.v.1.*	100%
• Orientation completed within 24 hours of admission. *V.D.3.vi. (1-5)*	50%
• Discharge Planning was initiated during the enrollment process. *V.D.5.C. (i-iv)*	0%
• Clients are educated about their medications. *V.D.12.e.iv.*	100%

Observations

- The EHR does not contain evidence that staff at the CRU Caroline location completed orientation documentation within 24 hours of admission.

History

Compliance previously reviewed the CRU Program during the 1st. Qtr. FY 2018, 2nd and 3rd Qtrs. FY 2020, and 2nd Qtr. FY 2023.

Recommendations

The program should continue to review documentation for compliance with Information Item V requirements and ensure implementation of the POI corrections developed in response to the FY 2023 Audit findings. A POI for this review is not required; however, Compliance will conduct an

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additional POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the CRU Program Manager must sign and return this report to Compliance within seven (7) business days (February 22, 2024).

Management Response

We are grateful for the feedback and opportunities for improvement in this compliance audit.

Regarding 'discharge planning was initiated during the enrollment process;' staff will be trained on discharge planning documentation expectations. In some case discharge planning is mentioned in a cursory manner but the ideal is to reflect four elements of discharge planning into every admission: (1) appropriate education relevant to the individuals' condition, (2) information about the most effective treatment for the individuals' behavioral health disorder, (3) identification of potential obstacles to a successful return to the community and means to address these concerns, & (4) information about follow-up care and appropriate linkages to post discharge providers. The program is exploring options for template smart text in Epic to streamline material. These measures also align with treatment planning for the unit so we will work to better label discharge relevant elements in the treatment plan and initial note.

Regarding 'orientation completed within 24 hours of admission,' documented instances are specific to one location. Staff will be trained on uploading orientation documents into Epic since efficiency in using paper forms and scanning them into the system has produced bulletproof results in that method..

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Mental Health and IDD

Signature Page

X 3/11/24

Vice President of CPEP Division

X LPC-S

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Mental Health (MH) Division
Youth Empowerment Services (YES) Waiver
Plan of Improvement (POI) Follow-Up
Review Date: February 5, 2024, to February 7, 2024

I. Audit Type:
POI Follow-up.

II. Purpose:
The purpose of this review was to follow up on a POI action item to determine if the item had been implemented in response to the YES Waiver audit conducted during the 2nd Qtr. of FY 2023.

III. Audit Method:
Active records were randomly selected from the YES Waiver Inquiry List and the YES Waiver Open Assignment Client Roster Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023, to November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the YES Waiver Review Tool with only relevant sections present.

IV. Audit Findings and History:
Overall Program Score: 45%
Detailed finding(s) is presented below.
The initial wraparound plan development includes at least one needs statement for the youth and one for the family member/legal authorized representative (LAR) was completed 45% of the time. *HHS YES Waiver Manual Page 93.*

History

Compliance previously reviewed the YES Waiver Program during the 2nd Qtr. FY 2023.

V. Recommendations:
Compliance recommends that the YES Waiver program review the finding and assess its processes to ensure documentation is completed in accordance with the YES Waiver Manual. A POI is not required; however, the program should collaborate with Performance Improvement (PI) to assist with implementing program procedures. Compliance will continue to provide essential support for program compliance. The Vice President of the Child and Adolescent Services and the YES Waiver Program Director/Manager must sign and return this report to Compliance within seven (7) business days.

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Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Youth Empowerment Services (YES) Waiver
Plan of Improvement (POI) Follow-Up Audit

Compliance Auditor(s): Marvin Williams

Review Date: February 5, 2024, to February 7, 2024

Purpose

The purpose of this review was to follow up on a POI action item to determine if the item had been implemented in response to the YES Waiver audit conducted during the 2nd Qtr. of FY 2023.

Method

Active records were randomly selected from the YES Waiver Inquiry List and the YES Waiver Open Assignment Client Roster Report for persons served during the 1st Qtr. of FY 2024 (September 1, 2023, to November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the YES Waiver Review Tool with only relevant sections present.

Findings

Overall Program Score: 45%
Detailed finding is presented below.

Item (Reference)	Score
• The initial wraparound plan development includes at least one needs statement for the youth and one for the family member/LAR. *HHS YES Waiver Manual Page 93.*	45%

History

Compliance previously reviewed the YES Waiver Program during the 2nd Qtr. FY 2023.

Recommendations

Compliance recommends that the YES Waiver program review the finding and assess its processes to ensure documentation is completed in accordance with the YES Waiver Manual. A POI is not required; however, the program should collaborate with Performance Improvement (PI) to assist with implementing program procedures. Compliance will continue to provide essential support for program compliance. The Vice President of the Child and Adolescent Services and the YES Waiver Program Director/Manager must sign and return this report to Compliance within seven (7) business days on February 26, 2024.

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Management Response

The YES Waiver program will implement and follow the corrective measures discussed in the POI Follow-Up Review Meeting. Practice Manager and YES Waiver leadership team will review the program's quality monthly and make changes as appropriate, which includes staff being re-educated and re-trained in documentation within the wraparound plan. This is accordance with YES Wavier Manual, YES Waiver Program Operational guidelines, (TAC) and MH standards and guidelines.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of MH Division

X _____

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Psychiatric Emergency Services (PES) Plan of Improvement (POI) Follow-up Review
Review Dates: February 9, 2024-February 13, 2024

I. Audit Type:
POI Follow-up Review

II. Purpose:
The review was conducted to determine if the PES Program has implemented corrective action steps as stated in the POI submitted from a previous review conducted during the 2nd Qtr. (February 10, 2023-February 21, 2023) FY 2023 concerning agency policy and procedure *ACC.B.8 5. B.Discharge.D.2-3*.

III. Audit Method:
A client roster for services provided during the 1st Qtr. FY 2024 (September 1, 2023 - November 30, 2023) was requested from and provided by program leadership. Twenty (20) records were randomly selected by entering an Excel formula into a modified audit tool developed by Compliance. Only the applicable sections of the Compliance audit tool were utilized.

IV. Audit Findings/History:
Compliance noted the program was not documenting the date and reason persons served were discharged, and not including a summary of all services received by the person served since admission and the persons served response to each service. Compliance previously conducted a review of the PES Program during the 2nd Qtr. of FY 2023.

V. Recommendations:
The program should continue to review documentation for compliance with agency policies and procedures and ensure implementation of the POI corrections developed in response to the FY 2023 Audit findings. A POI for this review is not required; however, Compliance will conduct an additional POI Follow-up Review in 180 days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Psychiatric Emergency Services (PES) Plan of Improvement (POI) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Period: February 9, 2024-February 13, 2024

Purpose

This review was conducted to determine if the PES Program has implemented corrective action steps as stated in the POI submitted from a previous review conducted during the 2nd Qtr. (February 10, 2023-February 21, 2023) FY 2023 concerning agency policy and procedure *ACC.B.8 5. B.Discharge.D.2-3*.

Method

A client roster for services provided during the 1st Qtr. FY 2024 (September 1, 2023 - November 30, 2023) was requested from and provided by program leadership. Twenty (20) records were randomly selected by entering an Excel formula into a modified audit tool developed by Compliance. Only the applicable sections of the Compliance audit tool were utilized.

Findings

Overall Program Score: 70%
Detailed findings are presented below.

Item (Reference)	Score
• Date/reason for discharge (*ACC.B.8.5.B.D.2*)	100%
• Summary of all services received by the person served since admission and the persons served response to each service (*ACC.B.8 5. B.Discharge.D.3.*)	40%

History

Compliance previously reviewed the PES Program during the 2nd Qtr. of FY 2017, 1st Qtr. of FY 2018, 1st and 3rd Qtrs. of FY 2020, and 2nd Qtr. of FY 2023.

Recommendations

The program should continue to review documentation for compliance with agency policies and procedures and ensure implementation of the POI corrections developed in response to the FY 2023 Audit findings. A POI for this review is not required; however, Compliance will conduct an additional POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the PES Program Manager(s) must sign and return this report to Compliance within seven (7) business days, March 19, 2024.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of Division

X _____

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Child & Adolescent (CAS) Medical Services Mental Health (MH) Division
Physician Documentation Review
Review Date: February 9, 2024, to March 6, 2024

I. **Audit Type:** Focused Review

II. **Purpose:**
The purpose of this review was to assist the MH Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC) and Agency Policy and Procedures (P&P) concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

III. **Audit Method:**
Compliance ran the AFF HC Encounter Data OP Services Details Report in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2nd Qtr. of FY 2024 (12/01/2023 – 01/31/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 02/09/2024. This desk review was conducted using the E/M Coding Audit Review Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
The following findings were noted in the records reviewed for Adult Medical Services. The Overall Physician (provider) Score – 94%. The primary billing codes (99212 – 99215) chosen did not accurately reflect the appropriate “medical decision making” (MDM) selection criteria as provided by CMS regulations and guidelines, AMA E/M Coding Guidelines. *(2024 AMA E/M MDM Guidelines). The* Element Score was 81% of the Medication Maintenance encounters reviewed, and 19% were deficient in appropriate primary code based on MDM. face-to-face interaction did not occur on the Observations: Suitable Telehealth (TH) add-on code, Modifier 95, excluded from encounters where documentation clearly states face-to-face interaction did not occur on the date of service. *(TAC 354.1432; P&P MED.B.6; EM.P.4; CMS coding regulations & guidelines for Telehealth services).* Element Score: 69%; Of the Intake and Medication Maintenance encounters reviewed, 31% were deficient for appropriate secondary code based on TH services.

V. **Recommendations:**
It is recommended that the Vice President (VP) of Mental Health Medical Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with TAC, CPT, CMS, E/M guidelines and Agency P&P. Any services that have been identified as not meeting the appropriate criteria will need to be communicated to Revenue Management to ensure appropriate reconciliation. Compliance will continue to provide essential support to the physicians regarding their documentation of services, to include training and review of documentation from a credentialed professional coder. In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with individual physicians regarding their documentation. This modified approach will help identify and address immediate deficiencies to maintain compliance with regulations.

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Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Children & Adolescent Services (CAS) Mental Health (MH) Division
Physician Documentation Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: February 9, 2024 to March 6, 2024

Purpose

The purpose of this review was to assist the MH Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (*TAC 354.1432*) and Agency Policy and Procedures (P & P) *(MED.B.6, EM.P.4)* concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

Method

Active records were randomly selected by generating the *Client Services Listing Report* in the EPIC (EHR) system for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023 – January 31, 2024). Compliance reviewed thirty-five (35) of client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Above mentioned sample size was obtained on 02/09/2024. This desk review was conducted using the *E/M Coding Audit Review Tool.*

Findings

Detailed data for services reviewed are presented in the findings section below.

Overall Physician (provider) Score – 94%

- Primary billing codes (99212 – 99215) chosen did not accurately reflect the appropriate "medical decision making" (MDM) selection criteria as provided by CMS regulations & guidelines, AMA E/M Coding Guidelines. *(2024 AMA E/M MDM Guidelines)*
    - Element Score: 81% - Of the Medication Maintenance encounters reviewed **19%** were deficient for appropriate primary code based on MDM.

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Observations:

- Suitable Telehealth (TH) add-on code, Modifier 95, excluded from encounters where documentation clearly states face to face interaction did not occur on date of service. *(TAC 354.1432; P&P MED.B.6; CMS coding regulations & guidelines for Telehealth services)*
    - Element Score: 69% - Of the Intake and Medication Maintenance encounters reviewed 31% were deficient for appropriate secondary code based on TH services.

No prior review history.

Recommendations

It is recommended that the Vice President (VP) of Mental Health Medical Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with TAC, CPT, CMS, E/M guidelines and Agency P&P. Any services that have been identified as not meeting the appropriate criteria will need to be communicated to Revenue Management to ensure appropriate reconciliation. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with Provider liaison/Division Head regarding their documentation. This modified approach will help to identify and address immediate deficiencies to maintain compliance with regulations. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (7) business days.

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Signature Page

Management Response:
[Insert Response Here]

X

Vice President of MH Medical Services

X

Program Director/Manager

X Demetria Luckett

Compliance Director/Manager

The HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Adult Medical Services Mental Health (MH) Division
Physician Documentation Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: February 14, 2024 to March 7, 2024

Purpose

The purpose of this review was to assist the MH Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (*TAC 354.1432*) and Agency Policy and Procedures (P&P) *(MED.B.6, EM.P.4)* concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

Method

Active records were randomly selected by generating the *Client Services Listing Report* in the EPIC (EHR) system for persons served during the 2nd Qtr. of FY 2024 (January 1, 2024 – January 31, 2024). Compliance reviewed thirty - five (35) client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Above mentioned sample size was obtained on 02/14/2024. This desk review was conducted using the *E/M Coding Audit Review Tool.*

Findings

Overall Physician (provider) Score – 92%

- Primary billing codes (99212 – 99215) chosen did not accurately reflect the appropriate "medical decision making" (MDM) selection criteria as provided by CMS regulations and guidelines, AMA E/M Coding Guidelines. *(2024 AMA E/M MDM Guidelines)*
    - Element Score: 64%; Of the Medication Maintenance encounters reviewed **36%** were deficient for appropriate primary code based on MDM.

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Observations:

- Suitable Telehealth (TH) add-on code, Modifier 95, excluded from encounters where documentation clearly states face to face interaction did not occur on date of service. *(TAC 354.1432; P&P MED.B.6; CMS coding regulations & guidelines for Telehealth services)*
    - Element Score: 63%; Of the Intake and Medication Maintenance encounters reviewed **37%** were deficient for appropriate secondary code based on TH services.

No prior review history.

Recommendations

It is recommended that the Vice President (VP) of Mental Health Medical Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with TAC, CPT, CMS, E/M guidelines and Agency P&P. Any services that have been identified as not meeting the appropriate criteria will need to be communicated to Revenue Management to ensure appropriate reconciliation. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with Provider liaison/Division Head regarding their documentation. This modified approach will help to identify and address immediate deficiencies to maintain compliance with regulations. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (7) business days.

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Management Response:
[Insert Response Here]

X

Vice President of MH Medical Services

X Demetria Luckett

Program Director/Manager

X

Compliance Director/Manager

The HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Adult Medical Services Mental Health (MH) Division
Physician Documentation Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: February 14, 2024 to March 7, 2024

Purpose

The purpose of this review was to assist the MH Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (*TAC 354.1432*) and Agency Policy and Procedures (P&P) *(MED.B.6, EM.P.4)* concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

Method

Active records were randomly selected by generating the *Client Services Listing Report* in the EPIC (EHR) system for persons served during the 2nd Qtr. of FY 2024 (January 1, 2024 – January 31, 2024). Compliance reviewed thirty - five (35) client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Above mentioned sample size was obtained on 02/14/2024. This desk review was conducted using the *E/M Coding Audit Review Tool.*

Findings

Overall Physician (provider) Score – 92%

- Primary billing codes (99212 – 99215) chosen did not accurately reflect the appropriate "medical decision making" (MDM) selection criteria as provided by CMS regulations and guidelines, AMA E/M Coding Guidelines. *(2024 AMA E/M MDM Guidelines)*
    - Element Score: 64%; Of the Medication Maintenance encounters reviewed **36%** were deficient for appropriate primary code based on MDM.

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Observations:

- Suitable Telehealth (TH) add-on code, Modifier 95, excluded from encounters where documentation clearly states face to face interaction did not occur on date of service. *(TAC 354.1432; P&P MED.B.6; CMS coding regulations & guidelines for Telehealth services)*
    - Element Score: 63%; Of the Intake and Medication Maintenance encounters reviewed **37%** were deficient for appropriate secondary code based on TH services.

No prior review history.

Recommendations

It is recommended that the Vice President (VP) of Mental Health Medical Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with TAC, CPT, CMS, E/M guidelines and Agency P&P. Any services that have been identified as not meeting the appropriate criteria will need to be communicated to Revenue Management to ensure appropriate reconciliation. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. In lieu of a Plan of Improvement (POI) for this review, Compliance will adjust its approach to the review of physician services, to now include direct communication with Provider liaison/Division Head regarding their documentation. This modified approach will help to identify and address immediate deficiencies to maintain compliance with regulations. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (7) business days.

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Management Response:
[Insert Response Here]

X

Vice President of MH Medical Services

X Demetria Luckett

Program Director/Manager

X

Compliance Director/Manager

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Homeless Outreach Team (HOT) Comprehensive Review
Review Dates: February 19, 2024-March 4, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if client and staff records, and service provision to persons served by the HOT Program complied with *Program Operational Guidelines*; *The Harris Center for Mental Health and IDD Policies and Procedures HIM.EHR.B.5 Content of Patient/Individual Records and HIM.EHR.B.9 Patient/Individual Records Administration*; Texas Administrative Code (TAC) *Competency and Credentialing 26 TAC §301.331 (h)(1)* and *(4)*; and *Supervision 26 TAC §301.363 (a)*.

III. Audit Method:
An active client roster was requested from and provided by program leadership. Twenty-one (21) clients were selected by utilizing an Excel formula to generate a random number list. Client records from September 1, 2023-November 30, 2023, were reviewed. The review utilized an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted the program was not documenting the locations at which services were provided, was not documenting the services provided to persons served, was documenting linkages provided to persons served, was not indicating if staff had previous experience with the persons served, was not including a subjective assessment of the person served, staff was not compliant with required annual training courses, and staff did not document a minimum of one hundred (100) person served contacts per month.

V. Recommendations:
The program should continue to review documentation and training requirements for compliance with Agency Policies and Procedures. A Plan of Improvement (POI) is required to address deficiencies in the content of patient outreach notes (i.e., location at which the client was encountered, services offered to the client, linkages provided to the client, indication of previous experience with the client, and a subjective assessment of the client) and staff training (i.e., mental health first aid, trauma-informed care, active shooter, and emergency fire preparedness). Compliance will conduct a POI Follow-up Review in 180 days.

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Compliance Department (Compliance)Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Services (CPEP) Division
Homeless Outreach Team (HOT) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Date: February 19, 2024-March 4, 2023

Purpose

This review was conducted to determine if client and staff records, and service provision to persons served by the HOT Program complied with *Program Operational Guidelines*; *The Harris Center for Mental Health and IDD Policies and Procedures HIM.EHR.B.5* and *HIM.EHR.B.9*; *Texas Administrative Code (TAC) Title 26, Part 1, Chapter 301, Subchapter G, Division 2, Rule §301.331 (h)(1) and (4)*; and *TAC Title 26, Part 1, Chapter 301, Subchapter G, Division 3, Rule §301.363 (a)*.

Method

An active client roster was requested from and provided by program leadership. Twenty-one (21) clients were selected by utilizing an Excel formula to generate a random number list. Client records from September 1, 2023-November 30, 2023, were reviewed. The review utilized an audit tool developed by Compliance and consisted of two components: Records Review and Personnel.

Findings

Overall Score: 85%
Detailed findings are presented below.

Item (Reference)	Score
• Records Review (*Per Program Manager, HIM.EHR.B.5,* and *HIM.EHR.B.9.5*)	79%
• Personnel (*Per Program Manager; TAC §301.331 (h)(1)* and *(h)(4); TAC 301.363;* and *Agency Training Policy*)	90%

History

Compliance has not previously reviewed the HOT Program.

Recommendations

The program should continue to review documentation and training requirements for compliance with Agency Policies and Procedures. A Plan of Improvement (POI) is required to address deficiencies in the content of patient outreach notes (i.e., location at which the client was encountered, services offered to the client, linkages provided to the client, indication of previous experience with the client, and a subjective assessment of the client) and staff training (i.e.,

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mental health first aid, trauma-informed care, active shooter, and emergency fire preparedness). Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the HOT Program must sign and return this report to Compliance within seven (7) business days (April 2, 2024).

Management Response
Training provided to staff on 3/19/24 addressing services offered to clients, linkage, indication of previous experiences with clients and providing a subjective assessment when conducting outreach and documenting the details using a Patient Outreach note in Epic. The findings for employee not documenting a minimum of 100 clients contacts has been removed considering days off and shortage of officers (partners). All required trainings have been assigned to staff for completion and have been completed.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X 4/11/24

Vice President of CPEP Division

X LPC-S 6/11/24

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Multisystemic Therapy (MST)
Comprehensive Review
Review Date: February 20, 2024, to February 23, 2024

I. Audit Type:
Comprehensive Review

II. Purpose:
The purpose of this review was to assess the Multisystemic Therapy (MST) program for Compliance with Code 45 C.F.R. Parts 169 and 164, Interlocal Agreement Between the Harris County Juvenile Board and the Harris Center for Mental Health and IDD, MST Goals and Guidelines, MST Overview Pamphlet, MST Job Description, MST and the Harris Center Documentation Requirements for the Harris center and Harris Center\Harris County Juvenile Probation Department MST Referrals.

III. Audit Method:
Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling fifteen (15) records using the Comprehensive Review Tool developed by Compliance. Compliance reviewed the progress notes only for missing notes, wrong names, wrong case numbers, and wrong genders.

IV. **Audit Findings and History:**
The MST program overall score was 100%. The Program scored 100% on All demographic entered the day of the intake assessment, 100% on HIPAA, 100% on open cases of MST Referral, 100% on Staff Training, 100% on No Missing Progress Notes. The MST Progress Note in the Electronic Health Record (HR) are listed as Psychoactive Notes. The MST program has not developed an internal operational guideline***.*** *There was 78% compliance with the indicated in the Interlocal Agreement concerning allegations made against a prospective employee, 78% compliance with Employee Criminal Background Checks and 56% compliance the Multisystemic Job Description concerning Valid Driver's License* No audits of this type have been previously conducted.

V. Recommendations:
Compliance recommends that the Multisystemic Therapy Program continue to assess its processes with the Interlocal Agreement Between the Harris County Probation Board and the Harris Center. The Multisystemic Therapy Program is not required to submit a Plan of Improvement (POI). Compliance will follow up with the appropriate department regarding the compliance on Disclosure of Allegations against a prospective employee or the Agency, Employee Criminal Background Check and Valid Driver's License; however, a management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to compliance within seven (7) business days by the close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Multisystemic Therapy (MST) Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: February 20, 2024, to February 23, 2024

Purpose

The purpose of this review was to assess the Multisystemic Therapy (MST) program for Compliance with Code 45 C.F.R. Parts 169 and 164, Interlocal Agreement Between the Harris County Juvenile Board and the Harris Center for Mental Health and IDD, MST Goals and Guidelines, MST Overview Pamphlet, MST Job Description, MST and the Harris Center Documentation Requirements for the Harris center and Harris Center\Harris County Juvenile Probation Department MST Referrals.

Method

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling fifteen (15) records using the Comprehensive Review Tool developed by Compliance. Compliance reviewed the progress notes only for missing notes, wrong names, wrong case numbers, and wrong genders.

Findings

Overall Score: 100%
Detailed findings are presented below.

Item (Reference)	Score
• ***All demographics entered the day of the intake assessment.***	100%
• HIPAA ***45 C.F.R. Parts 169 and164***	100%
• Open Case ***MST Referral***	100%
• Staff Training ***HR. A16 Organizational Development***	100%
• No Missing Progress Notes	100%

Observations

- MST Progress notes in the Electronic Health Record (HER) are listed as Psychotherapy notes.
- The MST program has not developed an internal operational guideline.
- 78% Compliance with the Standard indicated in the Interlocal Agreement Between Harris County Juvenile Board and the Harris Center concerning allegations made against a prospective employee.

- 78% Compliance with the Standard indicated in the Interlocal Agreement Between Harris County Juvenile Board and the Harris Center concerning Employee Criminal Background Checks.
- 56% Compliance with the Standards indicated in the Multisystemic Therapy Job Description concerning Valid Driver's License.

History

No previous review of this type has been completed.

Recommendations

Compliance recommends that the Multisystemic Therapy Program continue to assess its processes with the Interlocal Agreement Between the Harris County Probation Board and the Harris Center. The Multisystemic Therapy Program is not required to submit a Plan of Improvement (POI). Compliance will follow up with the appropriate department regarding the Compliance standard on Disclosure of Allegation made against an employee or the Agency, Criminal Background check and Valid Driver's License; however, a management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to compliance within seven (7) business days by the close of business, March 14, 2024.

Management Response

The HARRIS CENTER for Mental Health and IDD

Signature Page

X 

Vice President of MH Division

X Raul Oreste

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency (CPEP) Division
Mobile Crisis Outreached Team (MCOT)
Plan of Improvement (POI) Follow-Up
Review Date: February 21, 2024, to February 23, 2024

I. Audit Type:
POI Follow-up.

II. Purpose:
The purpose of this review was to conduct a POI Follow-up review to determine if the program has implemented the corrective action steps from its previous review in response to the MCOT audit conducted during the 2nd Qtr. of FY 2023.

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023, to November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the MCOT Review Tool with only relevant sections present.

IV. Audit Findings and History:
Overall Program Score: 90%
Detailed finding(s) is presented below. During the review it was evident the coordination of crisis services was provided to every individual which consist of identifying and linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care where MCOT completed 100% of the time. *HHS Information Item V: II.D.7a.i.ii.* The safety plan was completed for each individual served at the time of the first service following intake and reviewed/updated following each crisis episode or annually, the program completed 95% of the time. *The Harris Center Procedure ACC.B.2* The individualized crisis treatment plan must be developed for everyone and must include interventions, outcomes, plan for follow-up and referrals, the program met the standard 75% of the time. *HHS Information Item V: II.D.6.c.*

History

Compliance previously reviewed the MCOT Program during the 2nd Qtr. FY 2023.

V. Recommendations:
Compliance recommends that the MCOT program review the finding(s) and continue to assess its processes to ensure documentation is completed in accordance with *HHS Information Item V MCOT* requirements. A POI is not required; however, the program should collaborate with Performance Improvement (PI) to assist with implementing program processes. Compliance will continue to provide essential support for program compliance and may conduct an additional follow-up review in one hundred and eighty (180) days.. The Vice President of CPEP Services and the MCOT Program Director/Manager must sign and return this report to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Mobile Crisis Outreach Team (MCOT)
Plan of Improvement (POI) Follow-Up Audit

Compliance Auditor(s): Marvin Williams

Review Date: February 21, 2024, to February 23, 2024

Purpose

The purpose of this review was to conduct a POI Follow-up review to determine if the program has implemented the corrective action steps from its previous review in response to the MCOT audit conducted during the 2nd Qtr. of FY 2023.

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023, to November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the MCOT Review Tool with only relevant sections present.

Findings

Overall Program Score: 90%
Detailed findings are presented below.

Item (Reference)	Score
• An individualized crisis treatment plan must be developed and implemented for everyone and must include interventions, outcomes, plan for follow-up/aftercare, and referrals. *HHS Information Item V: II.D.6.c.*	75%
• Coordination of crisis services must be provided to every individual and consist of identifying and linking the individual with all available services necessary to stabilize the behavioral health crisis and ensure transition to routine care. *HHS Information Item V: II.D.7a.i.ii*	100%
• A safety plan is completed for each individual served at the time of the first service following intake and reviewed/updated following each crisis episode or annually at minimum. *The Harris Center Procedure ACC.B.2*	95%

History

Compliance previously reviewed the MCOT Program during the 2nd Qtr. FY 2023.

Recommendations

Compliance recommends that the MCOT program review the finding(s) and continue to assess its processes to ensure documentation is completed in accordance with *HHS Information Item V MCOT* requirements. A POI is not required; however, the program should collaborate with Performance Improvement (PI) to assist with implementing program processes. Compliance will continue to provide essential support for program compliance and may conduct an additional follow-up review in one hundred and eighty (180) days.. The Vice President of CPEP Services and the MCOT Program Director/Manager must sign and return this report to Compliance within seven (7) business days on March 14, 2024.

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Management Response

Regarding item reference #2

Consumer did score into crisis on their CANS and an Individualized Crisis Treatment Plan was completed on 9/19 at time of assessment. This information is located in the assessment note and includes information detailing Crisis Intervention and Outcome; Follow Up and Aftercare Plan; Educational Information, Crisis Support Resources, and Referrals provided; Treatment Preferences/Objections; and Consumer Preferences Regarding Family.
PROOF If you want to go see for yourself MRN is 900985.

INDIVIDUALIZED CRISIS TREATMENT PLAN

Crisis Intervention and Outcome:
Jocelyn D Guerra 900985
Consumer appears to be experiencing a mental health crisis, but does not present at imminent risk to self or others evidenced by factors outlined above. Consumer could benefit from receiving continued MCOT transitional services secondary to: the consumer needs transitional services until stabilized and community-based provider has been identified.as indicated by the assessment. Consumer and MCOT staff were able to safety plan on scene.

Follow Up and Aftercare Plan:
MCOT will provide continued crisis intervention and relapse prevention services 2 time(s) per week and for stabilization, administer ANSA/CANS routinely to assess current needs and aid in transition planning.

Educational Information, Crisis Support Resources, and Referrals provided include (s): MCOT HOPE handout which includes the Harris Center's crisis line number: 713-970-7000, option 1.

Treatment Preferences/Objections:
Consumer's preferences/objections to treatment: Has open availability (Morning or evening staff)
Preferred Name: Jocelyn D Guerra
Gender Identity: female
Pronouns:She/Her/Hers
Language: Spanish
Consumer Location: NW

Consumer Preferences Regarding Family:
Patient Contacts: SIMEON,IDALIA
To what extent do you want your family/support system involved in your mental health treatment?
Consent was obtained to contact family/friend? Yes

Ciera Avery, LPC-Associate

The HARRIS CENTER for Mental Health and IDD

Signature Page

X

Vice President of CPEP Division

X Sarah Strang 3/12/2024

Sarah Strang
MCOT Program Director

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
The P.E.E.R.S. for Hope House (Hope House) Comprehensive Review
Review Dates: February 26, 2024-March 8, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if client and staff records, service provision to persons served, and policies and procedures complied with the *Health and Human Services Commission (HHSC) Information Item V.VII*; *Texas Administrative Code (TAC) Tac Title 1, Part 15, Chapter 354, Subchapter N, Division 2, Rule §354.*3011; *TAC Title 1, Part 15, Chapter 354, Subchapter N, Division 3, Rule §354.3051 (d)*; *TAC Title 1, Part 15, Chapter 354, Subchapter N, Division 4, Rule §354.3103 (b)(1)-(2), (d)*; *title 1, Part 15, Chapter 354, Subchapter N, Division 6, Rule §354.3205 (f); Title 26, Part 1, Chapter 301, Subchapter G, Division 2, Rule §301.331 (h)(1) and (4)*; *TAC Title 26, Part 1, Chapter 301, Subchapter G, Division 3, Rule §301.361*; *TAC Title 26, Part 1, Chapter 301, Subchapter G, Division 3, Rule §301.363*; *TAC Title 26, Part 1, Chapter 748, Subchapter O, Division 5, Rule §748.3191*; and *The Harris Center for Mental Health and IDD Agency Policies and ProScedures HIM.EHR.B.9.5.I* and *ACC.B.8.5.Discharge.1-4*.

III. Audit Method:
An active client roster was requested from and provided by program leadership. Twenty (20) clients were selected by utilizing an Excel formula to generate a random number list. Client records from the 1st Qtr. FY 2024 (September 1, 2023-November 30, 2023), were reviewed. The review utilized an audit tool developed by Compliance.

IV. Audit Findings/History:
Compliance noted the program was not conducting weekly or monthly supervision meetings; was not documenting monthly observations of peer specialists providing services to persons served; was not providing a unit orientation to persons served within 24 hours of admission; was not providing persons served with wellness and recovery tools; was not offering persons served a Declaration of Mental Health Treatment; was not identifying, linking, or providing necessary assistance to persons served to access community resources; was not compliant with progress note content requirements, completing progress notes within two business days, or individualizing progress notes; and was not completing discharge summaries with the required information. Compliance has not previously audited the PEERS for HOPE House Program.

V. Recommendations:
The program should continue to review documentation (e.g., progress notes, admission documentation, and discharge summaries) for compliance with Agency Policies and Procedures, TAC requirements, and Information Item V requirements. A Plan of Improvement (POI) is required to address deficiencies in employee supervision, guest orientation, provision of wellness and recovery tools, declaration for mental health treatment, daily progress note entries, identifying and linking guests to community-based services, progress note content, and discharge summary requirements.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
2nd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
P.E.E.R.S for Hope House (Hope House) Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Date: February 26, 2024-March 8, 2024

Purpose

This review was conducted to determine if client and staff records, service provision to persons served, and policies and procedures complied with the *Health and Human Services Commission (HHSC) Information Item V.VII*; *Texas Administrative Code (TAC) Tac Title 1, Part 15, Chapter 354, Subchapter N, Division 2, Rule §354.*3011; *TAC Title 1, Part 15, Chapter 354, Subchapter N, Division 3, Rule §354.3051 (d)*; *TAC Title 1, Part 15, Chapter 354, Subchapter N, Division 4, Rule §354.3103 (b)(1)-(2), (d)*; *title 1, Part 15, Chapter 354, Subchapter N, Division 6, Rule §354.3205 (f)*; *Title 26, Part 1, Chapter 301, Subchapter G, Division 2, Rule §301.331 (h)(1) and (4)*; *TAC Title 26, Part 1, Chapter 301, Subchapter G, Division 3, Rule §301.361*; *TAC Title 26, Part 1, Chapter 301, Subchapter G, Division 3, Rule §301.363*; *TAC Title 26, Part 1, Chapter 748, Subchapter O, Division 5, Rule §748.3191*; and *The Harris Center for Mental Health and IDD Agency Policies and Procedures HIM.EHR.B.9.5.I* and *ACC.B.8.5.Discharge.1-4*.

Method

An active client roster was requested from and provided by program leadership. Twenty (20) clients were selected by utilizing an Excel formula to generate a random number list. Client records from the 1st Qtr. FY 2024 (September 1, 2023-November 30, 2023), were reviewed. The review utilized an audit tool developed by Compliance and consisted of five (5) components: policy and procedure requirements (Policy), personnel requirements (Personnel), environment and safety requirements (Environment), medical requirements (Medical), and client record requirements (Client Records).

Findings

Overall Program Score: 91%
Detailed findings are presented below.

Strengths:

Item (Reference)	Score
• Policy requirements (*Information Item V.VII.D*)	100%
• Personnel (i.e., agency-mandated training, background check, signed job description, supervision; *Agency Policies and Procedures*; *TAC §301.331 (h)(1)* and *(4)*; *TAC § 354.3051 (d)*; *TAC §354.3205 (f)*; *TAC §301.363 (a)*; and *TAC §354.3103 (b)(1)-(2), (d)*	96%
• Environment and Safety (*Information Item V.VII.D*; *TAC § 748.3191*)	100%
• Medical (*Information Item V.VII.D*)	100%

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Areas of Improvement:

Item (Reference)	Score
• Client Records (*TAC § 301.361; § 354.3011; Information Item V.VII.D; and Agency Policy and Procedures)*	59%

History

Compliance has not previously reviewed the program.

Recommendations

The program should continue to review documentation (e.g., progress notes, admission documentation, and discharge summaries) for compliance with Agency Policies and Procedures, TAC requirements, and Information Item V requirements. A Plan of Improvement (POI) is required to address deficiencies in employee supervision, guest orientation, provision of wellness and recovery tools, declaration for mental health treatment, daily progress note entries, identifying and linking guests to community-based services, progress note content, and discharge summary requirements. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the Hope House Program Director must sign and return this report to Compliance within seven (7) business days (April 2, 2024).

Management Response

The program has greatly taken in consideration the recommendation for improvement and have initiated a plan of implementation.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X _____

Vice President of Division

X _____

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Northwest (NW) & Southeast (SE) Assertive Community Treatment (ACT) & Forensic Assertive Community Treatment (FACT)
Comprehensive Review
Review Date: March 7, 2024, to April 9, 2024

I. Audit Type:
Comprehensive Review

II. Purpose:
The purpose of the review was to assess the Northwest (NW) and Southeast Assertive Community Treatment ACT) and Forensic Assertive Community Treatment (FACT) programs for compliance with Provider Responsibilities for Treatment Planning and Service Authorization , 26 TAC §301.353(d)(1)(C), §301.353(e)(1)(A-G), §301.353(e)(1)(H)(i-iii), §301.353(e)(2)(A-E), §301.353(f)(1)(A), §301.353(f)(1)(C), §301.353(f)(1)(D), Evaluation and Diagnosis, 25 TAC 415.5 (e), Documentation of Service Provision, 26 TAC §301.161(b)(1)(A), Provider Responsibilities for Treatment Planning and Service Authorization, 26 TAC §301.353(a)(9-10), §301.353(a-b) (a)(10), Evaluation and Diagnosis, 25 TAC §415.6(c), Documentation of Informed Consent, 25 TAC §414.405(a-b), ACC.B.2 Plan of Care, Determination of Ability to Pay, 25 TAC §412.106 (a), Provider Responsibilities for Treatment Planning and Service Authorization, 26 TAC §301.353(h)(1-3), ACT Operational Guidelines, Authorization for Mental Health Case Management, 26 TAC §306.261(a)(1-3), Mental Health Case Management Employee Competencies, 26 TAC §306.273 (a)(1)(A-D), HR.A.16 Organizational Development, Staff Training in Rights of Person Receiving Mental Health Services,25 TAC §404.165(1)(2), and Documentation of Service Provision 26 TAC 301.361.

III. **Audit Method:**
Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the Comprehensive Review Tool developed by Compliance.

IV. Audit Findings and History:
The NW and SE ACT/FACT overall score is 96%. The NW and SE ACT/FACT Program scored 100% on Recovery Plan, 100% on Eligibility and Screening, 100% on Psychiatric Evaluation, 100% Abnormal Involuntary Movement Scale (AIMS) assessment, 79% on Documentation of Informed Medication Consent, 100% on Skills Training and Development, 100% on Medication Training and Support Services, 32% on Personal Crisis/Safety Plan, 100% on Documented Communication of Rights, 100% on Financial Assessment, 75% on Team Leader Documented in Performance Pro, 100% on ACT Staff Member on Call all Hours, 100% on Mental Health Case Management Employee Competencies, 99% on Organizational Development Job Specific Competency Training, 100% on New Employee Training on Rights of Receiving Mental Health Services, 100% on Licensed Nursing Personnel Training, 87 on Documentation of Annual Training and Refreshers and 100% on Progress Notes . The Compliance Department has not previously conducted a comprehensive Review of NW and SE ACT/FACT Program

V. Recommendations:
Compliance recommends that the Program should continue to assess its processes for compliance with TAC requirements, ACT/FACT Operational Guidelines, Agency Plan of Care procedures, Organizational Development Training requirements, and Supervisor documentation in Performance Pro. The program did not meet the Compliance threshold score of 95%. The program is required to submit a plan of improvement (POI) addressing the findings listed in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the ACT/FACT Program Director/Manager acknowledging receipt of this report must sign and return this report to Compliance within seven (7) business days

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Compliance Department Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Northwest (NW) & Southeast (SE) Assertive Community Treatment (ACT) & Forensic Assertive Community Treatment (FACT) Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: March 7, 2024-April 9, 2024,

Purpose

The purpose review was to assess the Northwest (NW) and Southeast Assertive Community Treatment ACT) and Forensic Assertive Community Treatment (FACT) programs for compliance with 26 TAC §301.353(d)(1)(C), §301.353(e)(1)(A-G), §301.353(e)(1)(H)(i-iii), §301.353(e)(2)(A-E), §301.353(f)(1)(A), §301.353(f)(1)(C), §301.353(f)(1)(D), 25 TAC 415.5 (e), 26 TA §301.161(b)(1)(A), §301353(a)(9-10), §301.353(a-b) (a)(10), 25 TAC §415.6(c), 25 TAC §414.405(a-b), ACC.B.2 Plan of Care, 25 TAC §412.106 (a), 26 TAC §301.353(h)(1-3), ACT Operational Guidelines, 26 TAC §306.261(a)(1-3), 26 TAC §306.273 (a)(1)(A-D), HR.A.16 Organizational Development, 25 TAC §404.165(1)(2), and 26 TAC 301.361

Method

Active records were randomly selected from the Affiliated Harris Center Encounter Data Outpatient Service Detail listing report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2024 (September 1, 2023 – November 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the Comprehensive Review Tool developed by Compliance.

Results

Overall Program Score: 96%
Detailed findings are presented below:

Strength:

Item (Citation)	Score
• Recovery Plan ***26 TAC §301.353(f)(1)(A)(C)(D)***	100%
• ACT/FACT Requisite ***25 TAC§412.106(a)(1-5), §26 301(h(1-3)***	100%
• Case Management ***26 TAC §306.261(b)(c)(1-2),26 TAC§306.263(b)(1-6,9,13(c)(1-2)(A)(B)(C) (d)***	100%
• Employee Competency ***26 TAC §306.273(a)(1)(A-D)(a)(2)(3)(a)(4-11)***	100%
• Staff Training HR.A.16, ***25 TAC §404.165(1)(2))***	97%
• Progress Note ***26 TAC §301.361***	100%

Areas of Improvement:

- ACT/FACT Service Compliance 26 ***TAC §301.161(b)(1)(A), §301.353(a)(1, 3-5, 8)(9-10)*** 85%
- ACT/FACT Operational Guidelines clinical Hours of Operations 88%

Observations

- No observations were made during this comprehensive review.

History

The Compliance Department has not previously conducted a comprehensive review of the NW SE ACT FACT Program.

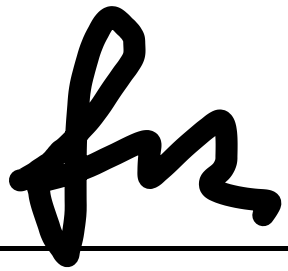
Recommendations

Compliance recommends that the Program should continue to assess its processes for compliance with TAC requirements, ACT/FACT Operational Guidelines, Agency Plan of Care procedures, Organizational Development Training requirements, and Supervisor documentation in Performance Pro. The program did not meet the Compliance threshold score of 95%. in Service Compliance (Informed Medication Consent and Personal Safety Plan and ACT/FACT Operational Guidelines (Clinical Hours of Operation). The program is required to submit a plan of improvement (POI) addressing the findings listed in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the ACT/FACT Program Director/Manager acknowledging receipt of this report must sign and return this report to Compliance within three (3) business days, June 13, 2024.

Management Response

> Acknowledged.

Signature Page

X 

Vice President of MH Division

X Rena Stropes, PM

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Mental Health (MH) Forensic Division
Youth Diversion Center
Comprehensive Review
Review Date: March 18, 2024, to April 8, 2024

I. Audit Type:
Comprehensive Review.

II. Purpose:
The purpose of this review was to assess Youth Diversion service documentation, facility posting requirements, infection control procedures, medication management standards, and staff trainings for compliance with *Health and Human Services Information Item V: Crisis Respite Standards* and *The Harris Center Policy ACC.B.2 Plan of Care on Guidelines for Personal Safety Plans*.

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023, to February 29, 2024), the *Organizational Development Staff Training Roster* report and *The Harris Center Infection Control Department*. Compliance conducted a desk review, sampling ten (10) records using the Youth Diversion Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 88%
Detailed finding(s) is presented below.
The program scored 100% in meeting medication management requirements. The program scored 95% in meeting posting requirements.
The program did not meet the requirements in the following areas: 91% assessment and intake, 63% infection control, 86% staffing requirements, and 94% service documentation.

History

No reviews of this type have been conducted.

V. Recommendations:
Compliance recommends that the Youth Diversion program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with the agency *P&P on Safety Planning* and *HHS Information Item V Crisis Respite* requirements. The Youth Diversion program is required to submit a Plan of Improvement (POI) focusing on the findings outlined within the POI report. The Vice President (VP) of MH Forensic Division and the Program Manager/Director must sign and return this report (management response is optional) along with the POI to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Forensic Division
Youth Diversion
Comprehensive Review

Compliance Auditor(s): Marvin Williams

Review Date: March 18, 2024, to April 8, 2024

Purpose

The purpose of this review was to assess Youth Diversion service documentation, facility posting requirements, infection control procedures, medication management standards, and staff trainings for compliance with *Health and Human Services Information Item V: Crisis Respite Standards, The Harris Center Policy ACC.B.2 Plan of Care on Guidelines for Personal Safety Plans and Texas Administrative Code (TAC) 26 §301.361.*

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data IP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023, to February 29, 2024), the *Organizational Development Staff Training Roster* report and *The Harris Center Infection Control Department*. Compliance conducted a desk review, sampling ten (10) records using the Youth Diversion Review Tool. Detailed data for this review is presented below.

Findings

Overall Program Score: 88%
Detailed findings are presented below.

Strengths:

- Posting requirements (*HHS Information Item V: VI.D.9.a-h*) **95%**
- Medication Management requirements (*HHS Information Item V: VI.D.12.a-e)* **100%**

Areas of Improvement:

- Assessment and Intake (*HHS Information Item V: VI.D.3.c.d.i.(1)-(5), D.3.c.d.i.(1)-(5), and VI.D.4.c.iv)* **91%**
- Infection Control requirements. (*HHS Information Item V: VI.D.11.b.i.ii.and Item V: VI.D.11.b.i.ii).* **63%**
- Staffing requirements (*HHS Information Item V: VI.D.2.a-d)* **86%**
- Service Documentation requirements (*TAC 26 §301.361(a)(4)(11)(12))* **94%**

History

No review of this type has been conducted.

Recommendations

Compliance recommends that the Youth Diversion program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with the agency *P&P on Safety Planning* and *HHS Information Item V Crisis Respite* requirements. The Youth Diversion program is required to submit a Plan of Improvement (POI) focusing on the findings listed in this report. The Vice President (VP) of MH Forensic Division and the Program Manager/Director must sign and return this report (management response is optional) along with the POI to Compliance by the close of business on June 11, 2024.

Management Response

Refer to the attached Plan of Corrective Action

Signature Page

X MonaLisa Jiles

Vice President of MH Forensic Division

X Thelma Adams

Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary
Psychiatric Emergency Services (PES) Focused Review
Review Dates: 04/03/2024 to 05/02/2024

I. **Audit Type:**
Focused Review

II. **Purpose:**
The purpose of this review was to assist the PES Program, Comprehensive Psychiatric Emergency Program (CPEP) Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC), HHS Information Item V, and Agency Policy and Procedures (P&P) concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

III. **Audit Method:**
Compliance ran the AFF HC Encounter Data OP Services Details Report in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2rd Qtr. of FY 2024 (02/01/2024 – 02/29/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 04/03/2024. This desk review was conducted using the Coding Audit Review Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records reviewed for PES Program, CPEP Division, the program met and exceeded standards for all 9 of the 9 elements reviewed with an overall Score of 98%.

V. **Recommendations:**
It is recommended that the Vice President (VP) of Comprehensive Psychiatric Emergency Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Current PES audit findings satisfy the minimum threshold score and as such, no Plan of Improvement is necessary. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (3) business days.

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Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Services (CPEP) Division
PES Program – Physician Coding & Documentation Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 04/03/2024 to 05/02/2024

Purpose

The purpose of this review was to assist the CPEP Division, Psychiatry Emergency Services (PES), in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (*TAC 354.1432; TAC 510.2; TAC 577.010*) and Agency Policy and Procedures (P&P) *(MED.B.6, EM.P.4, GA.B.6, LD.A.13,)* concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

Method

Active records were randomly selected by generating the *Client Services Listing Report* in the EPIC (EHR) system for persons served during the 2rd Qtr. of FY 2024 (February 1, 2024 – February 29, 2024). Compliance reviewed seventy - five (75) client encounters containing physician documentation for crisis service codes and E/M service codes 99702, 99212, 99213, 99214 and 99215. After initial review, client services encounters for PES and CSU encounters were separated based on services utilized within the different programs in CPEP division. Above mentioned sample size was obtained on 04/03/2024. This desk review was conducted using the *E/M Coding Audit Review Tool.*

Findings

Overall Physician (provider) Score – 98%

- Physician documentation met and exceeded expectations in the following areas:
  (1) Evidence of Overlap in Appointment Time – 100%
  (2) Evidence of Copy & Pasting / Cloning within Documentation – 97%
  (3) Evidence of Medically Appropriate History – 97%
  (4) Evidence of Medically Appropriate Examination – 100%
  (5) Appropriate Medical Decision Making (MDM) codes for service – 94%
  (6) Appropriate codes for Face to Face / Telehealth (TH) on date of service – 100%
  (7) Appropriate consent received for services rendered by QMHP – 100%
  (8) Appropriate secondary services billed and documented from Assessment & Plan – 97%
  (9) Evidence for authorized and approved codes for secondary services – 100%

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Recommendations

It is recommended that the Vice President (VP) of Comprehensive Psychiatric Emergency Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. Current PES audit findings satisfy the minimum threshold score and as such, no Plan of Improvement is necessary. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (3) business days.

The HARRIS CENTER for Mental Health and IDD

Management Response:
[Insert Response Here]

X Vinay Kapoor

Program Director/Manager 6/5/2024

X

Program Director/Manager

X

Compliance Director/Manager

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary
Crisis Stabilization Unit (CSU) Focused Review
Review Dates: 04/03/2024 to 05/02/2024

I. **Audit Type:**
Focused Review

II. **Purpose:**
The purpose of this review was to assist the CSU Program, Comprehensive Psychiatric Emergency Program (CPEP) Division in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 American Medical Association (AMA) Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (TAC), HHS Information Item V, and Agency Policy and Procedures (P&P) concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

III. **Audit Method:**
Compliance ran the AFF HC Encounter Data OP Services Details Report in the Electronic Health Record (EHR) system to identify an appropriate sample size for persons served during the 2rd Qtr. of FY 2024 (02/01/2024 – 02/29/2024). Compliance reviewed client encounters containing physician documentation for service codes 99702, 99212, 99213, 99214 and 99215. Sample size was obtained on 04/03/2024. This desk review was conducted using the Coding Audit Review Tool. Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records reviewed for CSU Program, CPEP Division, the program met and exceeded standards for 7 of the 9 elements reviewed with an overall Score of 88%. There was however, evidence for copy & pasting / cloning within documentation as well a significant global finding affecting all service encounters within the Crisis Stabilization Unit (CSU). All current service encounters are documented and coded as out-patient services while crisis, in-patient services are provided and utilized.

V. **Recommendations:**
It is recommended that the Vice President (VP) of Comprehensive Psychiatric Emergency Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. A suitable determination that reflects state guidelines between inpatient and outpatient care must be made and documented within Agency Policy & Procedures to reflect the ongoing 24 hour crisis care provided at the Agency CSU facility. Appropriate inpatient and crisis coding options should be integrated within the context of current EMR systems as deemed appropriate. Key program/division stakeholders are required to present a Plan of Improvement during subsequent audits. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (3) business days.

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Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Services (CPEP) Division
CSU Program – Physician Coding & Documentation Review

Compliance Auditor(s): Prakash Thomas

Compliance Review: 04/03/2024 to 05/02/2024

Purpose

The purpose of this review was to assist the CPEP Division, Crisis Stabilization Unit (CSU), in assessing Physician Documentation for compliance with Centers for Medicare and Medicaid Services (CMS) Regulations and Guidance, Current Procedural Terminology (CPT) guidelines, 2024 AMA Evaluation and Management (E/M) Documentation guidelines, the Texas Administrative Code (*TAC 354.1432; TAC 510.2; TAC 577.010*) and Agency Policy and Procedures (P&P) *(MED.B.6, EM.P.4, GA.B.6, LD.A.13,)* concerning mental health documentation standards. This review is a follow-up to an externally contracted review regarding Physician Documentation.

Method

Active records were randomly selected by generating the *Client Services Listing Report* in the EPIC (EHR) system for persons served during the 3rd Qtr. of FY 2024 (February 1, 2024 – February 29, 2024). Compliance reviewed seventy - five (75) client encounters containing physician documentation for crisis service codes and E/M service codes 99702, 99212, 99213, 99214 and 99215. After initial review, client services encounters for PES and CSU encounters were separated based on services utilized within the different programs in CPEP division. Above mentioned sample size was obtained on 04/03/2024. This desk review was conducted using the *E/M Coding Audit Review Tool.*

Findings

Overall Physician (provider) Score – 88%

- Physician documentation met and exceeded expectations in the following areas:
  (1) Evidence of Overlap in Appointment Time – 100%
  (2) Evidence of Medically Appropriate History – 100%
  (3) Evidence of Medically Appropriate Examination – 100%
  (4) Appropriate Medical Decision Making (MDM) codes for service – 100%
  (5) Appropriate codes for Face to Face / Telehealth (TH) on date of service – 100%
  (6) Appropriate consent received for services rendered by QMHP – 100%
  (7) Evidence for authorized and approved codes for secondary services – 100%

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- Physician documentation did not meet expectations in the following areas:
  (1) Evidence for copy & pasting / cloning within documentation – 88%
  (2) Appropriate services billed and documented bases on Assessment and Plan – 0%

Observations:

Finding #2 (above) was determined to be a global finding affecting all service encounters within the Crisis Stabilization Unit (CSU). All current service encounters are documented and coded as out-patient services while crisis, in-patient services are utilized. As per HHS definitions and regulations stated in Information Item V, a Crisis Stabilization Unit is defined as the following:

> **Crisis Stabilization Unit (CSU)** – a crisis stabilization unit providing short-term residential treatment 24 hours a day, every day of the year, in a secure and protected treatment environment licensed in accordance with Texas Health and Safety Code Chapter 577 (relating to Private Mental Hospitals and Other Mental Health Facilities)
>
> a. CSU services are provided by medical personnel, mental health professionals, and trained support staff with documented competency in the provision of crisis services designed to reduce an individual's acute mental health symptoms.
>
> b. CSU services are provided in accordance with standards in 26 TAC, Chapter 306, Subchapter B (relating to Standards of Care in Crisis Stabilization Units) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards).

As per HHS definitions and regulations stated in Information Item V, an Inpatient service is defined as the following:

> Inpatient Services – Services including medical, nursing, and mental health professionals providing 24-hour monitoring, supervision, and interventions designed to relieve acute psychiatric symptomatology and restore an individual's ability to function in a less restrictive setting. Inpatient units must comply with 26 TAC Chapter 568 (relating to Standards of Care and Treatment in Psychiatric Hospitals).

No prior review history.

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Recommendations

It is recommended that the Vice President (VP) of Comprehensive Psychiatric Emergency Services review the findings and collaborate with the appropriate personnel to assess and ensure physician services are documented in accordance with Information Item V, TAC, CPT, CMS, E/M guidelines and Agency P&P. A suitable determination that reflects state guidelines between inpatient and outpatient care must be made and documented within Agency Policy & Procedures to reflect the ongoing 24 hour crisis care provided at the Agency CSU facility. Appropriate inpatient and crisis coding options should be integrated within the context of current EMR systems as deemed appropriate. Key program/division stakeholders are required to present a Plan of Improvement during subsequent audits. Compliance will continue to provide essential support to the physicians regarding their documentation of services, including review of documentation from a credentialed professional coder. The VP of Mental Health Medical Services must return a signed copy acknowledging receipt of this report to Compliance within seven (3) business days.

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Management Response:
[Insert Response Here]

X Vinay Kapoor

Program Director/Manager 6/5/2024

X

Program Director/Manager

X Demetria Luckett

Compliance Director/Manager

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
The Harris Center Independent Living (IL) Comprehensive Review
Review Dates: April 12, 2024-April 17, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the IL Program was compliant with the Texas Administrative Code (TAC) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (e)-(f), Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d), and Staff Training in Rights of Persons Receiving Mental Health Services 25 TAC § 404.165; Environment 25 TAC § 448.211; Operational Plan, Policies, and Procedures 25 TAC §§ 448.502 (a)-(c), General Environment 25 TAC §§ 448.505 (a)-(h), Required Postings 25 TAC §§ 448.506 (a)-(b), Client Transportation 25 TAC §§ 448.510 (a)-(b), Hiring Practices 25 TAC §§ 448.601 (d)-(f), Training 25 TAC §§ 448.603 (c)-(d), Client Bill of Rights 25 TAC §§ 448.701 (a)-(c), Client Grievances 25 TAC §§ 448.702 (a)-(f), Program Rules 25 TAC §§ 448.704 (a)-(d), Responding to Emergencies 25 TAC §§ 448.707 (a)-(d), Searches 25 TAC §§ 448.708 (a)-(f), Treatment Planning, Implementation and Review 25 TAC §§ 448.804 (b)-(h), General Provisions for Medication 25 TAC §§ 448.1001 (a)-(e), Medication Storage 25 TAC §§ 448.1002 (a)-(f), Medication Inventory and Disposal 25 TAC §§ 448.1003 (a)-(e), Administration of Medication 25 TAC §§ 448.1004 (a)-(f), Meals Provided by a Food Service 25 TAC § 448.1104 (c), Emergency Evacuation 25 TAC §§ 448.1203 (1)-(4), Exits 25 TAC §§ 448.1204 (a)-(b)(d), Space, Furniture and Supplies 25 TAC §§ 448.1205 (a)(c)-(f), Fire Systems 25 TAC §§ 448.1206 (a)-(f),* and *Other Physical Plant Requirements 25 TAC §§ 448.1207 (a)-(j); Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §§ 301.353 (a)(e)(h), Documentation of Service Provision 26 TAC §§ 301.361 (a)-(b), and Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b),* and *Documenting MH Case Management Services 26 TAC § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services; The Harris Center Policies and Procedures ACC.B.2 Plan of Care, Agency Procedure ACC.B.8 Referral, Transfer, and Discharge, Agency Procedure ACC.B.14 Declaration of Mental Health Treatment, HIM.EHR.B.5 Content of Patient/Individual Record, HIM.EHR.9 Patient/Individual Records Administration,* and *required employee training courses.*

III. Audit Method:
A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients and five (5) employee records were selected by using an Excel formula to generate a random number list. The review utilized an audit tool developed by Compliance and consisted of five (5) components: policy and procedure requirements (policy), environment requirements (environment), medical requirements (medical), personnel requirements (personnel), and client record requirements (client records).

IV. Audit Findings and History:
The IL Program had an overall score of 80%. The program scored 100% on medical requirements. The program scored 90% on policy requirements, 78% on environment requirements, 90% on personnel requirements, and 42% on client record requirements. Compliance has not previously audited the IL Program. A Plan of Improvement was required because of this review.

V. The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation), employee records (i.e., annual training requirements), program documentation (i.e., operational guidelines), and environment requirements (i.e., posting the Client Bill of Rights) for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
The Harris Center Independent Living (IL) Program Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: April 12, 2024-April 17, 2024

Purpose

This review was conducted to determine if the IL Program was compliant with the Texas Administrative Code (TAC) *Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (e)-(f), Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d), and Staff Training in Rights of Persons Receiving Mental Health Services 25 TAC § 404.165; Environment 25 TAC § 448.211; Operational Plan, Policies, and Procedures 25 TAC §§ 448.502 (a)-(c), General Environment 25 TAC §§ 448.505 (a)-(h), Required Postings 25 TAC §§ 448.506 (a)-(b), Client Transportation 25 TAC §§ 448.510 (a)-(b), Hiring Practices 25 TAC §§ 448.601 (d)-(f), Training 25 TAC §§ 448.603 (c)-(d), Client Bill of Rights 25 TAC §§ 448.701 (a)-(c), Client Grievances 25 TAC §§ 448.702 (a)-(f), Program Rules 25 TAC §§ 448.704 (a)-(d), Responding to Emergencies 25 TAC §§ 448.707 (a)-(d), Searches 25 TAC §§ 448.708 (a)-(f), Treatment Planning, Implementation and Review 25 TAC §§ 448.804 (b)-(h), General Provisions for Medication 25 TAC §§ 448.1001 (a)-(e), Medication Storage 25 TAC §§ 448.1002 (a)-(f), Medication Inventory and Disposal 25 TAC §§ 448.1003 (a)-(e), Administration of Medication 25 TAC §§ 448.1004 (a)-(f), Meals Provided by a Food Service 25 TAC § 448.1104 (c), Emergency Evacuation 25 TAC §§ 448.1203 (1)-(4), Exits 25 TAC §§ 448.1204 (a)-(b)(d), Space, Furniture and Supplies 25 TAC §§ 448.1205 (a)(c)-(f), Fire Systems 25 TAC §§ 448.1206 (a)-(f),* and *Other Physical Plant Requirements 25 TAC §§ 448.1207 (a)-(j); Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §§ 301.353 (a)(e)(h), Documentation of Service Provision 26 TAC §§ 301.361 (a)-(b), and Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b),* and *Documenting MH Case Management Services 26 TAC § 306.275 (c); the Texas Health and Human Services Commission Information Item V Section VI Crisis Respite Services; The Harris Center Policies and Procedures ACC.B.2 Plan of Care, Agency Procedure ACC.B.8 Referral, Transfer, and Discharge, Agency Procedure ACC.B.14 Declaration of Mental Health Treatment, HIM.EHR.B.5 Content of Patient/Individual Record, HIM.EHR.9 Patient/Individual Records Administration,* and *required employee training courses.*

Methods

A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients and five (5) employee records were selected by using an Excel formula to generate a random number list. The review utilized an audit tool developed by Compliance and consisted of five (5) components: policy and procedure requirements (policy),

environment requirements (environment), medical requirements (medical), personnel requirements (personnel), and client record requirements (client records).

Findings

Overall Score: 80%
Detailed findings are presented below:

Strengths:

• Medical requirements (*TAC §§448.1001, 1002, 1003, 1004;* and *Item V: VI*)	**100%**

Areas of Improvement:

• Policy requirements (*TAC §§448.502, 510, 702, 704, 707, 708, 1001; TAC §404.161;* and *Item V: VI*)	90%
• Environment requirements (*TAC §§448.506, 510, 701, 702, 704, 707, 708, 1104, 1203, 1204, 1205, 1206, 1207; TAC §404.165; and Item V: VI*)	78%
• Personnel requirements (*TAC §301.363; TAC §404.165; TAC §§448.601* and *603*; and *Agency training requirements*)	90%
• Client Records (*TAC §§301.353* and *361; TAC §306.263* and *275; TAC §448.804*)	42%

Observations

- Case management services were not documented during the review period.

History

Compliance has not previously audited the IL Program.

Recommendations

The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation), employee records (i.e., annual training requirements), program documentation (i.e., operational guidelines), and environment requirements (i.e., posting the Client Bill of Rights) for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the IL Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (May 10, 2024).

, The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Optum Integrated Behavioral Health Home Care Comprehensive Review
Review Date: April 18, 2024, to April 26, 2024

I. Audit Type:
Comprehensive Review

II. Purpose:
This review was conducted to determine if the Optum Integrated Behavioral Health Home Care Program was compliant with the *Integrated Behavioral Health Home (IBHH) Incentive Agreement, Agency Procedures Referral, Transfer and Discharge ACC.B. 8*, *Plan of Care ACC.B2, Documentation of Service Provision 26 TAC §301.361 and Organizational* Development Required Employee Training HR.16.

III. **Audit Method:**
A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients were randomly selected, and six (6) employee training records were provided to Compliance by the Human Resources (HR) Department. The review utilized an audit tool developed by Compliance and consisted of seven (7) components: Enrollment and Assessment, Health Action Plan (HAP), Discharges, Administrative Review, Staff Training, Safety Plan and Progress Notes.

IV. Audit Findings and History:
The Optum Integrated Behavioral Health Home Care overall score is 45%. The Optum Integrated Behavioral Health Home Care Program scored 100% on Documentation of Service Provision, 8% on Enrollment and Assessment, 86% on Administrative Review, 10% on Health Action Plan, 67% on Staff Training and 0% on Personal Safety Plan. Optum Integrated Behavioral Health Hoe Care did not have operational guideline that they follow. Compliance has not previously audited the Optum Integrated Behavioral Health Home Care Program.

V. Recommendations:
The Program should continue to review client record (e.g., Client Enrollment and Assessment, HAP, Administrative records, Staff Training, Personal Safety Plan, and progress notes, for compliance with Integrated Behavioral Health Home Incentive Program Agreement Between Harris Center and United Health Care and Agency Procedures. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the Optum Integrated Behavioral Hea Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH)) Division
Optum Integrated Behavioral Health Home Car Comprehensive Review

Compliance Auditor(s): Emmanuel Golakai

Review Dates: April 18, 2024-April 26, 2024

Purpose

This review was conducted to determine if the Optum Integrated Behavioral Health Home Care Program was compliant with the *Integrated Behavioral Health Home (IBHH) Incentive Agreement, Agency Procedures Referral, Transfer and Discharge ACC.B. 8*, *Plan of Care ACC.B2, Documentation of Service Provision 26 TAC §301.361 and Organizational* Development Required Employee Training HR.16.

Methods

A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Twenty (20) clients were randomly selected, and six (6) employee training records were provided to Compliance by the Human Resources (HR) Department. The review utilized an audit tool developed by Compliance and consisted of seven (7) components: Enrollment and Assessment, Health Action Plan (HAP), Discharges, Administrative Review, Staff Training, Safety Plan and Progress Notes.

Findings

Overall Score: 45%
Detailed findings are presented below:

Strengths:

- Documentation of Service Provision ***(26 TAC §301.361)*** 100%

Areas of Improvement:

- Enrollment and Assessment (***IBH Agreement)*** 8%
- Administrative Review (***IBHH Agreement)*** 86%
- Health Action Plan (HAP ***(IBHH Agreement)*** 10%
- Staff Training ***(HR.A.16 Organizational Development)*** 67%
- Personal Safety Plan ***(ACC.B.2 Plan of Care)*** 0%

Observations

- Optum Integrated Behavioral Health Home Care do not have operational guidelines that they follow.

History

Compliance has not previously audited the Optum Integrated Behavioral Health Home Care Program.

Recommendations

The Program should continue to review client record (e.g., Client Enrollment and Assessment, HAP, Administrative records, Staff Training, Personal Safety Plan, and progress notes, for compliance with Integrated Behavioral Health Home Incentive Program Agreement Between Harris Center and United Health Care and Agency Procedures. A Plan of Improvement (POI) is required to address the deficiencies noted in this report.
Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the Optum Integrated Behavioral Hea Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (May 31, 2024).

Management Response

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Plan of Improvement (POI) Review:
Community Unit Probation Services (CUPS)
Mental Health (MH) Division
Review Dates: April 23- 25, 2024

I. **Audit Type:**
POI Review

II. **Purpose:**
The purpose of this review is to ensure the CUPS Program is implementing the corrective action steps identified from the POI review that was conducted during the 3rd Qtr. of FY2023 and are complying with the rules and regulations from the Texas Administrative Code (TAC) *§301.353(e)(1) (A,B,D), §301.353(f)(1)(A), §301.361(b), §301.353*, and Agency P&P *ACC.B.2*.

III. **Audit Method:**
Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023- February 29, 2024). Compliance was provided five (5) individual names from the CUPS Program for the review. Compliance completed the review utilizing a Review tool created by Compliance.

IV. **Audit Findings and History:**
Of the records reviewed for CUPS, the program had an overall score of 98%. In the area of Treatment Planning, the program scored 100%. They met and exceeded standards in the following areas: The POCs were consistently signed within ten (10) business days after the date of receipt of notification from the department or its designee that the person served is eligible and has been authorized for routine care services (100%), the provider reviewed the individual's treatment plan prior to requesting authorization for the continuation of services (100%), and eligibility was documented with applicable guidelines (i.e., current POCs were authorized for services). In the area of Progress Note Documentation, the program scored 95%. They met and exceeded standards in the following areas: Eligibility was documented within applicable guidelines (i.e., the individual was eligible for the service) (100%) and there were progress notes not completed within two (2) business days (97%).

The Compliance Department conducted a previous audit during the 3rd Qtr. (April 11th, 2023- May 12th, 2023).

V. **Recommendations:**
The CUPS Program should continue to assess treatment planning and progress note documentation to ensure it is in accordance with TAC and Agency P&P. Due to an overall score of 98%, the Program will not be required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business.

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Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Division
Southwest (SW) Children and Adolescent Services (CAS)
Community Unit Probation Services (CUPS)
Plan of Improvement (POI) Review

Compliance Auditor(s): Coneka Caleb

Review Dates: April 23- 25, 2024

Purpose

The purpose of this review is to ensure the CUPS Program is implementing the corrective action steps identified from the POI review that was conducted during the 3rd Qtr. Of FY2023 and are complying with the rules and regulations from the *Texas Administrative Code (TAC) §301.353(e)(1) (A, B, D), §301.353(f)(1)(A), §301.361(b), §301.353,* and Agency P&P *ACC.B.2.*

Method

Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023- February 29, 2024). Compliance was provided five (5) individual names from the CUPS Program for the review. Compliance completed the review utilizing a Review tool created by Compliance.

Findings

The Program received an overall score of **98%.** Detailed findings are presented below.

Treatment Planning	**100%**
The POCs were consistently signed within ten (10) business days after the date of receipt of notification from the department or its designee that the person served is eligible and has been authorized for routine care services. *§301.353(e)(1)(A,B,D)*	100%
The provider reviewed the individual's treatment plan prior to requesting authorization for the continuation of services. *§301.353(f)(1)(A)*	100%
Eligibility was documented with applicable guidelines (i.e., current POCs were authorized for services). *§301.353; ACC.B.2*	100%
Progress Note Documentation	**95%**
Eligibility was documented within applicable guidelines (i.e., the individual was eligible for the service). *301.353*	100%
There were progress notes not completed within two (2) business days. *§301.361(a)(b)*	97%

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Observations

Juvenile Justice (JJ) is updating their CUPS Program. JJ is also working towards developing and expanding the CUPS Program to other MH clinics: Northeast, Northwest, and Southeast. At the time of this review, it should be noted that the CUPS Program is currently serving five (5) individuals.

History

A previous audit was conducted during the 3rd Qtr. (April 11th, 2023- May 12th, 2023).

Recommendations

The CUPS Program should continue to assess treatment planning and progress note documentation to ensure it is in accordance with TAC and Agency P&P. Due to an overall score of 98%, the Program will not be required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days by close of business, May 13, 2024.

Management Response:

Clinicians involved with the CUPS Program will be reminded to complete notes within 2 business days and will be documented in Performance Pro

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Signature Page

X _____

Vice President of IDD Division

X _____

Program Director/Manager

X Demetria Luckett

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Executive Summary Cover Sheet
Mental Health (MH) Forensic Division
Texas Correctional Office on Offender with Medical or Mental Impairments (TCOOMMI Jr)
Follow-Up Review
Review Date: April 25, 2024, to April 30, 2024

I. Audit Type:
Comprehensive Review.

II. Purpose:
The purpose of this review was to assess TCOOMMI Jr. case plan/treatment plan for compliance with *Texas Department of Criminal Justice PGP 01.05 Revision 2: Program Guidelines and Processes for Juvenile Case Management.*

III. Audit Method:
Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023, to February 29, 2024) and for one (1) person served during. Compliance conducted a desk review, sampling fifteen (15) records using the TCOOMMI Jr case plan/treatment plan Review Tool. Detailed data for this review is presented below.

IV. Audit Findings and History:
Overall Program Score: 98%
Detailed finding(s) is presented below.
The program scored 100% in meeting the requirements for parole treatment plans *(TAC §301.353 (e) (1) (A-H) (i-iii (2) (A-E)*. The program scored 95% in meeting probation case plan requirements *(PGP 01.05 Revision 2-III A-F)*.
The program did not the meet the requirements for providing the probation case plan to the juvenile and family with seven (7) calendar days and not reviewing and updating probation case plans within twenty-one (21) to thirty-five (35) days of the previous plan development.

History

A review of this type was conducted in the 3rd Qtr. FY 2023

V. Recommendations:
Compliance recommends that the TCOOMMI Jr program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with the *Texas Department of Criminal Justice PGP 01.05 Revision 2 Program Guidelines and Processes for Juvenile Case Management.*
The Youth Diversion program is required to submit a Plan of Improvement (POI) focusing on the findings listed in this report. The Vice President (VP) of MH Forensic Division and the Program Manager/Director must sign and return this report (management response is optional) along with the POI to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH) Forensic Division
Texas Correctional Office on Offender with Medical or Mental Impairments
(TCOOMMI Jr.)
Follow-up Review

Compliance Auditor(s): Marvin Williams

Review Date: April 25, 2024, to April 30, 2024

Purpose

The purpose of this review was to assess TCOOMMI Jr. case plans/treatment plan for compliance with *Texas Department of Criminal Justice PGP 01.05 Revision 2: Program Guidelines and Processes for Juvenile Case Management and Texas Administrative Code (TAC): Provider Responsibilities for Treatment Planning and Service Administration 26 TAC §301.353 (e) (1) (A-H) (i-iii (2) (A-E)*

Method

Active records were randomly selected from *the Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2024 (December 1, 2023, to February 29, 2024) and for one (1) person served during the 3rd Qtr. of FY 2024 (March 1, 20224 to March 31, 2024). Compliance conducted a desk review, sampling fifteen (15) records using the TCOOMMI Jr case plan/treatment plan Review Tool.

Findings

Overall Program Score: 98%
Detailed findings are presented below.

Strengths:
Parole: Treatment Plans requirements *(TAC §301.353 (e) (1) (A-H) (i-iii (2) (A-E):* **100%**

Areas of Improvement:
Probation: Case Plans/Treatment Plans requirements: *(PGP 01.05 Revision 2-III A-F):* **95%**

History

A review of this type was conducted in the 3rd Qtr. of FY 2023.

Recommendations

Compliance recommends that the TCOOMMI Jr program review the findings and continue to assess its processes to ensure all required standards are completed in accordance with the *Texas Department of Criminal Justice PGP 01.05 Revision 2 Program Guidelines and Processes for Juvenile Case Management and TAC standards on provider responsibilities for treatment planning*. The TCOMMII Jr. program is required to submit a Plan of Improvement (POI)

focusing on the findings listed in this report. The Vice President (VP) of MH Forensic Division and the Program Manager/Director must sign and return this report (management response is optional) along with the POI to Compliance within seven (7) business days on June 4, 2024.

Management Response

All case plans have been reviewed by the Assistant Program Director and the Consultant for Forensic Juvenile Justice Services. We agree with the findings. To maintain compliance with PGP 01.05 Revision 2-III A-F Case/Treatment Plan, the Assistant Program Director has met with the Epic and Program Improvement team to create a note in Epic that will track plan start/end dates, type of supervision, Juvenile Probation Officer, probation start/end dates, date of plan review, and date the plan was given to the family. This will allow the Assistant Program Director to generate a report detailing compliance with TCOOMMI guidelines. The Assistant Program Director will continue to meet with the LPHAs to review the TCOOMMI Program Guidelines and Processes for Juvenile Case Management to ensure understanding of program requirements.

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Signature Page

X 6/6/24

Monalisa Jiles, LPC, NCC
Vice President of MH Forensic Division

X

Jasper York, MS, LPC
Program Director/Manager

X Demetria Luckett

Director of Compliance

The Harris Center for Mental Health and IDD
The Compliance Department
Executive Summary Cover Sheet
Substance Use Recovery Services Detoxification (Detox) Program Comprehensive Review
Review Dates: April 29, 2024-May 6, 2024

I. Audit Type:
Comprehensive

II. Purpose:
This review was conducted to determine if the Detox Program was compliant with the Texas Administrative Code (TAC) *Admission Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TAC §§3.8007, Continued Stay Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TAC §§3.8008, Admission Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TAC §§3.8011, Continued Stay Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TAC §§3.8012, Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (e)-(f), Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d),* and *Staff Training in Rights of Persons Receiving Mental Health Services 25 TAC § 404.165; Environment 26 TAC § 564.14; Standards of Conduct 26 TAC §§564.21 (d), Operational Plan, Policies, and Procedures 26 TAC §§ 564.502 (a)-(c), Quality Management 26 TAC §§564.504, General Environment 26 TAC §§ 564.505 (a)-(i), Required Postings 26 TAC §§ 564.506 (a)-(b), Client Transportation 26 TAC §§ 564.510 (a)-(b), Hiring Practices 26 TAC §§ 564.601 (b)* and *(d)-(f), Training 26 TAC §§ 564.603 (c)-(d), Client Bill of Rights 26 TAC §§ 564.701 (a)-(c), Client Grievances 26 TAC §§ 564.702 (a)-(e), Abuse, Neglect, and Exploitation 26 TAC §§564.703 (j)(2), Program Rules 26 TAC §§ 564.704 (a)-(c), Responding to Emergencies 26 TAC §§ 564.707 (a)-(d), Searches 26 TAC §§ 564.708 (a)-(f), Screening 26 TAC §§564.801 (a), Admissions Authorization and Consent to Treatment 26 TAC §§564.802 (b)-(d), Assessment 26 TAC §§564.803 (a)* and *(f)-(g), Treatment Planning, Implementation and Review 26 TAC §§ 564.804 (b)-(h), Discharge 26 TAC §§564.805 (e)-(i), Requirements Applicable to All Treatment Providers 26 TAC §§564.901 (d)-(f)* and *(m), Requirements Applicable to Detoxification Services 26 TAC §§564.902 (a), (c), (e), (g),* and *(j)-(k), General Provisions for Medication 26 TAC §§ 564.1001 (a)* and *(d)-(e), Medication Storage 26 TAC §§ 564.1002 (a)-(e), Medication Inventory and Disposal 26 TAC §§ 564.1003 (a)-(e), Administration of Medication 26 TAC §§ 564.1004 (c)-(f), Meals Provided by a Food Service 26 TAC § 564.1104 (c), Emergency Evacuation 26 TAC §§ 564.1203 (1)-(4), Exits 26 TAC §§ 564.1204 (a)-(b)(d), Space, Furniture and Supplies 26 TAC §§ 564.1205 (a)(c)-(f), Fire Systems 26 TAC §§ 564.1206 (a)-(f),* and *Other Physical Plant Requirements 26 TAC §§ 564.1207 (a)-(f)* and *(h)-(j); Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §§ 301.353 (a)(e)(h), Documentation of Service Provision 26 TAC §§ 301.361 (a)-(b),* and *Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b),* and *Documenting MH Case Management Services 26 TAC § 306.275 (c); The Harris Center Policies and Procedures ACC.B.2 Plan of Care, Agency Procedure ACC.B.8 Referral, Transfer, and Discharge, Agency Procedure ACC.B.14 Declaration of Mental Health Treatment, HIM.EHR.B.5 Content of Patient/Individual Record, HIM.EHR.9 Patient/Individual Records Administration, Med.Nur.B.10 Supervision of Self Administration of Medication (SSAM),* and *required employee training courses*.

III. Audit Method:
A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Ten (10) records of persons served during the 2nd Qtr. FY 2024 were reviewed. Five (5) employee records were selected by using an Excel formula to generate a random number list. The review utilized an audit tool developed by Compliance and consisted of five (5) components: policy and procedure requirements (Policy), environment requirements (Environment), medical requirements (Medical), personnel requirements (Personnel), and client record requirements (Client Records).

IV. Audit Findings and History:
The Detox Program had an overall score of 92%. The program scored 100% on Medical requirements, 100% on Policy requirements, and 100% on Environment requirements. The program scored 82% on Personnel requirements and 79% on Client Record requirements. Compliance has not previously audited the Detox Program. A Plan of Improvement was required because of this review.

V. The Program should continue to review client documentation (e.g., progress notes, treatment plans, admission documentation, and discharge documentation) and employee records (i.e., annual training requirements) for compliance with regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd (Qtr.) of Fiscal Year (FY) 2024
Comprehensive Psychiatric Emergency Program (CPEP) Division
Substance Use Recovery Services Detoxification (Detox) Program Comprehensive Review

Compliance Auditor(s): Christopher Beard

Review Dates: April 29, 2024-May 6, 2024

Purpose

This review was conducted to determine if the Detox Program was compliant with the Texas Administrative Code (TAC) *Admission Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TAC §§3.8007, Continued Stay Criteria for Inpatient (Hospital or 24-hour Residential) Detoxification Services 28 TAC §§3.8008, Admission Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TAC §§3.8011, Continued Stay Criteria for Inpatient Rehabilitation/Treatment (Hospital or 24-hour Residential) Services 28 TAC §§3.8012, Rights Handbooks for Persons Receiving Mental Health Services at Department Facilities, Community Centers, and Psychiatric Hospitals Operated by Community Centers 25 TAC §§ 404.161 (e)-(f), Communication of Rights to Individuals Receiving Mental Health Services 25 TAC §§ 404.163 (a)-(d),* and *Staff Training in Rights of Persons Receiving Mental Health Services 25 TAC § 404.165; Environment 26 TAC § 564.14; Standards of Conduct 26 TAC §§564.21 (d), Operational Plan, Policies, and Procedures 26 TAC §§ 564.502 (a)-(c), Quality Management 26 TAC §§564.504, General Environment 26 TAC §§ 564.505 (a)-(i), Required Postings 26 TAC §§ 564.506 (a)-(b), Client Transportation 26 TAC §§ 564.510 (a)-(b), Hiring Practices 26 TAC §§ 564.601 (b)* and *(d)-(f), Training 26 TAC §§ 564.603 (c)-(d), Client Bill of Rights 26 TAC §§ 564.701 (a)-(c), Client Grievances 26 TAC §§ 564.702 (a)-(e), Abuse, Neglect, and Exploitation 26 TAC §§564.703 (j)(2), Program Rules 26 TAC §§ 564.704 (a)-(c), Responding to Emergencies 26 TAC §§ 564.707 (a)-(d), Searches 26 TAC §§ 564.708 (a)-(f), Screening 26 TAC §§564.801 (a), Admissions Authorization and Consent to Treatment 26 TAC §§564.802 (b)-(d), Assessment 26 TAC §§564.803 (a)* and *(f)-(g), Treatment Planning, Implementation and Review 26 TAC §§ 564.804 (b)-(h), Discharge 26 TAC §§564.805 (e)-(i), Requirements Applicable to All Treatment Providers 26 TAC §§564.901 (d)-(f)* and *(m), Requirements Applicable to Detoxification Services 26 TAC §§564.902 (a), (c), (e), (g),* and *(j)-(k), General Provisions for Medication 26 TAC §§ 564.1001 (a)* and *(d)-(e), Medication Storage 26 TAC §§ 564.1002 (a)-(e), Medication Inventory and Disposal 26 TAC §§ 564.1003 (a)-(e), Administration of Medication 26 TAC §§ 564.1004 (c)-(f), Meals Provided by a Food Service 26 TAC § 564.1104 (c), Emergency Evacuation 26 TAC §§ 564.1203 (1)-(4), Exits 26 TAC §§ 564.1204 (a)-(b)(d), Space, Furniture and Supplies 26 TAC §§ 564.1205 (a)(c)-(f), Fire Systems 26 TAC §§ 564.1206 (a)-(f),* and *Other Physical Plant Requirements 26 TAC §§ 564.1207 (a)-(f)* and *(h)-(j); Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §§ 301.353 (a)(e)(h), Documentation of Service Provision 26 TAC §§ 301.361 (a)-(b),* and *Supervision 26 TAC § 301.363 (a)(1); MH Case Management Services Standards 26 TAC § 306.263 (b),* and *Documenting MH Case Management Services 26 TAC § 306.275 (c); The Harris Center Policies and Procedures ACC.B.2 Plan of Care, Agency Procedure ACC.B.8 Referral, Transfer, and Discharge, Agency Procedure ACC.B.14 Declaration of Mental Health*

Treatment, HIM.EHR.B.5 Content of Patient/Individual Record, HIM.EHR.9 Patient/Individual Records Administration, Med.Nur.B.10 Supervision of Self Administration of Medication (SSAM), and *required employee training courses.*

Methods

A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024) and an employee roster was requested from and provided by program leadership. Ten (10) records of persons served during the 2nd Qtr. FY 2024 were reviewed. Five (5) employee records were selected by using an Excel formula to generate a random number list. The review utilized an audit tool developed by Compliance and consisted of five (5) components: policy and procedure requirements (Policy), environment requirements (Environment), medical requirements (Medical), personnel requirements (Personnel), and client record requirements (Client Records).

Findings

Overall Score: 92%

Detailed findings are presented below:

Strengths: Item (Citations)	Score
• Policy requirements (*TAC §§404.161; §§564.21, 502, 504, 510, 702, 703, 704, 707, 708, 1001*)	100%
• Environment requirements (*TAC §§564.14, 505, 506, 510, 701, 704, 707, 708, 901, 902, 1104, 1104, 1203, 1204, 1205, 1206, 1207*)	100%
• Medical requirements (*TAC §§564.902, 1001, 1002, 1003, 1004*)	100%
Areas of Improvement:	
• Personnel requirements (*TAC §301.363; TAC §404.165; TAC §§448.601* and *603*; and *Agency training requirements*)	82%
• Client Records (*TAC §§ 3.8007, 3008, 3011, 3012; TAC §§301.353* and *361; TAC §306.263* and *275; TAC §§404.161* and *163; TAC §564.702, 704, 802, 803, 804, 805,* and *901*)	79%

Observations

- Case management services were not documented during the review period.
- 25 TAC Chapter 448 was transferred to 26 TAC Chapter 564 during the review. Program documents referencing Chapter 448 need to be updated.

History

Compliance has not previously audited the Detox Program.

Recommendations

The Program should continue to review client documentation (i.e., assessment requirements, progress notes, treatment plans, admission documentation, client education, and discharge documentation) and employee records (i.e., annual training requirements) for compliance with

regulatory standards. A Plan of Improvement (POI) is required to address the deficiencies noted in this report. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the CPEP Division and the Detox Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days (June 5, 2024).

Management Response

The management of the Substance Use Recovery Services Detoxification (Detox) Program has reviewed the final report from the Compliance Department. Based on the findings provided, we will continue to review all client documentation, and improve on the employee training aspects that are required by the agency. Plans to implement these changes and the time frame have been included with this response. The hope of management is to address the deficiencies to improve the quality standards.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Kim K 6/4/24

Vice President of CPEP Division

X 6/14/24

Program Director/Manager

X Demetria Luckett

Director of Compliance

, The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Northwest community Service Center (NWCSC) Routine Review Plan of Improvement (POI) Follow Up
Review Date: May 9, 2024to May 10, 2024

I. Audit Type:
POI Follow Up Review

II. Purpose:
This review was conducted to determine if the POI action steps have been implemented from the previous review conducted April 17, 2023, to April 20, 2023 and for compliance with *Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §301.353 (e)(2)(B), Case Management Services Standards and 26 TAC §306.263(b)(3), §306.263(b)(6)(15) Documentation of Service Provision. 26 TAC §301.361(a)(14).*

III. **Audit Method:**
A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024). Twenty (20) clients were randomly selected. The review utilized an audit tool developed by Compliance and consisted of four (4) components: Plan of Care specifically addressing the individual's substance use or physical health, Case Management documentation identifying the strengths, service needs and assistance required to address the identified needs, developing a timeline for obtaining and reevaluating the individual's needs and progress notes that reflect.

IV. Audit Findings and History:
The NWCSC overall score is 98%.The NWCSC Program scored 100% on Plan of Care that specially addressed co-occurring substance use, 100% on Case Management Services Standards that identify the strength, service needs and assistance required, 95% on Case Management Services Standards that develop a timeline for obtaining and reevaluating the individual's need and 98% on Documentation of Service Provision progress notes that reflect person served issues in the plan of care. There were progress notes that did not match the service detail listing. Compliance conducted a Routine Comprehensive of the NWCSC program for services during the 3rd Quarter FY 2023 (March 1-31, 2023. A sample of twenty (20) persons' served reviewed. A POI was required for this review.

V. Recommendations:
The Program should continue to review client record (Plan of Care specially addressing co-occurring substance use, Case Management Services Standards that identify the strength, Service needs and assistance required, Case Management Services Standards that develop a timeline for obtaining and reevaluating the individual's need and progress notes service provision. The program completed its Plan of Improvement (POI) from the previous review and was completed satisfactorily. Staff training was completed in relation to the previous POI. A POI is not required. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the NWCSC Program Director must sign and return this report and the completed POI to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report
3rd (Qtr.) of Fiscal Year (FY) 2024
Mental Health (MH)) Division
Northwest Community Service Center (NWCSC) Routine Review Plan of Improvement (POI) Follow Up

Compliance Auditor(s): Emmanuel Golakai

Review Dates: May 9, 2024-May 10, 2024

Purpose

This review was conducted to determine if the POI action steps have been implemented from the previous review conducted April 17, 2023, to April 20, 2023 and for compliance with *Provider Responsibilities for Treatment Planning and Service Authorization 26 TAC §301.353 (e)(2)(B), Case Management Services Standards and 26 TAC §306.263(b)(3), §306.263(b)(6)(15) Documentation of Service Provision. 26 TAC §301.361(a)(14).*

Methods

A client roster that included persons served during the 2nd Qtr. FY 2024 (December 1, 2023-February 29, 2024). Twenty (20) clients were randomly selected. The review utilized an audit tool developed by Compliance and consisted of four (4) components: Plan of Care specifically addressing the individual's substance use or physical health, Case Management documentation identifying the strengths, service needs and assistance required to address the identified needs, developing a timeline for obtaining and reevaluating the individual's needs and progress notes that reflect.

Findings

Overall Score: 98%
Detailed findings are presented below:

Strengths:

- Plan of Care (specially addressed co-occurring substance use) ***(26 TAC §301.353 (e)((2)(B)*** — 100%
- Case Management Services Standards (identify the strength, Service needs and assistance required (***26 TAC §306.263 (b)(13)*** — 100%
- Case Management Services Standards (develop a timeline for obtaining and reevaluating the individual's need) ***26 TAC §263(b)(13)*** — 95%
- Documentation of Service Provision (Progress notes reflect persons served issues stated in the plan of Care) ***(26 TAC §301.361 (a) (14))*** — 98%

Areas of Improvement:

The HARRIS CENTER for Mental Health and IDD

- There are no areas of improvement for this review.

Observations

- There were progress notes that did not match the service detail listing from the Electronic Health Record.

History

Compliance conducted a Routine Comprehensive of the NWCSC program for services during the 3rd Quarter FY 2023 (Marcy 1-31, 2023. A sample of twenty (20) persons served records were reviewed. A POI was required for this review.

Recommendations

The Program should continue to review client documentation (Plan of Care specially addressing co-occurring substance use, Case Management Services Standards that identify the strength, Service needs and assistance required, Case Management Services Standards that develop a timeline for obtaining and reevaluating the individual's need and progress notes service provision. The program completed its Plan of Improvement (POI) from the previous review and was completed satisfactorily. Staff training was completed in relation to the previous POI. A POI is not required. Compliance will conduct a POI Follow-up Review in 180 days. The Vice President of the MH Division and the NWCSC Program Director must sign and return this report to Compliance within seven (7) business days (May 31, 2024).

Management Response

Findings	Total Cases	%-w/findings	%-w/no findings	Trend
0	20	0%	100%	CM documentation did not have evidence of identifying the individual's strengths
1	20	5%	95%	Progress notes did not reflect the persons served issues as stated in the plan of care.
1	20	5%	95%	CM documentation did not have evidence of a timeline for obtaining and reevaluating the individual's needs.
0	20	0%	100%	The POCs did not specially addressed the individual's co-occurring substance use.

Practice Manager will provide the findings to clinical teams for analysis of progress made since last audit, and review and correction of cited progress notes.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X 

Vice President of MH Division

Recoverable Signature

X Stephanie Johnson

Program Director/Manager
Signed by: Stephanie Johnson

X Demetria Luckett

Director of Compliance

CITY OF HOUSTON

Sylvester Turner, Mayor

Houston Police Department
1200 Travis Houston, Texas 77002-6000 713/308-1600

Troy Finner
Chief of Police

November 20, 2023

Wayne Young, Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, TX 77074

Re: American Rescue Plan Act Grants
MCOT
CORE
CIRT
CCD

Dear Mr. Young:

On behalf of the Office of Budget & Finance of the Houston Police Department we want to thank you for your staff's cooperation and assistance (with) in our desk review of your ARPA grants. Our review was required by federal regulations applicable to Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (commonly called Uniform Guidance) focusing on Subrecipient Requirements subpart §200.331 for the period ending June 30, 2023.

During our review, we examined certain functions of your organization related to the administration of funds under the ARPA grants listed herein, City of Houston Grant Program and the compliance requirements applicable to your case. No programmatic or administrative matters requiring formal resolution were identified during our desk review. The grants appear to

be progressing according to the plan presented in the approved application and is in compliance with Bureau of Justice Assistance guidelines for this program.

Please refer any questions or concerns about this letter to Robert Stewart at 713-308-1733.

Sincerely,

Rhonda Smith, Deputy Director & CFO
Office of Budget & Finance

rs:cw

cc: Vanessa McKeown, Chief Financial Officer
Hayden Hernandez, Accounting & Treasury Manager
Pinal Patel, Police Administrator, Office of Budget & Finance
LeAnn Hoang, Administration Manager, Office of Budget & Finance
Courtney Lytle, Staff Analyst, Office of Budget & Finance
Sheryal Armstrong, Division Manager, Office of Budget & Finance

Mental Health Rehabilitation (MHR) & Mental Health Targeted Care Management (MHTCM) Provider Review Feedback	
UM Completing Review:	Erin McLean
Quarter of Visit:	Q4 2023
Date Span Reviewed:	7/1/23-9/30/23
Date of Initial Feedback:	12/7/2023
Date of Feedback Meeting:	Thursday, December 7, 2023

Overall Chart Compliance Rating Chart	
80% and Above	Meets Expectations
79% and Below	Does Not Meet Expectations

Claims Compliance Rating Chart	
95% and Above	Meets Expectations
94% and Below	Does Not Meet Expectations

	CHART 1	CHART 2	CHART 3	CHART 4	
Member Name					**OVERALL CHART AVERAGE**
Please Indicate: Adult or Child/Adolescent	**Child/Adolescent**	**Child/Adolescent**	**Child/Adolescent**	**Child/Adolescent**	
OVERALL *CHART* COMPLIANCE	**98.33%**	**100.00%**	**98.33%**	**100.00%**	**99.17%**
OVERALL *CLAIMS* COMPLIANCE	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Section 1: Assessment (TAC RULE §354.2607, TAC RULE §301.363, TRR UM Guidelines)	100.00%	100.00%	100.00%	100.00%	**100.00%**
Section 2: Recovery Plan (TAC RULE §354.2609, TAC RULE §306.263, TAC RULE §307.9, TAC RULE §307.11)	100.00%	100.00%	100.00%	100.00%	**100.00%**
Section 3: Service Documentation (TAC RULE §306.323, TAC RULE §306.275)	100.00%	100.00%	100.00%	100.00%	**100.00%**
Section 4: Adult (TAC RULE §306.315, TAC RULE §306.327, TAC RULE §306.263, TAC RULE §306.271, TAC RULE §306.277, TAC RULE §306.319, TRR UM Guidelines, TAC RULE §306.317, TAC RULE §306.321, TAC RULE §306.313, TAC RULE §354.2707)	N/A	N/A	N/A	N/A	**#DIV/0!**
Section 5: Child & Adolescent (TAC RULE §306.315, TAC RULE §306.327, TAC RULE §306.263, TAC RULE §306.271, TAC RULE §306.277, TAC RULE §306.319, TRR UM Guidelines, TAC RULE §307.11, TAC RULE §307.5, TAC RULE §306.313)	90.91%	100.00%	90.91%	100.00%	**95.46%**
Reference:	TRR UM Guidelines		TRR UM Guidelines		
Example area of opportunity:	No July wraparound plan		No July wraparound plan		
Section 6: Claims Issues	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**
Did member fall within the average utilization guidelines for the review period?	N/A	N/A	N/A	N/A	
If no, was utilization above or below the average?					
	LOC YES	LOC YES	LOC YES	LOC YES	

Additional Comments from Reviewing UM Staff:

Individual Child Findings and Child Record Annotations

Legal Entity Name: MHMR of Harris County
Program Name: The Harris Center for Mental Health and IDD
Dates of Monitoring Visit: 12/12/23-12/15/23
Monitoring Team: Meaghan Ramgoolam & George Schock

Individual child findings reflect specific findings of noncompliance for an individual client. The contractor must correct each individual case of noncompliance by completing the required action (even though late) not completed unless the child is no longer within the jurisdiction of the program. Individual child findings must be corrected within six months of the monitoring report.

Case ID	Requirement(s) Not Met	Child Record Review Comments	Contractor Response	Disposition/ Status
	TKIDS Data Entry	Special Skills Training (SST) services from 8/25/23 (60 mins) was not entered into TKIDS	Services have been entered into TKIDS	While TKIDS was corrected during the monitoring, it remains a finding as it was not correct at the time of the monitoring.

Case ID	Requirement(s) Not Met	Child Record Review Comments	Contractor Response	Disposition/ Status
	A review of the Individualized Family Service Plan (IFSP) occurs every six months or more frequently, if conditions warranted or if the family requested it. [34 CFR §303.342; 26 TAC §350.1004(f); 26 TAC §350.1017]	Last periodic review was 1/3/23 and child is still enrolled	Annual was originally scheduled for 7/6/23. Parent requested reschedule and it was held on 7/12/23. Documentation in chart mislabeled visit as Therapy. Child didn't qualify for services. Service coordinator documentation not found for closure. Chart to be closed. NOTE: Development Improvement Plan is currently in place for this service coordinator employee.	While the documents submitted confirms the child was no longer eligible for Early Childhood Intervention (ECI) services in July 2023, documentation regarding reschedule request cannot be located. Therefore, the finding remains.
	Annual meeting to evaluate the IFSP must be conducted on at least an annual basis to evaluate and revise, as appropriate, the IFSP for a child and the child's family, and documentation meets the requirements for complete review. [CFR 303.342(c), 26 TAC 350.1019, 26 TAC §350.1307]	An annual IFSP for July was not conducted according to paper records, but there was an Occupational Therapy (OT) evaluation on 7/12/23 and child is still enrolled	Note on 7/12/23 was mislabeled. Annual IFSP was held on this date. NOTE: Development Improvement Plan is currently in place for this service coordinator employee.	While the documents submitted confirms the child was no longer eligible for ECI services in July 2023, documentation regarding reschedule request cannot be located. Therefore, the finding remains.
	Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]	No documentation of services or cancellations provided within scope	Child's closed case documentation not found. Services discontinued on 7/12/23. NOTE: Development Improvement Plan is currently in place for this service coordinator employee.	While the documents submitted confirms the child was no longer eligible for ECI services in July 2023, documentation regarding closure cannot be located. Therefore, the finding remains.
	TKIDS Data Entry	Transition steps; transition did occur but data was not entered into TKIDS	Transition steps have been entered in TKIDS.	While TKIDS was corrected during the monitoring, it remains a finding as it was not correct at the time of the monitoring.

Case ID	Requirement(s) Not Met	Child Record Review Comments	Contractor Response	Disposition/ Status
	The Eligibility Statement documents the child eligibility decisions of the IDT and reflects supporting documentation. [34 CFR §303.321; 26 TAC §350.811; 26 TAC §350.817]	While there is documentation regarding the child's eligibility in ECI, we still expect that the eligibility form is completed	Eligibility form was not completed	While there is documentation regarding the child's eligibility in ECI, we still expect for the eligibility form to be completed. Therefore the finding remains.
	TKIDS Data Entry	Eligibility statement not in record	Eligibility form was not completed	While there is documentation regarding the child's eligibility in ECI, we still expect for the eligibility form to be completed. Therefore the finding remains.
	TKIDS data entry	100% per eligibility statement 5/10/22; yet TKIDS states 62%	TKIDS corrected to current annual	While TKIDS was corrected during the monitoring, it remains a finding as it was not correct at the time of the monitoring.
	Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]	Initial IFSP held in June. No services delivered yet and no documented family cancellations	Previous manager, created dual assignments among service coordinators. This led to confusion with each person's role and client was not accounted for resulting in services not delivered. Corrections have been made to this practice and SC assignments have been revised to ensure clients are assigned appropriately.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Services are delivered within 28 days of the parental signature on the IFSP. [ECI Contract Section 6.5.4 Federal Indicators]	Initial IFSP held in June. No services delivered yet and no documented family cancellations	Child was missed due to miscommunicated assignments. No services delivered.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.

Case ID	Requirement(s) Not Met	Child Record Review Comments	Contractor Response	Disposition/ Status
	Case management services provided include assisting the family in identifying available services and making referrals to address identified needs and achieve goals specified in the IFSP. [34 CFR §303.34 (b)(2)(5); 26 TAC §350.405(a)(3)]	Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago	Previous manager, created dual assignments among service coordinators. This led to confusion with each person's role and client was not accounted for resulting in services not delivered. Corrections have been made to this practice and Service Coordinator (SC) assignments have been revised to ensure clients are assigned appropriately.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Case management services include following up with the family to assist the child with timely access to services and to determine if services have met the child's identified needs. [34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9)]	Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago	Previous manager, created dual assignments among service coordinators. This led to confusion with each person's role and client was not accounted for resulting in services not delivered. Corrections have been made to this practice and SC assignments have been revised to ensure clients are assigned appropriately.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]	Initial IFSP held in June. No services delivered yet and no documented family cancellations	Previous manager, created dual assignments among service coordinators. This led to confusion with each person's role and client was not accounted for resulting in services not delivered. Corrections have been made to this practice and SC assignments have been revised to ensure clients are assigned appropriately.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Services are delivered within 28 days of the parental signature on the IFSP. [ECI Contract Section 6.5.4 Federal Indicators]	Initial IFSP held in June. No services delivered yet and no documented family cancellations	Child was missed due to miscommunicated assignments. No services delivered.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.

Case ID	Requirement(s) Not Met	Child Record Review Comments	Contractor Response	Disposition/ Status
	Case management services provided include assisting the family in identifying available services and making referrals to address identified needs and achieve goals specified in the IFSP. [34 CFR §303.34 (b)(2)(5); 26 TAC §350.405(a)(3)]	Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago	Child was missed due to miscommunicated assignments. No services delivered.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Case management services include following up with the family to assist the child with timely access to services and to determine if services have met the child's identified needs. [34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9)]	Effective case management would have caught the child not yet having any delivered services. Yet the transition steps were completed.	Child was missed due to miscommunicated assignments. No services delivered.	Services were not delivered. Effective case management would have caught the child not yet having any delivered services or documented follow-up since enrolling almost 6 months ago, therefore finding remains.
	Services are delivered according to the IFSP. [34 CFR §303.13; 26 TAC §350.1104]	Although several family cancellations/non-response are noted for August SST, there is no documentation to support family reasons for not receiving Speech since July.	Both Speech Language Pathologist (SLP) and Speech Language Pathologist Assistant (SLPA) staff resigned in July. No provider available to deliver services.	While we recognize the difficulty in maintaining staffing, subrecipients have an obligation to provide program arranged services when they do not have the staff to provide the services needed. In addition, subrecipients may contract with therapists to provide Part C services. Services were not delivered therefore finding remains.

Date: December 14, 2023

Prepared for: [redacted]
Director
Community Services Department
Harris County, Texas

[redacted]
Compliance Manager
Office of County Administration
Harris County, Texas

Prepared by: [redacted], *MBA*
Federal Grants Management Specialist
Witt O'Brien's

Purpose: Monitoring Summary including any Quality Improvement Plan Recommendations for the American Rescue Plan Expenditures for Harris County Office of County Administration, Community COVID Housing Program (CCHP) 2.1 –Permanent Supportive Housing Phase 2.

Subrecipient: Harris Center Mental Health and IDD (Intellectual and Developmental Disability Services)

Grant Award: $1,142,550.00

Description

The Community COVID Housing Program (CCHP 2.0- Permanent Supportive Housing Phase 2) project includes a grant in the award amount of $1,142,554.00 from the Harris County, Community Services, Department for Community COVID Housing Program (CCHP 2.0- Permanent Supportive Housing Phase 2) to the Subrecipient Harris Center Mental Health and IDD. The program portion monitored and reported herein is to be utilized for housing placement assistance and supportive services access for the unhoused and is being expended by the Harris County Community Services Department in response to COVID-19.

The Coalition for the Homeless (CFTH), as lead agency to The Way Home CoC, has recommended a continued coordinated and large-scale community homeless housing initiative. Per the Centers for Disease Control and Prevention (CDC) and HUD, special, strategic endeavors are required to continue to protect people experiencing homelessness.

Therefore, in an effort to prevent the spread of COVID-19 among this highly susceptible population, ARPA funds have been made available for the provision of the following: Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), Diversion, Essential Client Support Services, and Navigation assistance to individuals currently living

unsheltered on the streets and in emergency shelters.

The Harris Center for Mental Health and IDD will provide mental health and substance supports for clients housed through The Way Home CoC with the ultimate goal being housing preservation.

Clients must be referred through the Coordinated Access System. The mental health supports will encompass a wraparound model to engage individuals with symptoms of mental illness and provide engagement services, clinical assessment, mental illness treatment coordination, and housing retention supports. The substance abuse supports will encompass a wraparound model to engage individuals with symptoms of substance use disorder and provide engagement services, clinical assessment, substance use disorder treatment, coordination with other behavioral health and physical health treatment, and housing retention supports.

The Subrecipient shall provide services to individuals and families who meet the definition of "homelessness" per 24 CFR 576.2 (1), (2), (3), (4) [1].

The Subrecipient must document demographic information, including race, ethnicity, sex, and homelessness status for all program participants. The Subrecipient shall collect homelessness documentation prior to providing ARPA services. The Subrecipient agrees to use the CoC's Coordinated Access System as the sole referral source. Other guidelines apply. See contract for additional details.

Monitoring Process

Programmatic Accuracy (Beneficiary Review)

For programmatic review, the Witt O' Brien's monitoring team was assigned fifty-one (51) beneficiary records to review in the Homeless Management Information System (HMIS) for Harris Center for Mental Health and IDD.

Because this portion of the project focuses on supportive services related to assisting clients in maintaining or obtaining housing placement, WOB monitors reviewed documentation related to demographics (age, gender, sex, ethnicity, etc.), referral obtainment, appropriate verification or attestation of homelessness or risk of homelessness in accordance with 24 CFR 576.2[2], COVID impact, confirmation of case management, therapy, transportation or other covered services as identified in the contract, and suitable identification documentation.

For programmatic reviews, the beneficiary record/s is/are reviewed by two Witt O'Brien's monitoring personnel, with the latter monitor functioning in the role of second set of eyes to ensure appropriate internal and quality control.

[1] https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-576/subpart-A/section-576.2
[2] https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-576/subpart-A/section-576.2

All supportive documentation reviewed and any associated notes and/or research compiled in the monitoring process is available to Harris Center for Mental Health and IDD and Harris County Office of County Administration for examination and follow up as needed. Be advised, however, that monitoring documentation includes personally identifiable information (PII) and is therefore subject to additional storage requirements. For additional details, review CFR 200.338.[3]

This monitoring for Harris Center for Mental Health and IDD was completed as part of the total monitoring process and is used for reporting and closeout purposes. Should Harris County encounter an issue during the monitoring, it should be noted, resolved, and documentation of all efforts should be maintained in the Program file.

Monitoring Summary

Programmatic Accuracy/ Beneficiary Review

Harris Center for Mental Health and Intellectual and Development Disability Services (IDD) HMIS, Beneficiary Review.

Table HCIDD_C (HMIS)

#	HMIS ID	Details
35	4[redacted]	File needs ID cards or other updated forms of identification.
36	[redacted]	Birth certificate is incorrect, belongs to another client.
37	[redacted]	File needs ID cards or other updated forms of identification.
38	[redacted]	Range monitored is in 2023, but documents loaded are from 2022. Ok for identification, but for things like COVID impact form, need more recent.
39	[redacted]	No referral notices in file. Additionally, several CM notices exist, but none within the date range selected for monitoring.

Quality Improvement Plan

Witt O' Brien's recommends the following actions and recommendations.

Programmatic Accuracy/ Beneficiary Review

1. The executed agreement between Harris County, Office of County Administration (for the CCHP 2.0 Supportive Housing Project), and Harris Center for Mental Health and IDD states, among other things, that demographics should be tracked for program beneficiaries, referrals should go through the Continuum of Care process, participants should meet definition of homelessness as defined in 24 CFR 576.2[4], and participants should be impacted by COVID.

[3] https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-D/subject-group-ECFR4acc10e7e3b676f

[4] https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-576/subpart-A/section-576.2

The incidents detailed in Table HCIDD_C (HMIS) reveal six beneficiary records where the above guidelines were either not applied or not appropriately documented in HMIS. These records should be reviewed and updated accordingly to ensure accuracy in HMIS representation.

2. Harris Center's scope of services is to provide mental health services to at least 300 individuals to help them preserve their housing. They have far exceeded their services goal based on their KPI reporting. Witt O'Brien's recommends that the Community Services Department and the Harris Center examine the 595 beneficiaries that have been served to date and identify how many have maintained their housing since receiving mental health services. How is that rate compared to other organizations providing similar services? Is it better than the national average?

Please work to resolve and implement any recommendations promptly. Any noted items in this monitoring summary and any suggested quality improvements should be implemented five days after receipt of this report.

Conclusion and Next Steps

Conclusion

Harris Center for Mental Health and IDD responded efficiently and provided records in a detailed well represented manner. However, there is still document that we recommend submitting to bring this review to a close. Please see the table below.

Next Steps

1	HCIDD_C (HMIS)	HMIS ID#[redacted], Load ID card or other updated forms of identification into HMIS. **10/31/2023…. Birth certificate and SSN now viewable**
2	HCIDD_C (HMIS)	HMIS ID#[redacted] Birth certificate is incorrect, belongs to another client. Remove incorrect Birth certificate from this HMIS file. **10/31/2023… Birth certificate still in file for "[redacted]"**
3	HCIDD_C (HMIS)	HMIS ID#[redacted], Load ID cards or other updated forms of identification into HMIS. **10/31/2023.. no additional information loaded**
4	HCIDD_C (HMIS)	HMIS ID#[redacted], Load more recent COVID Impact Form, or similar, into HMIS. Load documentation showing 2023 need. **10/31/2023.. COVID Impact Statement still from Jan 2022**
5	HCIDD_C (HMIS)	HMIS ID#[redacted]Load referral notice into HMIS file. For date of service range 1/3/23-1/18/23, confirm no case management or related services. **10/31/2023.. information has been updated and is appropriate**

TEXAS Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

January 3, 2024

Wayne Young, Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Dear Wayne Young,

In compliance with the Centers for Medicare and Medicaid Services, the Health and Human Services Commission (HHSC) completed the annual review of the Youth Empowerment Services (YES) program Harris Center for Mental Health and IDD on December 15, 2023.

HHSC staff reviewed clinical and administrative records and provided technical assistance regarding the YES program. The attached Desk Review Report summarizes the results of the review. For all review items below 90% compliance as well as all identified areas of concern that do not include a score, a Corrective Action Plan along with evidence of correction must be submitted by close of business on February 5, 2024 to YESWaiver@hhs.texas.gov.

While this report identified areas needing remediation, we would like to acknowledge that your YES team demonstrates a strong commitment to the service of YES Waiver participants, including your YES Waiver program staff's ongoing commitment to participation in Wraparound Coaching from the National Wraparound Implementation Center.

Sincerely,

Linda Gonzalez, YES Waiver, Quality Management Specialist
Medical and Social Services, Behavioral Health Services

Cc: Stella Olise, Practice Manger, Harris Center
Lance Britt, VP of Behavioral Health, Harris Center
Tiffanie Williams-Brooks, Director of Children & Adolescent Services, Harris
Demetria Martin, Compliance Manager, Harris Center
Nicole Weaver, HHSC, Manager YES Waiver
Chera Tribble, YES Waiver Liaison, HHSC
Rashida Broussard, Manager BHMP QM, HHSC
Simona Haqq, Quality Improvement Lead, HHSC
Fredrick Smith, Contract Manager, HHSC

1915c YES Waiver Site Review
Harris Center for Mental Health and IDD
December 15, 2023

The Health and Human Services Commission, Youth Empowerment Services (YES) program staff completed the annual desk review to ensure all planned waiver services were available and delivered in accordance with requirements. The following Performance Measures are based on the participant chart reviews in accordance with waiver requirements. YES program staff reviewed a sample of 10 participants during the time period of August 11, 2023-December 11, 2023. For all review items below 90% compliance and areas needing improvement, please address within the Plan of Correction and include evidence of correction for non-compliance. A sample of personnel records were also reviewed for compliance.

Positives:

- **Improvement in these areas:**
  - Wraparound Plans include at least one needs statement for the youth and one for the family member. Improvement in this area increased by 10%.
  - Wraparound Plan includes outcome statements, strategies and/or tasks addressing the actionable items (score of 2 or 3) identified on the CANS/Clinical Eligibility. Improvement in this area increased by 10%.
  - Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Child and Family Team Meeting to reflect progress or lack or progress in all areas. Improvement in this area increased by 10%.
  - Waiver participants whose services are delivered according to the duration specified in their Wraparound Plans. Improvement in this area increased by 40%.
  - Waiver participants whose services are delivered according to the location specified in their Wraparound Plans. Improvement in this area increased by 40%.
- All provider qualifications and trainings are current.

Concerns and Areas for Improvement:

- Ensure individual receives a face-to-face intake assessment/Clinical Eligibility within 7 business days of the initial demographic eligibility determination contact. Applicants on the YES waiver inquiry list are offered an assessment for eligibility on a first-come first-served basis by LMHAs or LBHAs.
- Ensure Waiver participant and LAR has a face-to-face meeting with Facilitator within 7 business days of CE approval.

- Ensure Waiver participant receives services according to the type, scope, and amount specified in their Wraparound Plans.
- Ensure Waiver participants whose services are delivered according to the frequency specified in their Wraparound Plans**.**
- Ensure Waiver participants whose services are delivered according to the duration specified in their Wraparound Plans**.**
- Ensure Waiver participants whose services are delivered according to the location specified in their Wraparound Plans**.**

Performance Measure	Compliance Score
Individual/LAR received a return call from the LMHA within 24 hours or 1 business day from registration on the Inquiry List.	**100%**
Individual received a **face-to-face intake assessment/Clinical Eligibility within 7 business days** of the initial demographic eligibility determination contact.	**56%**
Waiver participants are afforded choice between the home and community-based waiver services and institutional care, choice of waiver home and community-based waiver services, choice among home and community-based providers and are informed orally and in writing of the process for reporting Abuse, Neglect and/or Exploitation and filing complaints.	**100%**
Waiver participant and LAR has a face-to-face **meeting with Facilitator within 7 business days of CE approval**.	**89%**
Annual Renewal Clinical Eligibility Assessment was completed within 365 days.	**100%**
Crisis and safety plan is developed during the Wraparound facilitator's first face to face meeting with the child and LAR.	**100%**
The **crisis/safety plan addresses health and safety needs** identified in the reason for referral, CANS scoring and/or Clinical Eligibility. The crisis/safety plan(s) identifies triggers or behaviors that precipitated the referral and includes specific actions, interventions and contact information for persons and resources identified.	**100%**
Wraparound Plans includes at least **one needs statement for the youth**	**100%**
Wraparound Plans includes at least **one needs statement for the youth and one for a family member**.	**100%**
Wraparound plans reflect the reason for referral.	**100%**
Wraparound Plan includes **outcome statements, strategies and/or tasks addressing the actionable items** (score of 2 or 3) identified on the CANS/Clinical Eligibility.	**100%**

Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Child and Family Team Meeting to reflect progress or lack or progress in all areas.	**100%**
Waiver participant receives services according to the **type, scope, and amount specified in their Wraparound Plans.**	**70%**
Waiver participant receives services according to the **frequency specified in their Wraparound Plans.**	**70%**
Waiver participants whose services are delivered according to the **duration specified in their Wraparound Plans**.	**70%**
Waiver participant whose services are delivered according to the **location specified in their Wraparound Plans.**	**70%**
Wraparound plans are updated at least every 90 days as the youth and family's needs change (including critical incidents or change in family, school, environmental dynamics, etc.). DART will assess providers on the continued requirement to update the wraparound plans every 30 days.	**100%**
Incidents noted during the review period have a corresponding **Critical Incident Report**.	**100%**
Facilitator submitted the **Critical Incident Report to HHSC within 72 hours** (or 3 business days) after being informed of the incident.	**100%**
The Facilitator has a **face to face meeting with the youth and family within 72 hours**, but no later than 7 business days, after learning of a critical incident. If the youth is hospitalized, in detention or otherwise unavailable, face to face meeting takes place within 72 hours of discharge.	**100%**
Response to critical incidents are appropriate to ensure the health and safety of the participant.	**100%**
All incidents involving **restraint applications, seclusion or other restrictive interventions** meet the requirements (see Review Tips).	**N/A**

A Termination Clinical Eligibility document is entered for all youth discharging from YES Waiver services	**100%**
There is a **discharge/transition plan** for youth who successfully graduate the YES program or request termination of services. If the youth is turning 19 there is a discharge/transition plan that includes a summary of community mental health services, current status, and plans to coordinate ongoing services.	**100%**
Wraparound facilitators do not exceed 1:10 caseload ratios without expressed authorization from HHSC	**100%**
Wraparound facilitators do not provide or bill for any service other than Intensive Case Management without expressed authorization from HHSC	**100%**
Did the contractor document the appropriate information in the free text field as required by EVV policy? Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system. Free text is also required whenever the following reason codes are used:*Reason Code 131 - Emergency: The program provider must describe the nature of the emergency and document any missing actual clock in or clock out time.*Reason Code 600 - Other: The program provider must document the reason why "other" was selected and document any missing actual clock in or clock out time.	N/A
Did the Provider/Contractor use EVV system as required by HHSC EVV Policy?	N/A

Provider Qualifications and Trainings Performance Measure	Compliance Score
Current Criminal Background Check (TDPS) - Include date of check (Prior to employment and annually thereafter)	**100%**
Employee Misconduct Registry (DADS) - Include date of check (Prior to employment and annually thereafter)	**100%**
State license or certification, with documented training and experience relative to the specific service provided.	**100%**
Waiver Provider Agencies that have a process to complete annual criminal history and employee misconduct checks. Provider submits documentation of process to complete annual criminal history and employee misconduct checks.	**100%**
Waiver Provider agency has a process that ensures direct service providers meet state requirements for provider training. Provider submits documentation of the procedure for provider training.	**100%**
Identifying and reporting of abuse, neglect, and exploitation (Annually)	**100%**
HIPAA Training (Annually)	**100%**
Critical incident reporting (Annually)	**100%**
"National wraparound initiative (Intro to Systems of Care): 1. What's This Thing Called Wraparound? 2. Team Roles in Wraparound; and 3. YES 101 Training	**100%**

Service Documentation requirements (One Time)	**100%**
Crisis and Safety planning (Once)	**100%**
Restraint and Restrictive Interventions. (Annually)	**100%**
CPR and First Aid (Must be Current)	**100%**
DFPS Trauma Informed Care (Must be completed every two years)	**100%**
Did the Provider/Contractor select an EVV system prior to delivering EVV services?(Once)	**N/A**
Did the Provider/Contractor complete all required EVV training initial and annually. Required training includes training with EVV vendor or Proprietary System, EVV portal training with TMHP and EVV Policy training with HHSC or MCO. Must keep update to date record of training and all users of the EVV system (Annually)	**N/A**

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

January 4, 2024

Wayne Young, Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Mr. Young,

Thank you for your corrective action response to the Notice of Findings regarding the August 11, 2023, inspection of your licensed facility in Houston (HQ license [redacted] Satellite – Dacoma). The deficiencies noted from the Notice of Findings have been sufficiently corrected and no further documentation regarding this inspection is required. This will serve as notification the inspection is closed.

Please note that the items cited in this inspection may be reviewed by other HHSC units, and during subsequent inspections to ensure the plan of correction has been adequately implemented.

Should the facility discontinue services or make changes to the existing services, please notify the Facility Licensing Department in writing prior to implementing the change.

I want to thank you for your assistance during the inspection process. Please contact me at 512/542-9989, or charles.reubens@hhs.texas.gov if you have any questions regarding facility inspections.

Sincerely,
Charles A. Reubens

Charles Reubens, Inspector VI
Substance Use Disorder and Professional Licensing Compliance

cc: Byanca Hernandez - Clinical Team Leader

ADMINISTRATIVE AND PROGRAMMMATIC FOLLOW-UP REVIEW

INITIAL REPORT

Date: February 4, 2023

Provider: MHMR of Harris County

Program Name	Contract Number	Award Amount	Contract Period
The Harris Center for Mental Health and IDD	[redacted]	**$20,099,705.00**	**9/1/2023-8/31/24**

Date of Review: December 12, 2023-December 14, 2023

Scope of Review: June 1, 2023-August 31, 2023

Date of Original Review: January 17, 2023-January 19, 2023

Scope of Original Review: December 1, 2021-November 31, 2022

HHS ECI Reviewers:

- [redacted] Specialist Team Lead

Exit Conference Participants:

- [redacted], Performance Specialist, HHSC/ECI
- [redacted], Performance Specialist Team Lead, HHSC/ECI
- [redacted], ECI Program Director, The Harris Center
- [redacted], Director of Children, Adolescent & ECI Services, The Harris Center
- [redacted] HR Personnel, The Harris Center
- [redacted], ECI Assistant Director, The Harris Center
- [redacted], ECI Business Manager, The Harris Center

Summary of Review

Purpose & Authority: Contract # [redacted]was reviewed for compliance required by federal, state and Health and Human Services Commission Early Childhood Intervention (HHS/ECI) regulations. The review included:

1. The effectiveness of the organization's programs, activities, or functions;
2. Whether the organization has complied with laws and regulations applicable to the program;
3. Whether the organization corrected all the individual child findings from the comprehensive review conducted in January 2023;
4. Verification of implementation of your corrective action; and
5. Review of child and administrative records to clear systemic level findings from the January 2023 comprehensive monitoring review.

The following items were compliant with all rules and regulations:

ADMINISTRATIVE REVIEW

Personnel Records: All personnel records were reviewed to ensure ECI staff have licenses, certifications, background checks are up-to-date, and providers can bill Medicaid as required by the ECI Contract and Rules with **0%** out of compliance.

Requirement: 26 TAC §350.309

Verification of Personnel Training and Supervision: Personnel records were reviewed to ensure that all staff providing services were compliant and up to date with required training and documented supervision activities are in place. A sample of **10** records were reviewed and confirmed with contractor records and the HHSC TKIDS Database with **0%** noted as out of compliance.

Requirement: 26 TAC §350.309

PROGRAMMATIC REVIEW

HHS ECI Program reviewed **20** complete records within a 12-month review scope. Of the **20** reviewed, some requirements were out of scope or were not applicable to the child whose record was being reviewed.

Of the **20** records reviewed, compliance requirements were met for the area(s) identified below:

Pre-Enrollment and Procedural Safeguards: Procedural Safeguards

Records were reviewed to determine if procedural safeguards were implemented. Eight requirements were reviewed for each record with **0%** procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- Prior written notice was provided to the family for the evaluation and consent was obtained.
- A copy of the ECI Parent Handbook was provided to the family.
- Prior written notice of the IFSP meeting was provided to the family.
- Informed written consent was obtained from the family before providing any ECI services.

Requirement: 34 CFR 303.420; 26 TAC §350.204; 26 TAC §350.207 (a)(2); 34 CFR §303.400; 26 TAC §350.203(c); 26 TAC §350.707(a)(2); 34 CFR §303.421; 34 CFR §303.342(d)(e); 26 TAC §350.233(a); 26 TAC §350.207; 26 TAC §350.219; 34 CFR §303.321; 26 TAC §350.817.

Pre-Enrollment and Procedural Safeguards: Limited English Proficiency

Reasonable effort was made to provide services in the child and family's native language. Four requirements were reviewed for each record with **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- Contractor did provide the family rights publication (parent handbook) in the appropriate language.
- The required program forms in Spanish or other appropriate language based on needs were provided.
- Contractor did provide the appropriate interpreter or translation services in the child's native language or other communication assistance necessary for a parent or child with limited English proficiency or communication impairments to participate in ECI services
- Oral and written explanation was provided to the parent during the pre-enrollment process and other times when parental consent is required as reflected in documentation.

Requirement: 34 CFR 303.420; 26 TAC §350.204; 26 TAC §350.207 (a)(2); 34 CFR §303.400; 26 TAC §350.203(c); 26 TAC §350.707(a)(2); 34 CFR §303.421; 34 CFR §303.342(d)(e); 26 TAC §350.207; 26 TAC §350.219; 34 CFR §303.321; 26 TAC §350.817.

Individualized Family Service Plan (IFSP): Service Planning

Records were reviewed to determine if service planning was reflective of the child and family's needs. Six requirements were reviewed for each record with **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- The IFSP did contain all the following: the service, discipline of the provider, frequency, intensity, location, method, start and end date, and payments sources.
- Documentation did reflect a description of the child's present level of functioning across all developmental domains, how the child functions, and pertinent medical information.
- The IFSP did reflect needs identified in the evaluation and assessment.
- The initial IFSP meeting and the annual meeting to evaluate the IFSP were conducted by an interdisciplinary team.
- The initial IFSP was conducted within 45 days from the date of referral receipt.
- The IFSP did document medical and other services that the child or family needed or was receiving through other services.

Requirement: 20 USC §1436 & 34 CFR §§303.340 - 303.346; 26 TAC §350.1004 (a), 34 CFR §303.344; 26 TAC §350.1004(a); 26 TAC §350.1015 (a)(1)(A-E), 34 CFR §303.20; 34 CFR §303.321; 26 TAC §350.1004(d), CFR §303.24; CFR §303.340; 26 TAC §350.1009, 34 CFR §303.344; 26 TAC §350.405 (a)(2); 26 TAC §350.1015(a)(2), 34 CFR §303.344(d); 26 TAC §350.1009 (a)(b); 26 TAC §350.1015 (a)(4-6), (c),(d),(e),(f),(h)

IFSP: Outcomes

Records were reviewed to determine if the IFSP included outcomes that addressed the child's and family's needs. Two requirements were reviewed for each record with **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- The IFSP did include measurable outcomes expected to be achieved for the child and family.
- Outcomes were developed or modified and dated based on the child's progress and needs changed.

Requirement: 34 CFR §303.342; 26 TAC §350.1017; 34 CFR §303.342(b); 26 TAC §350.1004(b)(g); 26 TAC §350.1009(a)(b); 26 TAC §350.1019; 26 TAC §350.501; 26 TAC §350.1015(b); 34 CFR 303.342(c), 26 TAC §350.1019; 26 TAC §350.1307.

IFSP: Transitions

Records were reviewed to determine if the transition plan is completed in accordance with ECI requirements. Four requirements were reviewed for each record with **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- A transition conference was held at least 90 days before age 3 or, if late, the reasons for any delay is documented.
- The parent was educated about transition.
- The local education agency was invited to transition meeting.
- With written parental consent, the most recent evaluations, assessments, and IFSPs and the parents' contact information were provided to the LEA.

Requirement: 26 TAC §350.1207 (d)(1,3)(A-H). 26 TAC §350.1207; TAC §350.1211.

Services and Case Management: Service Delivery Documentation

Records were reviewed to determine if service delivery documentation met requirements. Two requirements were reviewed for each record with **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- Documentation of each service contained the name of the child, name of the ECI contractor, service provider, date, start time, length of time, location, and provider's signature.
- Documentation of each service contact included a description of the contact, the child's progress, and family or routine caregiver participation in the activities.

Requirement: 34 CFR §303.13; 34 CFR §303.31; 26 TAC §350.303-350.319; 26 TAC §350.1104; 34 CFR §303.34(b)(2)(5); 26 TAC §350.405(a)(3); 34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9).

Annual Verification of Third-Party Coverage:

Records were reviewed to ensure third-party coverage is verified at least annually. A sample of **20** records were reviewed from the monthly verification reports, with **0%** noted as out of compliance.

FINDINGS

The following items were not compliant with all applicable rules and regulations:

PROGRAM REVIEW

Of the **20** client records reviewed, compliance requirements were not met for the area(s) identified below:

Finding #1: Pre-Enrollment and Procedural Safeguards: Evaluation, Eligibility and Assessment: Eligibility Determinations

Records were reviewed to determine if eligibility determination was appropriate and consistent. Five requirements were reviewed for each record with **1%** of procedures noted as out of compliance.

Findings of non-compliance include:

- The Eligibility Statement did not document the child eligibility decisions of the interdisciplinary team or did reflect supporting documentation.

Compliance requirements were met for the areas identified below:

- The interdisciplinary team provided a review of nutrition status, assistive technology and an autism screening (as warranted) as part of the assessment.
- The Battelle Developmental Inventory, Second or Third Edition, or the Developmental Assessment of Young Children, Second Edition was used to conduct the comprehensive evaluation (when required) to determine eligibility.
- All Family Cost Share Forms are present, complete, and accurate as needed and updated at least annually and IFSP services subject to out-of-pocket payment are not initiated until the parent signs the family cost share agreement.
- Hearing and vision statuses were documented as part of the evaluation to determine the need for any further assessment.

Requirement: 34 CFR §303.321; 26 TAC §350.809; 26 TAC §350.817; 26 TAC §350.811; 34 CFR §303.21(a)(1)(ii); 26 TAC §350.813; 26 TAC §350.815; 26 TAC §350.817; 34 CFR 303.321(c); 26 TAC §350.829; 26 TAC §350.831; 26 TAC §350.833. 26 TAC §350.1417 (a)(b)(c)

Corrective Action: Noncompliance was less than 10%. Since noncompliance is less than 10%, it is not systemic; therefore, no written corrective action plan is required. All individual child findings must be corrected and/or cleared.

Finding #2: IFSP: Reviews and Revisions

Records were reviewed to determine if the IFSP was reviewed periodically to determine progress toward achieving outcomes and changes needed to service in the IFSP. Four requirements were reviewed for each record with **4%** of procedures noted as out of compliance.

Findings of non-compliance include:

- A review of the IFSP did not occur every six months or more frequently, if conditions warranted or if the family requested it.

- The periodic IFSP review did not document the degree to which progress toward achieving the outcomes identified in the IFSP is being made, and changes or no changes in service.

Compliance requirements were met for the areas identified below:
- A Licensed Professional of the Healing Arts was planned on the IFSP, and the service was monitored by the Interdisciplinary Team at least every six months with documentation of the review in the case record.
- A meeting to evaluate the IFSP was conducted on at least an annual basis to evaluate and revise, as appropriate, the IFSP for a child and the child's family and documentation meets the requirements for complete review.

Requirement: 34 CFR §303.342; 26 TAC §350.1017; 34 CFR §303.342(b); 26 TAC §350.1004(b)(g); 26 TAC §350.1009(a)(b); 26 TAC §350.1019; 26 TAC §350.501; 26 TAC §350.1015(b); 34 CFR 303.342(c), 26 TAC §350.1019; 26 TAC §350.1307.

Corrective Action: Noncompliance was less than 10%. Since noncompliance is less than 10%, it is not systemic; therefore, no written corrective action plan is required. All individual child findings must be corrected and/or cleared.

Finding #3: Services and Case Management: Services Provided

Records were reviewed to determine if services provided met requirements and were delivered in accordance with the IFSP. Six requirements were reviewed for each record with **12%** of procedures noted as out of compliance.

Findings of non-compliance include:
- Case management services provided did not include assisting the family in identifying available services or making referrals to address identified needs.
- Case management services did not include following up with the family to assist the child with timely access to services to determine if services have met the child’s identified needs.
- Services were not delivered within 28 days of the parental signature on the IFSP.
- Services were not delivered according to the IFSP.

Compliance requirements were met for the areas identified below:
- Services were delivered in the child's natural environment unless it is documented in the case record and with the written consent of the parent.
- Services were provided by qualified personnel.

Requirement: 34 CFR §303.13; 34 CFR §303.31; 26 TAC §350.303-350.315; 26 TAC §350.1104; 34 CFR §303.34(b)(2)(5); 26 TAC §350.405(a)(3); 34 CFR §303.34(b)(7); 26 TAC §350.405(a)(4)(5)(6)(7)(9). ECI Contract Section 6.5.4 Federal Indicators. 34 CFR §303.26; 34 CFR §303.126; TAC 26 TAC §350.1104 (4).

Corrective Action: Since this was a systemic finding during the original review in January 2023, the program must provide a revised written corrective action plan, including management oversight to ensure service planning is reflective of the child and family's needs. Submit a revised plan using the attached template with specific timelines for implementation to ensure compliance with this requirement. All individual child findings must also be corrected and/or cleared.

Finding #4: Verification of TKIDS Data Accuracy

Records were reviewed to verify that data entered in TKIDS accurately reflected data in the child's record. Data reviewed consisted of demographic data, child outcomes data, IFSP data and transition data. A total of **244** TKIDS data entry items were reviewed from all client records with **1%** noted as out of compliance.

Requirement: ECI Contract, Section XXXVIII.A

Corrective Action: Noncompliance was less than 10%. Since noncompliance is less than 10%, it is not systemic; therefore, no written corrective action plan is required. All individual child findings must be corrected and/or cleared.

INDIVIDUAL CHILD FINDINGS

All individual child findings from the comprehensive review in January 2023 have been cleared.

Individual child findings are listed in an attachment titled Child Findings Harris Center December 2023 to this report. Within three months of receipt of the final monitoring report, Subrecipient must correct each individual case of noncompliance by completing the required action (even though late) that was not completed, unless the child is no longer within the jurisdiction of the program.

FOLLOW-UP

An on-site programmatic follow-up visit to this review is not recommended at this time. In three months from the date of the final report a follow-up desk review will be conducted to ensure that all corrective action plans have been implemented successfully and that all individual child findings have been cleared.

OFFICE OF INSPECTOR GENERAL
TEXAS HEALTH AND HUMAN SERVICES
Raymond Charles Winter, Inspector General

February 7, 2024

The Harris Center for Mental Health and IDD
9401 Southwest Fwy
Houston, TX 77074

☐ **SENT VIA CERTIFIED MAIL (RETURN RECEIPT REQUESTED)– XXXX**
☐ **SENT VIA Secure email (RECEIPT CONFIRMATION REQUESTED)**
☒ **OTHER RightFax**

NOTICE OF REQUEST FOR COPIES OF MEDICAL (PATIENT) RECORDS

RE: Request for Medical and Business Records from:
The Harris Center for Mental Health and IDD
OIG Investigation Number: [redacted]

Dear Custodian of Records:

The Investigations and Utilization Reviews (I&UR) section of the Office of Inspector General (OIG), a division of the Texas Health and Human Services (Texas HHS), is conducting an investigation of certain claims paid by the Medicaid program and submitted by or on behalf of The Harris Center for Mental Health and IDD.

The OIG is authorized to evaluate the need for, the quality, and the timeliness of all Medicaid services and to ensure compliance with all Medicaid statutes, rules, regulations, policies, and procedures on the behalf of the Texas HHS.[1] Services billed under your provider number(s) to the Medicaid program have been selected for investigative review. This request for records is pursuant to state regulations and consistent with federal requirements as related to the provider agreement you entered into with the Medicaid program under which you agreed to retain and produce or make records available upon request and *as requested* by the OIG or a requesting agency.[2,3] This requirement to retain records and produce records upon request and as requested is also included in the current Texas Medicaid Provider Procedures Manual (TMPPM) where it states "Requested records must be provided promptly and at no cost to the state."[4] In addition, pursuant to the requirements of the current TMPPM, Vol. 1, Section 1.7.3, you are notified of your continuing obligation to retain all records for any client with dates of service indicated below until all audit questions, appeal hearings, investigations, or court cases are resolved.[5]

[1] Tex. Gov't Code § 531.102
[2] 1 Tex. Admin. Code § 371.1667
[3] 42 C.F.R. § 431.107(b)(1), (b)(2)
[4] HHSC Medicaid Provider Agreement, Section 1.2.3
[5] Texas Medicaid Provider Procedures Manual, Volume 1, Section 1.7.3

In accordance with 1 Tex. Admin. Code § 371.1667, OIG may impose sanctions if you fail or refuse to provide documents as requested that are responsive to this request, including completed records affidavits and evidence receipts. Possible sanction actions include vendor hold and exclusion from participation as a provider in the Texas Medicaid and other federally funded health care programs until the matter is resolved.[6] In the event of any such sanction action, separate notice will be provided as required by the cited authorities.[2]

Clinical Records Requested
For dates of service from **June 1, 2019, through May 31, 2023**, please provide a **complete copy** of the entire original client record for each of the clients who are named on the attached Client Record Inventory. The Client Record Inventory is made a part of and is incorporated by reference into this request. The copies of the client records must be complete, exact duplicates of the original records as they exist at the time you are notified of this request.

These records must be provided to the OIG in the format in which they are regularly maintained at the office of The Harris Center for Mental Health and IDD; the records must also be organized and labeled as requested in the **Record Submission Instructions**, which is incorporated by referenced into this request.

The client records must include all documents held by The Harris Center for Mental Health and IDD that relate to items or services billed to the Medicaid Program. The client records must include all documentation to support that the services billed to Medicaid were medically necessary, provided in a quality manner, and billed appropriately. Accordingly, the client records responsive to this request should include, but are not limited to, the following:

- Prior authorization documentation supporting requests and approvals.
- Consent(s) for treatment.
- Treatment plan(s).
- Progress and/or clinical and/or treatment notes.
- Diagnostic reports.
- Inpatient hospitalization.
- Any other document(s) made by or on behalf of The Harris Center for Mental Health and IDD as part of normal business practices for each of the clients for the dates specified and that support or document the services billed to the Medicaid program.

If your office uses electronic health records and/or electronic signatures, please provide the system process for validating the signatures.

[6] 1 Tex. Admin. Code § 371.1709(a)(1); 1 Tex. Admin. Code § 371.1707(b)(2)(C)

Please also note that, while OIG is presently requesting medical records only relating to the clients identified on the attached client record inventory, OIG may expand this request to include additional clients at a later time.

Business Records Requested
For the same period of time noted above, please provide the business records listed on the attached Business Record Inventory. At my discretion, you must also provide any additional documentation that I request verbally while you are in the process of complying with this written request.

All documents being turned over to the OIG must be accompanied by a completed and notarized Records Affidavit. Upon receipt and review of the evidence you have been requested to provide, the OIG will provide an Evidence Receipt for your records.

Absent a subsequent written agreement between the OIG and The Harris Center for Mental Health and IDD that states otherwise, the deadline for the arrival of the requested client records and business documents at the designated OIG mailing address (below) is **Tuesday, February 13, 2024, by 4:00pm**. This deadline also applies to any additional records and/or documentation requested by the OIG, if applicable.

Please contact the undersigned in the event of any questions or concerns. Your assistance is greatly appreciated.

Sincerely,

Sandra De La Torre, Investigator
Investigations and Utilization Reviews
Office of Inspector General
Telephone: (940) 536-8925
Email: sandra.delatorre@hhs.texas.gov

Attachments:
- Client Record Inventory
- Business Record Inventory
- Information Sheet
- Signature Sheet
- Records Affidavit
- Affidavit of No Record
- Record Submission Instructions

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

February 12, 2024

Wayne Young, Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Subject: Corrective Action Plan

Dear: Wayne Young:

The Texas Health and Human Services Commission (HHSC) received your Corrective Action Plan (CAP) to address areas of non-compliance discovered during a Quality Management Review of your agency on December 15, 2023.

HHSC has determined that your CAP sufficiently addresses all required elements. As outlined in the plan, you will implement the corrective action on or before February 12, 2024.

Please feel free to contact me at YESWaiver@hhs.texas.gov if you have questions regarding this letter.

Sincerely,

Linda Gonzalez
Quality Management Specialist
Health and Human Services Commission
Medical and Social Services, Behavioral Health Services

CC: Stella Olise, Practice Manger, Harris Center
Lance Britt, VP of Behavioral Health, Harris Center
Tiffanie Williams-Brooks, Director of Children & Adolescent Services, Harris
Demetria Martin, Compliance Manager, Harris Center
Nicole Weaver, HHSC, Manager YES Waiver
Chera Tribble, YES Waiver Liaison, HHSC
Rashida Broussard, Manager BHMP QM, HHSC
Simona Haqq, Quality Improvement Lead, HHSC
Fredrick Smith, Contract Manager, HHSC

Form 3045

TEXAS Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 15, 2024

Wayne Young, Executive Director
The Harris Center for Mental Health and IDD
PO Box 25381
Houston, TX 77265

Dear Mr. Young:

The Texas Health and Human Services (HHS) Early Childhood Intervention (ECI) program is required under Section 616 of the Individuals with Disabilities Education Act to make annual determinations on the performance of local ECI programs.

States must assign one of the following three determinations:

- Meets the Requirements of Part C;
- Needs Assistance to Meet the Requirements of Part C; or
- Needs Intervention to Meet the Requirements of Part C.

HHS ECI has determined that The Harris Center for Mental Health and IDD **needs assistance to meet the requirements of Part C**. This means that your performance is below the statewide average, considering all compliance indicators across the network of Texas ECI providers. Based on this determination, you will be asked to provide an update during your quarterly calls on the indicators as seen on the attached table attached below (page 3). Additionally, the ECI state office will provide targeted technical assistance for specific indicators that fall below the statewide average.

Your agency's 2022 determination is based on its performance on compliance indicators; whether data submitted are valid, reliable, and timely. Your organization's average month enrollment exceeded your contracted performance target in fiscal year 2022, and your ability to continue providing necessary services to all eligible children is commendable.

The following are the factors used in making fiscal year 2022 determinations:

- Indicator 1 – Timely Services
- Indicator 2 – Natural Environments
- Indicator 4C – Family Outcomes (helped their child develop and learn)
- Indicator 6 – Percentage of the Population 0-3 years served
- Indicator 7 – 45 days Referral to Enrollment
- Indicator 8C – Transition Conference
- Average Delivered Hours of Service per Child per Month (not parent choice)[1]
- Timely Submission of Required Financial Reports
- Accurate Financial Data
- Results from Monitoring Visits, if applicable

The attached table provides more information on the federal performance indicators contributing to your determination and the indicators offering the most opportunity for improvement. (Indicators that scored below the target are shaded.)

The annual determinations are used as a quality improvement process and a way to support continual performance improvement at the system, state, and local levels. We are committed to working with you to achieve the best results for children and families.

If you have questions about the process, your program's determination, or if you'd like to request specific technical assistance related to any of the indicators, please contact your assigned performance specialist Meaghan Ramgoolam.

Sincerely,

Meghan Young

Meghan Young, MPAff
Director, Early Childhood Intervention
Family Health Services Department

[1] Q3 had the highest average number of delivered hours at the statewide level for this fiscal year and was used for this indicator.

Attachment

Federal Performance Indicators – The Harris Center for Mental Health and IDD

Indicator	Score	State Performance	Target
Indicator 1: 28 Days	99.3%	95.4%	100%
Indicator 2: Natural Environments	100%	99.6%	99.2%
Indicator 3A: Positive Social-Emotional Skills - Summary Statement I	70.1%	65.2%	69.5%
Indicator 3A: Positive Social-Emotional Skills - Summary Statement II	43.5%	43.1%	46.3%
Indicator 3B: Knowledge and Skills - Summary Statement I	73.7%	72.9%	77.1%
Indicator 3B: Knowledge and Skills - Summary Statement II	22.8%	32.9%	35.3%
Indicator 3C: Meet Their Needs - Summary Statement I	72.1%	73.7%	77.5%
Indicator 3C: Meet Their Needs -Summary Statement II	39.2%	40.3%	44.1%
Indicator 4A: Know Their Rights	77.6%	86.2%	87.0%
Indicator 4B: Communicate Their Child's Needs	82.5%	88.9%	88.0%
Indicator 4C: Help Their Children Develop and Learn	81.8%	88.4%	88.0%
Indicator 5: Child Find (0-12 months)	0.9%	1.2%	1.0%
Indicator 6: Child Find (0-36 months)	3.3%	2.7%	2.1%
Indicator 7: 45 Days	100%	97.3%	100%
Indicator 8A: 90 Days Before 3rd Birthday Transition Plan Steps	100%	97.2%	100%
Indicator 8B: 90 Days Before 3rd Birthday Notification Potentially Eligible Part B	99.5%	91.7%	100%
Indicator 8C: 90 Days Before 3rd Birthday Transition Conference	99.5%	92.4%	100%

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

April 5, 2024

Adiministrator:
Applewhite
526 Applewhite Drive
Katy TX 77450

Provider #: [redacted]
Facility ID #[redacted]
Type: [redacted]

Dear Administrator:

On April 1, 2024, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

If you have any questions, please contact Mark Smith, Life Safety Code Program Manager at 713-767-2271.

Sincerely,

[redacted]n, Life Safety Code Program Manager
Regulatory Services Division, Region 06

Ms/cab

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 04-01-2024 4:00 PM	Exit Date: 04-01-2024

Facility Name APPLEWHITE	Telephone 7133924482	FAX
Address – Street (physical location) 526 APPLEWHITE DRIVE KATY, TX 77450	TULIP [redacted] County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 02-15-2024

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
MARK SMITH	LSC PROGRAM MANAGER

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC);SUBSTANTIAL COMPLIANCE (LSC)

REFERRALS

ADMINISTRATIVE

[redacted]

NARRATIVE

Date Printed: 04/01/2024 3:01:07PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	526 APPLEWHITE DRIVE KATY, TX 77450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of Visit: Non-Onsite Follow-Up No deficiencies cited.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Date Printed: 04/01/2024 3:00:56PM
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN BUILDING** B. WING _____	R **04/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	**526 APPLEWHITE DRIVE** **KATY, TX 77450**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Purpose of Visit: Non-Onsite Follow-Up No deficiencies cited.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 04/01/2024 3:00:44PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	R **04/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWHITE	**526 APPLEWHITE DRIVE KATY, TX 77450**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments Purpose of Visit: Non-Onsite Follow-Up No violations cited.	{S 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

TEXAS Health and Human Services

Survey/Inspection Summary Report

Form 3630
August 2023

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on 04/01/2024

Facility Name	Type of Facility
Applewhite	☐ Adult Day Care ☐ Assisted Living ■ ICF/IID ☐ Nursing Facility
Street Address	**City, State, ZIP Code**
526 Applewhite	Katy TX 77450

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection (All Facility Types)

	Compliance Yes	Compliance No		Compliance Yes	Compliance No		Compliance Yes	Compliance No
1. Fire Alarm System	■	☐	3. Emergency Electrical System	■	☐	5. Other: See CMS Form 2567	■	☐
2. Sprinkler System	■	☐	4. Physical Plant and Environment	■	☐	6. Other:	☐	☐

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management	☐	☐	5. Client Behavior and Facility Practices	☐	☐	9. State Standards for Participation	☐	☐
2. Client Protections	☐	☐	6. Health Care Services	☐	☐	10. Other:	☐	☐
3. Facility Staffing	☐	☐	7. Physical Environment	☐	☐			
4. Active Treatment	☐	☐	8. Dietetic Services	☐	☐			

Health Survey or Inspection (Nursing Facility)

1. Resident Rights	☐	☐	7. Nursing Services	☐	☐	13. Infection Control	☐	☐
2. Admission, Transfer and Discharge Rights	☐	☐	8. Dietary Services	☐	☐	14. Physical Plant and Environment	☐	☐
3. Resident Behavior and Facility Practice	☐	☐	9. Physician Services	☐	☐	15. Administration	☐	☐
4. Quality of Life	☐	☐	10. Specialized Rehabilitation Services	☐	☐	16. State and Local Regulations	☐	☐
5. Resident Assessment	☐	☐	11. Dental and Other Professional Services	☐	☐	17. Other:	☐	☐
6. Quality of Care	☐	☐	12. Pharmacy Services	☐	☐			

Health Survey or Inspection (Assisted Living Facility)

1. Policies: Operational/Admission, Restraint, Authorized Electronic Monitoring	☐	☐	7. Resident Assessment, Health Exams, Service Plan	☐	☐	13. Fire Drills, Smoking Regulations, Disaster Preparedness	☐	☐
2. Infection Control	☐	☐	8. Personal Belongings	☐	☐	14. Required Postings	☐	☐
3. Resident Characteristics	☐	☐	9. Pharmacy and Medication Requirements	☐	☐	15. Physical Environment	☐	☐
4. Staff Requirements, Orientation, Training	☐	☐	10. Accident, Injury, Acute Illness Procedures	☐	☐	16. Resident Bill of Rights	☐	☐
5. Advance Directives	☐	☐	11. Storage of Medications	☐	☐	17. Respite Care	☐	☐
6. Activity/Social Program	☐	☐	12. Dietary Requirements	☐	☐	18. Other:	☐	☐

Health Survey or Inspection (Adult Day Care)

1. Staff Requirements	☐	☐	5. Consultant Responsibilities	☐	☐	9. Dietary Requirements	☐	☐
2. Staff Qualifications	☐	☐	6. Fire, Disaster, Evacuation Training	☐	☐	10. Required Postings	☐	☐
3. Staff Responsibilities	☐	☐	7. Medication Requirements	☐	☐	11. Physical Environment	☐	☐
4. Staff Training	☐	☐	8. Accident, Injury, Acute Illness Procedures	☐	☐	12. Other:	☐	☐

If you need further information, you may call the HHSC regional office at 713-767-2200

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 40, Part 1, Chapter 90, §90.326; Chapter 19, §19.1921; Chapter 92, §92.127; or Chapter 98, §98.61.

Date Printed: 04/11/2024 12:20:38PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Purpose of visit: Focused Fundemental Survey Entrance Date: March 26, 2024 Facility Census: 6 ABBREVIATIONS: AM MORNING DIR DIRECTOR FC FACILITIES COORDINATOR OK OKAY PS PROGRAM SUPERVISOR PA PROGRAM ASSISTANT PM AFTERNOON PM PROGRAM MANAGER QIDP QUALIFIED INTELECTUAL DISABILITY PROFESSIONAL RD REGISTERED DIETICIAN RN REGISTERED NURSE RS RESIDENTIAL SPECIALIST TECH TECHNICIAN	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure specific client protection requirements were met for 1 of 3 individuals (Individual #3) reviewed for client protection. Specifically, the facility failed to ensure Individual #3's bed shaker was in proper function. These deficient practices could place the health, safety, and wellbeing of Individual #3 at risk by not been able to promptly evacuate the facility in the event of a fire.	W 122	W 122 The facility will ensure individual # 3 bed shaker functions properly. Individual # 3 Bed shaker was repaired on 03-28-2024. 1 out of 3 residents had the potential to be affected by this deficient practice. (W 122- Client Protections) but only one was affected. This will be added to the Checklist: The Program Assistant will place a upkeep request regarding repair/replace the bed shaker. a.) The DSP will verify the bed shaker is working daily. b.) The Program Assistant will verify weekly the bed shaker is in working condition. c.) The QIDP will verify monthly the bed shaker is in working condition. d.) The Residential Director will verify quarterly that the bed shaker is in working condition. A policy was implemented to address what to do if the bed shaker has any problems.	5/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Patrina Anthony — Program Manager of Residential — 4/21/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	03/28/2024

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W 122	Continued From page 1 Refer to W189 for evidence.	W 122	W158	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure facility staffing requirements were met for 1 of 3 (Individual #3) individuals reviewed. Specifically, the facility failed to ensure staff received initial and on-going training regarding Individual #3's bed shaker. These deficient practices could place the health, safety, and wellbeing of Individual #3 at risk by not been able to promptly evacuate the facility in the event of a fire. Refer to W189 for evidence.	W 158	Refer to W189 for evidence.	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure staff received continued training that enabled them to perform their duties effectively, efficiently, and competently in a timely manner for 1 of 3 individuals (Individuals #3) reviewed for staff training.	W 189		

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W 189	Continued From page 2 Specifically, 1. The facility failed to ensure Individual #3's bed shaker was in proper function 2. The facility failed to ensure staff received proper training regarding Individual #3's bed shaker This failure could place the health, safety, and wellbeing of Individual #3 at risk by not been able to promptly evacuate the facility in the event of a fire. Findings: Record review of Individual #3's 2023-2024 chart revealed she was a 63-year-old female with diagnoses of moderate intellectual developmental disability, deaf, and nonverbal who was admitted on 9/10/1989. Observation at the home on 3/27/24 from 8:30AM-11:30AM revealed that the bed shaker for Individual #3 did not shake when a mock fire drill was conducted. Bed shaker was connected, with a green light and spare batteries; however, did not shake when required to. Record review of undated Bed Shaker Checklist located in the fire drill book revealed the last sign off for an "OK" status on the bed shaker was on 3/5/24. Record review of undated Acknowledgment for Completing Monthly Testing of Bed Shaker revealed the following: I, _____acknowledge that as a provider of essential services, I have been informed that if I am on duty on the day/date/time that physical testing is scheduled to be completed	W 189	W189 The facility will ensure Individual #3 bed shaker is functioning properly. Bed shaker repaired 03-28-2024. The facility will ensure all staff received training regarding individual #3 bed shaker. Staff were trained in individual # 3 bed shaker on 03-29-2024. 1 out of 3 residents had the potential to be affected by this deficient practice but only one was. This will be added to the Checklist: a.) The Program Assist will monitor weekly the bed shaker is in working condition. b.) The QIDP will monitor the bed shaker monthly to verify working condition and will in-service all staff on how to operate the bed shaker and the policy on what to do if the bed shaker has a problem. c.) The Program Director will verify quarterly the bed shaker is in working condition.	5/26/2024

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W 189	Continued From page 3 on the Bed shaker of the bed occupied by, Individual #3. I must complete the task as required. I must initial/sign the provided verification form. I acknowledge that I have been trained on how to complete the testing of the bed shaker and I have been informed of the importance of assuring that the shaker is operative at all times. I understand that I am expected to become familiar with the testing process. I have been given the opportunity to ask questions. I understand that knowingly and willfully initialing/signing the test verification form without actually, following the outlined procedure amounts to fraud and will incur disciplinary actions up to and including termination of employment. No record review was provided for any of the facility staff regarding initial or ongoing training for Individual #3's bed shaker. Bed shaker was required due Individual #3 being unable to hear fire alarm while she is sleeping, in the event of an emergency. In an interview with [redacted] and [redacted] on 3/27/24 at 8:45AM revealed they know the bed shaker should always be plugged up and under her bed, but they were unsure why it was not shaking or what the protocol for checking it was. Both staff were asked what the process during a mock fire drill was for Individual #3 and [redacted] made a gesture toward the bed and shaking it, she was asked whether she shook it, or the machine shook it, and no response was provided. Both [redacted] and [redacted] were asked what would happen in the event of a real fire during the night that Individual #3 was unable to see the flashing lights from the alarm, they sated "we would make sure	W 189		

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W 189	Continued From page 4 Individual #3 was up." In an interview with [redacted] and [redacted] on 3/27/24 at 12:45PM it was revealed that their assigned fire company came out and "replaced relays on the connection for bed shaker and it is now in proper function." Tech A confirmed the relay had sparked out, and that they had recently change the whole fire panel. Tech A and [redacted] confirmed they were responsible for all fire drill inspections annually, semiannually, and as needed. In an interview with Tech B on 3/28/24 at 10:48AM he revealed he was an alarm and detection technician who worked for the company the facility uses to provide fire panel and emergency services. Tech B stated "there was a relay that had failed, we replaced the panel a month or two ago and when I tested it, it was functioning, but something happened between then and now, the part could have just failed. I had to replace the relay." Tech B confirmed "the bed shaker would not function at all if that relay failed." Tech B was asked how the staff or facility would be aware of this not working properly, he confirmed the facility would contact them if there was any trouble with the fire boxes and they also perform yearly inspections. Tech B stated, "I assume they do monthly inspections as well." Tech B stated a deaf individual would be unable to hear the alarm in the event of an emergency and the bed shaker was not working. In an attempted interview with Individual #3 on 3/28/24 at 10:57AM revealed she liked to communicate with nonverbal hand gestures because she is deaf and nonverbal. Client was happy and cheerful as evidence by smiling and patting surveyor on back. Individual #3 did not	W 189		

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W 189	Continued From page 5 comprehend questions that were being asked regarding the bed shaker, or whether she felt safe in her home or now, she only continues to smile and point toward the bird she was coloring. In an interview with the [redacted] and [redacted] on 3/28/24 at 3:39PM it was revealed that the person responsible for ensuring Individual #3's bed shaker was in proper function was the QIDP. The nurses revealed they did not know it was not in proper function, stated it was not done due to a "missed opportunity." The nurses stated a possible adverse outcome of this deficient practice was "if there was an emergency, she would not be able to evacuate not be able to hear or identify the emergency situation or alarm." They agreed this affected Individual #3. In an interview with the [redacted] QIDP, and [redacted] on 3/28/24 at 4:14PM it was agreed that there should be a better system in place to ensure Individual #3's bed shaker was being monitored and always functioning correctly. All staff agreed the QIDP was responsible for ensuring the bed shaker was in proper function and system was in place for staff to be trained to do so. QIDP agreed this was not completed due to oversight, she stated "at the time it was not reported that the system had a default and issue." The QIDP, [redacted], and [redacted] agreed a possible outcome of this deficient practice was Individual #3 not being alerted during potential emergency situation, a "safety issue" affecting Individual #3.	W 189		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454		

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W 454	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a sanitary environment to avoid sources and transmission of infections for 3 of 3 individuals (Individuals #1, #2, and #3) reviewed and 3 of 3 non-reviewed individuals (Individual #3, #4, and #6) for environmental concerns. Specifically, 1. The facility menu book was not sanitary as evidence by sticky substance on each page and black little dots all over the binder affecting 6 of 6 individuals (Individuals #1, #2, #3, #4, #5, and #6). This failure could place all individuals at risk of illness and cross contamination from an unsanitary environment. Findings: Record review of Individual #1's 2023-2024 chart revealed she was a 58-year-old female with diagnosis of moderate intellectual developmental disability, who was admitted on 07/14/2016. Record review of Individual #2's 2023-2024 chart revealed she was a 39-year-old female with diagnosis of traumatic brain injury, who was admitted on 11/1/2008. Record review of Individual #3's 2023-2024 chart revealed she was a 63-year-old female with diagnoses of moderate intellectual developmental disability, deaf, and nonverbal who was admitted on 9/10/1989.	W 454	W454 The facility will ensure the menu book is free from un-sanitary substance. The old menu book was replaced with a new book which included a new binder, with new sheet protector and all pages were replaced. All residents had the potential to be affected by this deficient practice (W 454 Infection Control) 6/6 were affected. This will be added to the Checklist: a.) The Program Assistant will monitor weekly the menu book is in good condition – (clean and free from Infection control issues) b.) The QIDP will verify monthly the menu book is in good condition – (clean and free from Infection control issues)	5/26/2024

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W 454	Continued From page 7 Observation in the home on 3/26/24 at 3:13PM revealed the menu book in the home to be sticky and dirty as evidence by stains on paper and grainy dark substances within the binder. [redacted] was observed to be using the menu book to assist with dinner for that evening. The menu book was being touched whole preparation of food was occurring. Record review of undated infection control in-service revealed "my signature indicates that I have read and understand the information about infection control, infectious diseases, signs and symptoms, and the prevention of spreading infections through good hand washing and universal precautions." "5. Keeping the environment clean helps prevent the spread and growth of infections or germs." In an interview with the PM on 3/26/24 at 3:13PM she revealed the home manager would be responsible for ensuring the menu books are maintained in a sanitary clean condition; however, she stated the house manager recently resigned, and the QIDP was who oversees her job duties. In an interview with Individual #2 on 3/28/24 at 11:01AM it was revealed she did not comprehend the question asked regarding the sticky menu book with grainy substance inside. Individual #2 did not respond to the question. In an attempted interview with Individual #3 on 3/28/24 at 10:57AM revealed she liked to communicate with nonverbal hand gestures because she is deaf and nonverbal. Client was happy and cheerful as evidence by smiling and patting surveyor on back. Individual #3 did not	W 454		

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W 454	Continued From page 8 comprehend questions that were being asked regarding infection control or her menu book, she only continues to smile and point toward the bird she was coloring. In an interview with Individual #1 on 3/28/24 at 11:11AM revealed her having lunch, she stated she was enjoying was made by staff. Individual #1 was indifferent when asked about the sticky menu book. In an interview with [redacted] and [redacted] on 3/28/24 at 3:39PM it was revealed that [redacted] was the infection control nurse. They both stated the menu book not being clean was "concerning" and that "it should be clean. They need to get a new one out there." The [redacted] and [redacted] confirmed staff and QIDP need to replace the menu books accordingly, and that it has not been done "because they haven't really paid attention to it." They stated an adverse outcome of the menu books in the home not being clean, especially when staff use them to assist in making meals was "whatever is on their hands it can spread an infection." The nurses confirmed this affected all clients in the home. In an interview with the [redacted], QIDP, and [redacted] on 3/28/24 at 4:14PM it was revealed that the QIDP was responsible for ensuring there was a clean and sanitary menu book in the home for staff to use when assisting in meal preparations for the individuals in the home. They stated this was not done due to the previous house coordinator not reporting it to the QIDP so she could follow-up on. The QIDP revealed a likely adverse outcome of this deficient practice would be an infection control issue with cross contamination that affected "all consumers."	W 454		

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W 479	MENUS CFR(s): 483.480(c)(1)(iii) Menus must be different for the same days of each week and adjusted for seasonal changes. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to provide menus that were different for the same days of each week and adjusted for seasonal changes for 1 of 3 individuals (Individuals #1) reviewed for dietetic services. The facility failed to utilize a menu with more than one week of planned meals and with seasonal changes. This deficient practice could result in the individuals' nutritional needs not being met. Findings included: Record review of Individual #1's 2023-2024 chart revealed she was a 58-year-old female with diagnosis of moderate intellectual developmental disability, who was admitted on 07/14/2016. Record review of nutrition assessment for Individual #1 dated 2/13/23 revealed a diet order recommendation of "Soft Diet cut into bite size pieces." Record review of undated "Soft and Bite-sized Menu" for Individual #1 revealed only one week, seven days Sunday-Saturday worth of meal planning. No other record review was provided to show a Spring/Summer/Fall/Winter menu prepared in advance for Individual #1. Observation in the home on 3/27/24 at 8:19AM	W 479	W479 The facility will ensure that individual #1 has a menu with more than 1 week of planned meals. A Soft, Bite size menu will be implemented for Individual # 1 for at least 90 days of planned meals and with seasonal changes. All residents had the potential to be affected by this deficient practice (W 479 Menu) But only 1 of 6 were affected by this deficiency. This will be added to the Checklist: a.) The Program Assistant will monitor monthly the menu are available for at least 3 months offering different meals. b.) The QIDP will verify quarterly the menu are available for at least 3 months offering different meals.	5/26/2024

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W 479	Continued From page 10 revealed the undated menu book for SPRING/SUMMER MENU WEEK4 had no "soft menu" observed. The menu book revealed only 2,000 calories, 2,000 calories low cholesterol, 1500 calorie low cholesterol, 1800 calorie ADA, 1500 calorie high fiber and 1800 calorie ADA low cholesterol 4 GM sodium options within it. In an interview with RS B on 3/27/24 at 8:19AM staff noted that Individual #1 did have a soft diet and they were trained on do's and don'ts for her meals; however no "soft menu" was in the home. The staff stated they used the forms they were trained on to use including the weekly menu to create Individual #1's meals and ensure they were abiding by her reccomended diet. In an interview with the [redacted] and QIDP on 3/27/24 at 8:21AM she revealed "soft menu should be here; we are using a new in-house dietician and she is revamping the menus." The QIDP revealed the new [redacted] did not start until 3/11/23. The QIDP stated the house coordinator would be responsible for ensuring the menus were in the home; however, she resigned. The QIPD and PM confirmed the QIDP is who oversees the house coordinator duties. In an interview with Individual #1 on 3/28/24 at 11:11AM revealed her having lunch, she stated she was enjoying was made by staff. Individual #1 shook her head "no" when asked if she had trouble swallowing her food, she stated "yeah" when asked if she got served a variety of foods. In an interview with the [redacted] on 3/28/24 at 12:55PM she revealed she did not know who was responsible for creating the menus of the home. She revealed "I cannot give an answer because I	W 479		

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W 479	Continued From page 11 was not aware of the situation" when asked why there were no menus created for a soft diet with bite sized pieces, for more than one week that could account for seasonal changes. The [redacted] confirmed an adverse outcome of no menus being prepared for Individual #1would be "staff not knowing what to prepare for a meal." The [redacted] confirmed this would affect Individual #1 as she cannot go without food. The RD confirmed she was "contacted to be a temporary not full time." In an interview with the [redacted], QIDP, and [redacted] on 3/28/24 at 4:17PM it was revealed the [redacted] and QIDP were responsible for ensuring the facility had a menu available for staff to use in meal preparation with more than one week of planned meals and account for seasonal changes. They revealed this was not done due to oversight on the QIDP's part as well as "the dietician retired in October and a new dietician came on board this month." They confirmed a likely adverse outcome of this deficiency would be "staff won't have guidance on preparing the individual with special diet's food." They agreed the individuals affected would be those with specially prescribed diets. Undated policy on DIETETIC SERVICES PROCEDURES revealed the following: "1.A qualified dietician shall develop menu plans in accordance with the latest edition of the Nutrition Board of the National Research Council, National Academy of Sciences. b. The menus shall be different the same days of each week and adjusted for seasonal changes. Menus shall provide for a variety of foods at each meal. c. Menus shall be posted inconspicuously in the kitchen, on the inside of a cupboard or door so as not to be readily viewable by the general public.	W 479		

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WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

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W 479	Continued From page 12 Menus are to be filed and maintained for at least four (4) weeks." W 481 MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure food served was documented and kept on file for at least 30 days for 1 of 3 individuals (Individual #1) reviewed for dietetic services. There was no record of foods served over the past 30 days for Individual #1. This failure to track meals had the potential to prevent monitoring of food intolerances, and foods served in variety. Findings: Record review of Individual #1's 2023-2024 chart revealed she was a 58-year-old female with diagnosis of moderate intellectual developmental disability, who was admitted on 07/14/2016. Record review of nutrition assessment for Individual #1 dated 2/13/23 revealed a diet order recommendation of "Soft Diet cut into bite size pieces." Record review of undated "Soft and Bite-sized Menu" for Individual #1 revealed only one week, seven days Sunday-Saturday worth of meal planning.	W 479 W481 W 481	The facility will ensure food served is documented and kept on file for at least 30 days. Individual #1 has new menus for at least 30 days. 1 out of 3 residents had the potential to be affected by this deficient practice but only 1 was affected. This will be added to the Checklist: a.) The Program Assistant will monitor monthly that a 30-day record of food served is kept on file at the group home. b.) The QIDP will verify quarterly that a 30-day record of food served is kept on file at the group home	5/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 481	Continued From page 13 No record review was provided to show documented meals provided for Individual #1 for the past 30 days. Observation in the home on 3/27/24 at 8:19AM revealed the undated menu book for SPRING/SUMMER MENU WEEK4 had no "soft menu" observed. The menu book revealed only 2,000 calories, 2,000 calories low cholesterol, 1500 calorie low cholesterol, 1800 calorie ADA, 1500 calorie high fiber and 1800 calorie ADA low cholesterol 4 [redacted] sodium options within it. In an interview with [redacted] on 3/27/24 at 8:19AM staff noted that Individual #1 did have a soft diet and they were trained on do's and don'ts for her meals; however no "soft menu" is in the home. The staff stated they use the forms they were trained on to use including the weekly menu to create Individual #1's meals and ensure they are abiding by her reccomended diet. In an interview with the [redacted] and QIDP on 3/27/24 at 8:21AM she revealed "soft menu should be here; we are using a new in-house dietician and she is revamping the menus." The QIDP revealed the new RD did not start until 3/11/23. The QIDP stated the house coordinator would be responsible for ensuring the menus were in the home; however, she resigned. The QIPD and PM confirmed the QIDP is who oversees the house coordinator duties. In an interview with Individual #1 on 3/28/24 at 11:11AM revealed her having lunch, she stated she was enjoying what she was made by staff. Individual #1 shook her head "no" when asked if she had trouble swallowing her food, she stated "yeah" when asked if she gets served a variety of	W 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 481	Continued From page 14 foods. Individual #1 was indifferent when asked about the sticky menu book. In an interview with the [redacted] on 3/28/24 at 12:55PM she revealed she did not know who was responsible for creating the menus of the home. She revealed "I cannot give an answer because I was not aware of the situation" when asked why there were no menus created for a soft diet with bite sized pieces, for more than one week that could account for seasonal changes. The [redacted] confirmed an adverse outcome of no menus being prepared for Individual #1would be "staff not knowing what to prepare for a meal." The [redacted] confirmed this would affect Individual #1 as she cannot go without food. The [redacted] confirmed she was "contacted to be a temporary not full time." In an interview with the [redacted], QIDP, and [redacted] on 3/28/24 at 4:17PM it was revealed the [redacted] and QIDP were responsible for ensuring the facility had a record available for foods served over the past 30 days for all individuals. They revealed this was not done due to oversight on the QIDP's part as well as "the dietician retired in October and a new dietician came on board this month." They confirmed a likely adverse outcome of this deficiency would be "staff won't have guidance on preparing the individual with special diet's food." They agreed the individuals affected would be those with specially prescribed diets. Undated policy on DIETETIC SERVICES PROCEDURES revealed the following: "1.A qualified dietician shall develop menu plans in accordance with the latest edition of the Nutrition Board of the National Research Council, National Academy of Sciences. b. The menus shall be different the same days of	W 481		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 481	Continued From page 15 each week and adjusted for seasonal changes. Menus shall provide for a variety of foods at each meal. c. Menus shall be posted inconspicuously in the kitchen, on the inside of a cupboard or door so as not to be readily viewable by the general public. Menus are to be filed and maintained for at least four (4) weeks."	W 481		

BE WELL, TEXAS℠

EXIT CONFERENCE

The Harris Center for Mental Health and IDD (MAT-AUD)
Audited by Alayna Mackey

04/23/2024

FY 2023 Performance Improvement Plans Submitted
The Harris Center for Mental Health and IDD

- June 2023 (FY23): Spend down not properly managed.
  - Repeat Finding – Out of compliance as of FY2024

BE WELL, TEXAS

FY 2024 Audit Findings
The Harris Center for Mental Health and IDD

- Provider is not on track utilizing budget (Major)

Total Performance Improvement Plans Submitted: 01

PIP Monitoring Process

- The Be Well Quality team will request an update on the progress of your performance plans in the near future.
- Please look out for our email correspondence *and document all efforts you are making to resolve the issue.*

For a provider with *any* Major Findings	A follow-up will occur approximately *30 days* after the closure of Exit Conferences. (late May 2024)

BE WELL, TEXAS

superior healthplan

<Date>

Dear <Provider or Office Administrator>,

At Superior HealthPlan, we value everything you do to deliver quality care and ensure our members — your patients — have a positive healthcare experience. That's why each year, we are required to report on clinical quality measures to the Centers for Medicare & Medicaid Services (CMS). The quality measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®) specifications developed by the National Committee for Quality Assurance (NCQA) and other state-defined measures. In compliance with HEDIS, we request medical records regarding certain measures to collect information that typically cannot be found in a claim or an encounter.

Superior HealthPlan has engaged with several medical record collection vendors such as **Change Healthcare/Optum Insights, CIOX/Datavant, Datafied, MRO and Sharecare** to assist us in collecting the records required to complete this HEDIS review. As a Superior HealthPlan provider, you are required to fulfill any such requests made on our behalf.

These vendors have signed a Business Associate Agreement (BAA) with Superior HealthPlan, agreeing to comply and adhere to all Health Insurance Portability and Accountability Act (HIPAA) rules and regulations. They have processes in place to safeguard the Protected Health Information (PHI) of our members and your patients. All staff involved in collecting and reviewing charts have signed a HIPAA-compliant confidentiality agreement and are trained on HIPAA compliance rules and regulations.

HIPAA Rules Regarding Signed Release

Under HIPAA, Covered Entities, such as practitioners and their practices, are not required to obtain patient authorization to disclose PHI to another Covered Entity, such as Superior HealthPlan. Both parties *must* have a relationship with the patient and the PHI *must* pertain to that relationship for the purposes of treatment, payment, and/or healthcare operations.

Quality assessment and improvement activities are considered healthcare operations under the Privacy Rule (45 CFR 164.501). Healthcare operations include conducting or arranging for medical record review for compliance programs. The Superior HealthPlan Provider Handbook states that providers are required to make medical records available for quality care review purposes.

If you have any concerns regarding the HIPAA rules or would like to speak with someone about this, please call the QI contact for assistance.

Medical Record Collection Process

One or more vendors will contact your office to schedule medical record collection between **January 1 and April 28, 2024,** for member charts. They will contact you if we have identified you as the member's assigned or previous primary care provider (PCP), or, if you have submitted a claim or encounter that relates to a HEDIS measure that we are required to report to the state agency and CMS.

Due to the limited time frame to collect and abstract the medical records, we ask that your office accommodates this request for chart collection via fax, mail, or on-site sessions at the earliest mutually agreeable date, but ***no later than April 21, 2024****.*

Once the vendor has scheduled the session, they will fax you a copy of the member pull list that will include instructions for preparing the records. If you require assistance from them in pulling charts, you can ask for their help directly or have files ready for them when they arrive.

Please be aware that these vendors contract with other health plans to collect charts for HEDIS and Medicare Risk Adjustment Processing System (RAPS) reviews. This limits the number of health plans that will need to schedule time in your office.

If you have any questions or concerns regarding the process, please contact Superior's Quality Improvement Department at **512-642-7559**.

Sincerely,

Superior HealthPlan

aetna

Epi Reference ID: [redacted]

Be sure to send medical records for the annual risk adjustment collection

As a commercial health plan, we re required to submit risk adjustment data on our Aetna members to the U.S. Department of Health and Human Services (HHS). This is part of our annual risk adjustment data collection of medical records.

To comply with the federal government s request for data, we re requesting medical records for your Aetna patients. These records will only be used for annual risk adjustment submissions to the U.S. Department of Health and Human Services. (HHS). These records will be kept for ten (10) years, after which time they will be destroyed.

Episource will contact you regarding data collection.

We ve contracted with Episource to collect medical records on our behalf. In the next few weeks, they ll contact your office to collect medical records for patients enrolled in one of our commercial health plans, either on or off the exchange. Once they ve contacted you, we ask that you respond promptly.

To prepare for this collection, see the details on the next page. This page includes the information Episource will collect. It also tells you how you can send records.

You don t need patient consent to provide medical records to Episource

Under federal law, patient consent is not needed in order to provide medical and behavioral health records to Episource. Due to the purpose for which the records will be provided, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits you to provide medical records to Episource, who is a business associate of Aetna under HIPAA.

Specifically, the HIPAA Privacy Rule expressly permits the disclosure of protected health information without patient consent where the purpose of such disclosure is for purposes of risk adjustment. 45 CFR § 164.501. Please note that, while HHS does require us to provide records related to certain behavioral health conditions, Episource will not be requesting, and you should not provide psychotherapy notes. Enclosed with this notice is a set of Frequently Asked Questions of behavioral health providers.

What about records related to substance abuse?

The HHS risk adjustment program includes records related to certain substance abuse conditions. You may also provide Episource records concerning substance abuse and alcohol misuse arising from a federally assisted program under 42 C.F.R. Part 2. Like HIPAA, the Part 2 regulations permit disclosure without consent for purposes of audit and evaluation activities such as risk adjustment. 42 CFR § 2.53.

Epi Reference ID: L-04019955

superior healthplan.
Centene Company of Texas, LP

5900 E. Ben White Blvd.
Austin, TX 78741
1-800-218-7508
www.SuperiorHealthPlan.com

Fax Transmittal

To: The Harris Center for Mental Health and IDD
Fax: (713) 970-3817
Company: ATTN: Medical Records
Date: May 9, 2024
Subject: RA Medical Records Request
Comments:

From: [redacted]
Fax: (833) 498-1765

This is a request for Medical Records for our Risk Adjustment project.

If you have any questions, please contact me, Adriana Shelby at 512-575-6379 or SHP_RiskAdjustment@SuperiorHealthPlan.com -Attn: Adriana Shelby

Thank you for your help!

*Please include a Copy of the Face Sheet.
The member's name and date of birth must be on all pages transmitted*
Physician's dated signature is required on all office encounters

MAY 10 2024

RECEIVED

A special license for Utilization Review Agents (URA) is issued through the Texas Department of Insurance (TDI) and is necessary to perform medical reviews. Centene Company of Texas, LP is a Licensed URA (#4167), contracted with Superior HealthPlan to perform utilization review.

PRIOR AUTHORIZATION IS A CONDITION FOR REIMBURSEMENT; IT IS NOT A GUARANTEE OF PAYMENT

Optum Rx®

Audit ID: DSK-26250

PRELIMINARY AUDIT RESULTS NO RECOUPMENT

05/13/2024

SOUTHEAST CLINIC PHARMACY
NCPDP: [redacted]
5901 LONG DR
HOUSTON, TX 77087

Dear Pharmacy Owner/Manager,

Optum Rx, Inc. on behalf of itself and each of its pharmacy benefit manager affiliates (collectively "ORX"), routinely performs audits of pharmacies within the provider networks to support our overall fraud, waste, and abuse audit program. Optum RX conducted a desk audit on 03/18/2024. Please see the attached worksheet with our FINAL AUDIT FINDINGS. **These findings represent a total estimated overpayment amount of $0.00.**

For discrepancies identified with a $0.00 overpayment amount, these are educational only and do not require dispute documentation. If findings amount is $0.00, no further action is necessary.

Sincerely,
Anahi Contreras
Optum Rx Pharmacy Network Audit
f: 800-984-8431
p: 763-349-6533

Optum Rx®

Audit ID: DSK-26250

Audit Date: 03/18/2024
Store Name: SOUTHEAST CLINIC PHARMACY
NCPDP: 4533837

Desk Audit Report

Rx #	Fill date	Drug Name	Validated Qty	Validated Day Supply	Discrepancy Code(s)	Potential Overpayment	Discrepancy Comments
[redacted]	08/28/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
[redacted]	07/27/2023	INVEGA SUST INJ 117/0.75	0.75	30	N	$0.00	No discrepancy identified
[redacted]	08/11/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
[redacted]	08/03/2023	INVEGA SUST INJ 234/1.5	1.5	30	N	$0.00	No discrepancy identified
[redacted]	09/11/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
[redacted]	10/23/2023	ARISTADA INJ 882MG/3	3.2	28	N	$0.00	No discrepancy identified
[redacted]	08/28/2023	ARISTADA INJ 882MG/3	3.2	28	N	$0.00	No discrepancy identified
[redacted]	09/22/2023	ARISTADA INJ 882MG/3	3.2	28	N	$0.00	No discrepancy identified
[redacted]	11/21/2023	ARISTADA INJ 882MG/3	3.2	28	N	$0.00	No discrepancy identified
[redacted]	09/15/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
[redacted]	10/13/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
[redacted]	11/13/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
[redacted]	09/08/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
[redacted]	10/03/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
[redacted]	09/06/2023	INVEGA SUST INJ 156MG/ML	1	30	N	$0.00	No discrepancy identified

Rx #	Fill date	Drug Name	Validated Qty	Validated Day Supply	Discrepancy Code(s)	Potential Overpayment	Discrepancy Comments
[redacted]	09/22/2023	INVEGA SUST INJ 234/1.5	1.5	30	N	$0.00	No discrepancy identified
	09/22/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	09/27/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	10/24/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	12/13/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	09/27/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	10/12/2023	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified
	11/08/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	10/03/2023	ABILIFY MAIN INJ 300MG	1	30	N	$0.00	No discrepancy identified
	10/04/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	11/01/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	11/28/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	11/13/2023	ARISTADA INJ 662MG/2	2.4	28	N	$0.00	No discrepancy identified
	12/11/2023	ARISTADA INJ 662MG/2	2.4	28	N	$0.00	No discrepancy identified
	01/05/2024	ARISTADA INJ 662MG/2	2.4	28	N	$0.00	No discrepancy identified
	10/11/2023	ARISTADA INJ 1064MG	3.9	56	N	$0.00	No discrepancy identified
	10/12/2023	INVEGA SUST INJ 234/1.5	1.5	30	N	$0.00	No discrepancy identified
	10/12/2023	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified
	11/09/2023	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified
	12/05/2023	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified

Optum Rx®

Audit ID: DSK-26250

Rx #	Fill date	Drug Name	Validated Qty	Validated Day Supply	Discrepancy Code(s)	Potential Overpayment	Discrepancy Comments
[redacted]	01/04/2024	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified
	10/16/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	10/16/2023	ABILIFY MAIN INJ 400MG	1	28	N	$0.00	No discrepancy identified
	11/13/2023	ABILIFY MAIN INJ 400MG	1	28	N	$0.00	No discrepancy identified
	12/05/2023	ABILIFY MAIN INJ 400MG	1	28	N	$0.00	No discrepancy identified
	10/30/2023	RISPERDAL INJ 37.5MG	1	14	N	$0.00	No discrepancy identified
	10/18/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	10/18/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	11/14/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	11/02/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	10/25/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	11/06/2023	INVEGA SUST INJ 156MG/ML	1	28	N	$0.00	No discrepancy identified
	12/12/2023	ARISTADA INJ 1064MG	3.9	56	N	$0.00	No discrepancy identified
	11/15/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	11/21/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	11/15/2023	ABILIFY MAIN INJ 400MG	1	30	N	$0.00	No discrepancy identified
	12/12/2023	ABILIFY MAIN INJ 300MG	1	28	N	$0.00	No discrepancy identified
	12/15/2023	INVEGA SUST INJ 234/1.5	1.5	28	N	$0.00	No discrepancy identified
	12/15/2023	RISPERDAL INJ 50MG	1	14	N	$0.00	No discrepancy identified

Optum Rx®

Audit ID: DSK-26250

Rx #	Fill date	Drug Name	Validated Qty	Validated Day Supply	Discrepancy Code(s)	Potential Overpayment	Discrepancy Comments
[redacted]	12/29/2023	RISPERDAL INJ 50MG	1	14	N	$0.00	No discrepancy identified
	01/11/2024	RISPERDAL INJ 50MG	1	14	N	$0.00	No discrepancy identified
	12/18/2023	RISPERDAL INJ 25MG	1	14	N	$0.00	No discrepancy identified

Discrepancy Codes

Discrepancy Code(s)	Description
N	No discrepancy identified

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

May 8, 2024

Administrator
Westbury House
5707 Warm Springs
Houston TX 77035

Provider #: [redacted]
Facility ID #: [redacted]
Type: [redacted]

Dear Administrator:

On May 7, 2024, the Texas Health and Human Services Commission (HHSC) conducted a Life Safety Code non-onsite follow-up, to determine if your facility complies with state licensure requirements and federal participation requirements for ICF/IID facilities in the Medicare or Medicaid (or both) programs. The survey found that your facility **meets** state licensure requirements and **is in substantial compliance** with federal participation requirements.

If you have any questions, please contact Mark Smith, Life Safety Code Program Manager at 713-767-2271.

Sincerely,

Mark Smith, Life Safety Code Program Manager
Regulatory Services Division, Region 06

Ms/cab

Texas Health and Human Services

Report of Contact
Intermediate Care Facilities for Individuals with Intellectual Disabilities

Form 3614-A
Dec 2019

Region: 06	Life Safety Code Visit	Entrance Date: 05-07-2024 8:00 AM	Exit Date: 05-07-2024

Facility Name WESTBURY HOUSE	Telephone 7137235589	FAX
Address – Street (physical location) 5707 WARM SPRINGS HOUSTON, TX 77035	TULIP Facility ID: 003721 County: Harris	

PURPOSE OF CONTACT:

FOLLOW-UP TO LICENSURE INSPECTION;NON-ONSITE FOLLOW-UP

Follow Up Visit (original exit date) – SURVEY/INVESTIGATION 03-29-2024

Intakes Number(s) Investigated

IID Capacity: 6	IID Census:

LTCR STAFF REPORTING

Name	Title
MARK SMITH	**LSC PROGRAM MANAGER**

REGULATORY DECISIONS AND SANCTIONS RECOMMENDED

MEETS LICENSURE REQUIREMENTS (LSC);NO DEFICIENCIES CITED (LSC);NO LICENSURE VIOLATIONS CITED (LSC);SUBSTANTIAL COMPLIANCE (LSC)

REFERRALS

ADMINISTRATIVE

ACO ID: HLNQ22; EVT-0000455730

NARRATIVE

Date Printed: 05/07/2024 3:55:47PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	5707 WARM SPRINGS HOUSTON, TX 77035

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments Purpose of Visit: Non-onsite Follow Up No deficiencies cited.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Date Printed: 05/07/2024 3:55:35PM
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING **01 - MAIN-BUILDING** B. WING _____	R **05/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS** **HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Purpose of Visit: Non-onsite Follow Up No deficiencies cited.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Texas Health and Human Services Commission

STATEMENT OF LICENSING VIOLATIONS AND PLAN OF CORRECTION

Form HHSC 3724 April 2015

Date Printed: 05/07/2024 3:55:21PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING: **01 - MAIN-BUILDING** B. WING _____	R **05/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBURY HOUSE	**5707 WARM SPRINGS HOUSTON, TX 77035**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{M 000}	Initial Comments Purpose of Visit: Non-onsite Follow Up No violations cited.	{M 000}		

SOD - State Form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Texas Health and Human Services Commission

Survey/Inspection Summary Report

Form 3630
June 2010

The Texas Health and Human Services Commission Regulatory Services division conducted a survey or inspection on

05/07/2024

Facility Name	Type of Facility
Westbury House	Adult Day Care Assisted Living ICF/IID Nursing Facility
Street Address	**City, State, ZIP Code**
5707 Warm Springs	Houston,TX 77035

The items on the following charts represent areas that the survey team surveyed or inspected for compliance with state and/or federal requirements. Only the items checked Yes or No are applicable to this report; other deficiencies in areas not checked may still be pending and not reflected on this current report. You may obtain a copy of the complete report, including outstanding deficiencies, from the facility administration.

Life Safety Code Survey or Inspection (All Facility Types)

	Compliance			Compliance			Compliance	
	Yes	No		Yes	No		Yes	No
1. Fire Alarm System	X		3. Emergency Electrical System	X		5. Other: See CMS Form 2567	X	
2. Sprinkler System	X		4. Physical Plant and Environment	X		6. Other:		

Health Survey or Inspection (ICF/IID)

1. Governing Body and Management			5. Client Behavior and Facility Practices			9. State Standards for Participation		
2. Client Protections			6. Health Care Services			10. Other:		
3. Facility Staffing			7. Physical Environment					
4. Active Treatment			8. Dietetic Services					

Health Survey or Inspection (Nursing Facility)

1. Resident Rights			7. Nursing Services			13. Infection Control		
2. Admission, Transfer and Discharge Rights			8. Dietary Services			14. Physical Plant and Environment		
3. Resident Behavior and Facility Practice			9. Physician Services			15. Administration		
4. Quality of Life			10. Specialized Rehabilitation Services			16. State and Local Regulations		
5. Resident Assessment			11. Dental and Other Professional Services			17. Other:		
6. Quality of Care			12. Pharmacy Services					

Health Survey or Inspection (Assisted Living Facility)

1. Policies: Operational/Admission, Restraint, Authorized Electronic Monitoring			7. Resident Assessment, Health Exams,			13. Fire Drills, Smoking Regulations, Disaster Preparedness		
2. Infection Control			8. Personal Belongings			14. Required Postings		
3. Resident Characteristics			9. Pharmacy and Medication Requirements			15. Physical Environment		
4. Staff Requirements, Orientation, Training			10. Accident, Injury, Acute Illness Procedures			16. Resident Bill of Rights		
5. Advance Directives			11. Storage of Medications			17. Respite Care		
6. Activity/Social Program			12. Dietary Requirements			18. Other:		

Health Survey or Inspection (Adult Day Care)

1. Staff Requirements			5. Consultant Responsibilities			9. Dietary Requirements		
2. Staff Qualifications			6. Fire, Disaster, Evacuation Training			10. Required Postings		
3. Staff Responsibilities			7. Medication Requirements			11. Physical Environment		
4. Staff Training			8. Accident, Injury, Acute Illness Procedures			12. Other:		

If you need further information, you may call the HHSC regional office at

713-767-2200

The Survey/Inspection Summary Report must be posted in an area of the facility that is readily available to residents, clients, employees and visitors in accordance with the facility's appropriate licensure regulations at Texas Administrative Code, Title 26, Part 1, Chapter 551, §551.326; Chapter 19, §19.1921; Chapter 553, §553.127; or Chapter 98, §98.61.

EXHIBIT A-6

Executive Summary

SPECIAL MANAGEMENT REQUEST: BANK RECONCILIATION AUDIT (BANKREC0124)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit met with the Financial Services accountant for a demonstration of the Center's primary bank account reconciliation process on the JPM-Chase account, which is the Center's primary bank account.

The process required downloading the general ledger data from Ross financial system. Next the report comparing balances to show that accounts receivables were process successfully and that accounts payable transactions were completed. The reconciliation process is used to identify non sufficient funds (NSF) checks that did not process as payments, and examination of unreconciled checks which indicate that they have not yet been cashed. The basic use of bank reconciliations is to identify the amount of cash on hand for handling the Center's cash needs.

The accountant also discussed the methods that the department uses to reconcile ACH and electronic funds transfers that did not process as planned and spoke about the occasional ACH reversals process and checking escheat accounts. The accountant who demonstrated this reconciliation has worked in a similar position in the past and has firm expertise in explaining Center's monthly reconciliation process.

We found no issues with the methods used to conduct the current bank reconciliation process which is performed by Financial Services in a timely manner each month to gauge the Center's cash needs.

Management Response not required.

Bank Reconciliation Audit

(BANKREC0124)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

Internal Audit will meet with the Financial Services management team to discuss a review of the bank reconciliation process. Internal Audit will need to verify that at least three (3) data source locations are used in the reconciliation process, including but not limited to balances on the Chase Bank website, the Harris Center's general ledger periodic balances, and any subsidiary ledger accounts used to prepare any reconciliation that would be requested by the Chief Financial Officer or by the Board of Directors.

The Harris Center moved to electronic payments and direct deposit methods for payroll many years ago. The Center issues hard copy checks if specified as a contract requirement or if it is mandated necessary. The beginning and ending account balances are traceable in Ross Financial system, which allows the auditor the opportunity to view reconciliation from the bank statement to subsidiary financial reports, preferably online using Teams calls.

When transfer payments are made, the transactions are recorded in the designated banking account (e.g., Chase Bank, Bank of America, etc.) and recorded in Ross as accounts payable activity, which due to the nature of transaction processing becomes activity on the bank account. Wire transfers do not follow the same flows as accounts payable, but nonetheless are governed by controls and management review. These amounts should agree fully and exactly in amount, unless there is an unseen problematic transfer (e.g., check returned to the maker).

Payments to the Center are received and processed electronically including cash which follows a flow into a larger receivables process. The posting of receipt of personal and business checks, money orders and other media follow a workflow involving tracking the receipt of payment, and subsequent allocation to the appropriate sub-account (clinical administrative office, etc.). The consumers (patients) pay fees at the clinical administrative offices and the amounts are posted to the 412000 Local Patient Fees account. Payments from consumers or organizations marked 'non-sufficient funds will require prompt follow-up from the business unit contact, which in turn requires a Financial Services inquiry to the maker.

The Financial Services organization views reconciliations as a fundamental key to accounting integrity. The bank reconciliation process unveiled checks or other payments are late due to a timing error or posted incorrectly in the draft amount or human error, or a Center payment which was issued but not reconciled. We assume that some number of differences will be found between the presented sources and that balance discrepancies are justified with additional research and are under control, or require special investigations, which is extremely rare.

The 'triple check' method compares transaction balances on the source documents to confirm a match between the bank statements and The Harris Center's general ledger and all subsidiary financial records. Internal Audit will meet with Financial Services to evaluate the basic workflow and subsequently review the specific tasks laid out to substantiate material versus non-material discrepancies to use a work plan to investigate root causes for lateness, wrong amounts and so forth that suspend payment processing.

SCOPE AND OBJECTIVES

Audit Scope: The Bank, Treasury and Investments Audit is a Board-approved audit seeks to affirm that the Financial Services management successfully performs planned and periodic bank reconciliations to affirm agreement between general ledger balances, bank statements and the trial balance statements.

Audit Objectives: The Bank, Treasury and Investments Audit has been approved for inclusion in the Internal Audit Department's Fiscal Year 2024 Annual Audit Plan, and our audit objectives were to:

1. Enable a concise review of the methodology used to perform the period bank reconciliations and determine tests that can allow "reperformance" of a given period of payment processing to show that business controls effectively alert management of gaps in sequencing or other discrepancies.
2. Confirm that Financial Services is empowered and has full authority to address contingencies that are discovered during reconciliation and can be corrected and documented in a timely manner.
3. Assure that the Financial Services management team has unfettered access to the Board of Directors to report any anomalies and related concerns after performing periodic bank reconciliations.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. The Harris Center's senior management does not ask Financial Services to perform reconciliations or other special analysis during the preparation of Resource Committee Meeting presentations.
2. The Harris Center's senior management does not allocate sufficient staff resources to sustainably perform the tasks associated with regular performance of bank reconciliations and related activity.
3. The Harris Center's senior management has not prioritized periodic departmental reviews of the bank reconciliation process workflows to show accountability and control over business accounts.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Evaluate online and published bank reconciliation descriptions of the bank reconciliation process and identify sources to be used for reference during the on-site review of the bank reconciliation process with the Financial Services staff who normally perform the reconciliation and review it.
2. Verify that there is Harris Center policies and procedures documentation that can help define the managerial and operational objectives of the bank reconciliation process.
3. Contact the Controller and Chief Financial Officer (CFO) involved in conversation to gain their understanding of how the workflows should be performed in the Financial Services organization.
4. Assess how Financial Services delegates authority over bank reconciliations to subordinate staff and note the business controls that are commonly used to protect the organization's finances.
5. Review the work product and other recorded history of bank reconciliations to determine if similar types of issues seem to re-occur and identify issues that may appear to be unresolved over time.
6. Examine the financial value, nature, and frequency of transferring activity to the escheat accounts and determine if efforts to resolve have been adequately addressed by Financial Services efforts.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit met with the Financial Services accountant for a demonstration of the Center's primary bank account reconciliation process on the JPM-Chase account, which is the Center's primary bank account.

The process required downloading the general ledger data from Ross financial system. Next the report comparing balances to show that accounts receivables were process successfully and that accounts payable transactions were completed. The reconciliation process is used to identify non sufficient funds (NSF) checks that did not process as payments, and examination of unreconciled checks which indicate that they have not yet been cashed. The basic use of bank reconciliations is to identify the amount of cash on hand for handling the Center's cash needs.

The accountant also discussed the methods that the department uses to reconcile ACH and electronic funds transfers that did not process as planned and spoke about the occasional ACH reversals process and checking escheat accounts. The accountant who demonstrated this reconciliation has worked in a similar position in the past and has firm expertise in explaining Center's monthly reconciliation process.

We found no issues with the methods used to conduct the current bank reconciliation process which is performed by Financial Services in a timely manner each month to gauge the Center's cash needs.

Management Response not required.

CONCLUSION

The Board of Directors approved the Bank Reconciliation Audit for the Fiscal Year 2024 Audit Plan as one of the financial audit reports in FY2024. The previous bank reconciliation audit was performed in 2018, which was completed without issues with a previous Treasury and Investments Manager who provided unfettered access to all her relevant accounting records.

Internal Audit's 2018 audit report did not state if the Treasury and Investments Manager had performed the bank reconciliations routinely, monthly, or performed them on demand, or less often. The current Financial Services organization performs a bank reconciliation for each accounting period, using a due date coinciding with the monthly accounting period's closing date. The Financial Services staff involved in the reconciliation process are knowledgeable and experienced and provided professional guidance in recent discussions which reviewed the bank reconciliation process.

For this current audit, we asked the Chief Financial Officer (CFO) to join the conversation in this review, to gain his professional guidance on reviewing many of the ongoing projects at The Harris Center. The Financial Services Department has lost a number of experienced staff over a short period of time, and there are learning curve opportunities for remaining staff. The process of performing bank reconciliation is key to successful financial reporting and is needed to test financial integrity and financial conditions.

Respectfully submitted,

David W. Fojtik
David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey
Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP AUDIT: FLEET MANAGEMENT AUDIT (FUFM0124)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – The audit disclosed:

1) As of February 29, 2024, there were 21 agency-owned vehicles in inventory.

2) The average vehicle age of the remaining vehicles was 3.38 years.

3) The cost for operating 21 vehicles through February 29, 2024) was $188,265.

4) Enterprise Leasing invoices from 09/01/2023 - 02/29/2024 totaled $335,285 for 119 cars.

5) As of 02/29/2024, total fleet vehicle cost (Leased and Owned) totaled $523,550.

Management Response #1 (Director of Transportation): *"Entering into the contract with Enterprise just as the nation faced the COVID crisis presented some very real challenges with the nation shutting down for several months and that coupled with the semi-conductor shortage drove the fleet replacement time from months to years. With the conditions improving in FY 2024, we expect the fleet replacement to be completed late FY 2024 to early FY 2025. Once the fleet is replaced with only the rental fleet, I expect to see a drop in operating cost across the board; maintenance, fuel cost, etc. The enterprise management team has been very good in helping navigate this crisis and has kept the transportation team informed and engaged in the replacement process and options available to the Center. Internally we are working on purchasing internal software to assist in managing the fleet for our end, this should result in reduced cost fleet wide. Once the fleet is replaced it is my recommendation an audit be conducted on vehicle use by program to determine if the actual car count could be reduced which would also result in reduced yearly expenditures."*

Internal Audit Response

Once the leasing process is completed, we will perform a review of the leased vehicles by program to determine if actual car counts are adequate or could decreased based on usage which would result in reduced yearly expenditures.

Follow-Up: Fleet Management Audit

(FUFM0124)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

Last year, Internal Audit performed a Fleet Management Audit to review the status of the vehicle fleet program at the Harris Center. The primary focus was on the processing of new vehicles and the process to transfer titles to the Enterprise (lessor) for the ultimate sale of agency-owned vehicles at auction. At the time of the preparing this follow up audit, many vehicle title transfers were completed, but one of the goals was to update the fleet so that the administrative responsibility for maintenance is reduced.

We joined the Transportation Specialist on a conference call with the Enterprise Leasing Management team to talk about inventory and process used for transferring titles. The issues are resolvable and the Transportation Specialist reports a favorable working relationship with Enterprise Leasing Management contacts. The fleet management and related transition plan has been in place since April, 2022.

We found the total combined cost of operating agency-owned vehicles and leased vehicles totaled $1,132,009 as of August 31, 2023. In this follow-up report, we found there are 32 vehicles in inventory according to the Corporate Radar (The Harris Center's fixed asset inventory system). In last year's audit, we had 48 agency-owned vehicles in inventory and Transportation sold 44 agency-owned vehicles. In each vehicle's title transfer, Enterprise Leasing charges us a flat-rate $495 fee per vehicle, which includes the administrative costs, plus any towing charges.

The benefit of operating leased vehicles is the vehicles should be more predictable in terms of reliability; however, fitting the Center's fleet with Enterprise leased vehicles has introduced more fixed costs and overhead but they are more predictable expenditures. The major advantage of using Enterprise Leasing is that their staff ultimately perform all the routine maintenance scheduling and all tasks to ensure the vehicles are in good working order, including routine vehicle inspections. The vehicle insurance remains the responsibility of the Transportation Department staff.

This audit should look at utilization of the vehicles; there are questions about the use of the specific vehicles, for example are they all used to their full capacity or shared among multiple groups to assure more frequent use? The fixed cost nature of fleet management is best applied if vehicles can be used more often for transportation needs and not be idle in the 9401 garage or the Bristow Bldg. parking lot. We spoke with the Transportation Specialist who advised that the employee accountability is still in place because drivers write their Daily Report, which is submitted to the management team, and sent in at the end of the month. The data are not keyboarded, but the process provides basic business control.

The other issue is workplace changes. If the number of Center employees working from home increased did that workplace trend diminish the need to see their patient consumers in-person? In conversations we had with the Transportation Specialist, we were told there is strong demand to visit their consumers at home, just as in the past. The other change is the introduction of GPS tracking in the several mobile units, including 24 vehicles for MCOT, which replace the need to manually prepare these Daily Reports. The Transportation Specialist advised that these GPS trackers are more specific about a driver's status and can provide the detailed geographic whereabouts of the drivers.

SCOPE AND OBJECTIVES

Audit Scope: The Follow-Up: Fleet Management Audit has been added to Internal Audit's Fiscal Year 2024 Annual Audit Plan in order to assure that proper management controls remain in place.

Audit Objectives: This audit will review the Transportation Department's procedures that are being used to manage the fleet vehicles operations, and our audit objectives were designed to:

1. Assure that Transportation Department can reconcile all documentation for agency-owned and leased vehicles and they can provide safeguards for proper storage of keys and other collateral.
2. Determine that the Transportation Department records can be matched to the inventory records.
3. Affirm that Transportation Department can perform routine vehicle maintenance requirements while providing adequate vehicles and related services to the business units whenever required.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management does not acknowledge Transportation Department reports about inconsistent or weak controls over inventory issues or leasing process issues.
2. Management does not ask Transportation Department staff to identify process improvements and the Department's staff does not negotiate process improvements with the leasing vendor.
3. Management may pay excessively high administrative service fees for inventory reports but not act on the inventory vendor's recommendations to change inventory as shown in the reports.

FIELD WORK

Field Work: A high-level summary of audit work needed to address the audit objectives listed above:

1. Contact the Director of Transportation and discuss the nature of the special management request and key business controls used in the vehicle consignment process that are problematic to enforce.
2. Contact the Transportation Specialist to gain an understanding of the daily work activity involved in the position, and to understand how the Specialist has performed her role with consignment of agency-owned vehicles that are being replaced by the Enterprise leased vehicles.
3. Review the current physical flow of financial documents that might be erroneously misdirected and recommend possible improved flows to improve transparency and user access to information.
4. Review Enterprise Leasing's database of leased vehicle inventory to show timeliness of key metrics and frequency of updates by comparing odometer readings on 3-4 vehicles to database metrics.
5. Measure the costs of the Enterprise Fleet Management program since the previous review at the fiscal year-end (August 31, 2023) to determine if costs meet management's expectations, or see if some additional fees or other costs are now appearing in the fleet management tracking invoicing.
6. Determine the utilization of the fleet vehicles to see if Transportation Specialist can identify the business units with the highest demand and see if current usage trends follow previous patterns.
7. Compare fleet costs with overall personal vehicle cost trends (based on employee reimbursement) to assess if end-user demand is shifting to prefer use if their own personal vehicle for transport to see clients or attend occasional business meetings.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – The audit disclosed:

1) As of February 29, 2024, there were 21 agency-owned vehicles in inventory.

2) The average vehicle age of the remaining vehicles was 3.38 years.

3) The cost for operating 21 vehicles through February 29, 2024) was $188,265.

4) Enterprise Leasing invoices from 09/01/2023 - 02/29/2024 totaled $335,285 for 119 cars.

5) As of 02/29/2024, total fleet vehicle cost (Leased and Owned) totaled $523,550.

Management Response #1 (Director of Transportation): *"Entering into the contract with Enterprise just as the nation faced the COVID crisis presented some very real challenges with the nation shutting down for several months and that coupled with the semi-conductor shortage drove the fleet replacement time from months to years. With the conditions improving in FY 2024, we expect the fleet replacement to be completed late FY 2024 to early FY 2025. Once the fleet is replaced with only the rental fleet, I expect to see a drop in operating cost across the board; maintenance, fuel cost, etc. The enterprise management team has been very good in helping navigate this crisis and has kept the transportation team informed and engaged in the replacement process and options available to the Center. Internally we are working on purchasing internal software to assist in managing the fleet for our end, this should result in reduced cost fleet wide. Once the fleet is replaced it is my recommendation an audit be conducted on vehicle use by program to determine if the actual car count could be reduced which would also result in reduced yearly expenditures."*

Internal Audit Response

Once the leasing process is completed, we will perform a review of the leased vehicles by program to determine if actual car counts are adequate or could decreased based on usage which would result in reduced yearly expenditures.

CONCLUSION

Internal Audit performed a follow-up audit of the Enterprise Leasing program to assess if any significant program changes occurred after the previous Fleet Management audit report, which was presented to the Audit Committee in October, 2023. This follow-up audit reviewed combined leased vehicle invoices and actual reported expenditures incurred while operating the agency-owned vehicles.

The vehicles in the Enterprise Leasing program are newer vehicles that should have fewer mechanical problems than the Center drivers may have experienced in using higher-mileage agency-owned vehicles. The follow-up audit revealed eleven (11) additional agency-owned vehicles titles were transferred for the vehicle sales auction, which should reduce the agency-owned vehicle inventory count to 21 vehicles. There is a transfer fee of $495.00 per vehicle plus administrative and towing expenses as required, but management said the remainder of the 21 agency-owned vehicles are to be transferred by FY2025.

This audit questioned if the Transportation Specialist noticed any trend changes which may affect the employee usage of the leased fleet vehicles based on other workplace trends including more working from home locations, etc. The Transportation Specialist noted that vehicle usage is monitored at the unit locations, therefore there is no current consistent practice of tracking employees or vehicles. We learned that some business units at the Harris Center are transitioning to global positioning system (GPS) modules which are useful replacements for submitting Daily Vehicle Reports as users do today.

In our conversations with the Transportation Specialist, and based on other Center-wide activity trends, the demand for the leased vehicles continues to grow as the Center's travel needs continue to grow.

Respectfully submitted,

David W. Fojtik

David W. Fojtik, MBA, CPA, CFE, CIA
Director of Internal Audit
The Harris Center for Mental Health and IDD

Kirk D. Hickey

Kirk D. Hickey, MBA, MIM, CFE
Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

FOLLOW-UP AUDIT: FIXED ASSETS AND INVENTORY CONTROL AUDIT (FUFAINV0124)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 - Internal Audit generated the Fixed Assets Inquiry online report, dated 01/31/2024, and found 73 fixed assets, such as personal computers, scanners, cameras, and installed medical equipment that were still assigned to former and terminated employees.

Recommendation: Internal Audit recommends that the records containing names of former employees should be reassigned to show "general use" status if assets are not redeployed to another employee.

UPDATES

As of 06/04/2024, the Fixed Asset team ensured that all corrective activity had occurred to address this issue, and in Internal Audit's follow-up review found no laptops or other fixed assets assigned to former employees. This was accomplished by ongoing intensified emails sent by the FA team to the Fixed Asset Designees (FADs) to provide the required paperwork. Also, the FADs' supervisors and Internal Audit were added to these emails.

Note to Finding: The Fixed Asset Team is doing what it is empowered, by the agency, to do to keep the Fixed Asset inventory up to date. The Fixed Asset Team cannot make any updates to devices (location and employee assignment) without the proper paperwork, which is required by agency policy to authorize any updates.

Staff Comments – Internal Audit spoke with a number of fixed assets designees (FADs) who maintain the fixed assets inventory process. Here is a short list of additional comments from our conversations:

1. *Challenges include work environments where employees may trade or borrow laptops without the FAD's knowledge. but that type of exchange would occur after hours or weekends without the FAD's knowledge.*
2. *Another challenge is assigning a fixed location for equipment items when room numbers are updated during construction, or the equipment is a laptop used in the employee's home.*
3. *Whenever terminated employees leave employment, there is no automated process to identify the records that are no longer correct and require and amendment to show that or this laptop should be reassigned to "general use" or to "disposal" if it is no longer functional, or should be reassigned to another current employee in the business unit.*
4. *Fixed Asset Tags are placed in tough-to-read locations (back side, underneath side) of the equipment, which sometimes requires disassembling computer components to find Tag #.*
5. *There appears to be no tie-in to the Center's budgeting process or with the Ross financial system.*

Management Response #1 ***(Fixed Asset Examiner):***

- ✓ *"Remove all ASSIGNED GENERAL USE designations as an employee assignment. Replace with either your (FAD) name or the unit manager's name.*
- ✓ *Remove all former employees and old unit staff data and replace it with the new staff names. If the position is vacant for now, replace that data with either your name or unit manager's name.*
- ✓ *Update locations if devices are moved or the Program relocates."*

Follow-Up: Fixed Assets and Inventory Control Audit

(FUFAINV0124)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, CPA, CIA, MBA, CFE

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: This follow-up audit was requested to affirm that management has tools to track all fixed assets in accordance with the Harris Center's Fixed Assets Management policy and procedures.

Audit Objectives: The follow-up Fixed Assets and Inventory Control Audit project has been approved for inclusion in Internal Audit's FY2024 Audit Plan, and our audit objectives are to:

1. Review internal controls used to account for location of fixed assets;
2. Report on fixed assets that are misplaced, misused or misappropriated;
3. Determine new ways to improve the process of accounting for fixed assets.

AUDIT RISKS

Audit Risks:

1. The Center's management cannot identify fixed asset item controls in per policy and procedures.
2. The Center's management will not act on findings from a fixed assets audit report or see if these fixed assets are not appropriately accounted for according to the Center's policy and procedures.
3. The Center's management does not provide tighter controls over the use and location of fixed assets or does not agree to use automation, or otherwise improve accountability of items.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the audit objectives listed above:

1. Review the Center's fixed assets policies and procedures on managing fixed assets.
2. Plan a meeting with the Fixed Asset Examiner who had some communication with one or more of the Fixed Asset Designees (FADs) to discuss discrepancies that warrant more analysis.
3. Obtain a listing of facility location codes to compare them to codes assigned to the reported fixed asset location codes.
4. Obtain a listing of employees to compare to the employee names listed in the fixed asset reports, to assure that former and terminated employee names are no longer referenced in the reports.
5. Select business units with multiple fixed asset items and perform of their fixed asset tag numbers, to assure that the Fixed Asset Designees performed their roles and track to assigned fixed assets.
6. Discuss projects with the Fixed Asset Examiner to determine if new fixed asset and IT equipment shipments are planned to ship to the Center's locations.

CURRENT PROCESS

Internal Audit has performed annual fixed asset and inventory control audits over the past few years. We have sampled various fixed assets in their physical location and compared the items to the reports. Internal Audit collaborated with the Fixed Asset Examiner (FAE) on current issues of equipment status of alleged or potential misappropriations with members of the Center's staff. The Internal Audit process independently reviewed the fixed asset reports to assure currency and accuracy of the current database.

Our experience generally finds that timely preparation and/or approval of asset transfer forms improves the report's accuracy, yet for some employees the fixed assets process remains a cumbersome process. The current forms are effective in tracking items according to end-user (employee name), and assigned asset work location. The current process has greatly reduced potential for "losing track" of fixed assets. The Fixed Asset Examiner's role includes all periodic checks on reports of discrepancies by asset location.

According to **FM.B.19 Property Inventory** policy, capital assets are $5,000 or more in value) while the controlled asset 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: desktop computer; laptop computer; smartphone; tablet and other hand held devices; data projectors; TV's and video players/records, sound system and other audit equipment; camera-portable-digital SLR."

The **FM.A.3 Asset Tracking and Depreciation** policy states that "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." [1] [2]

Note: The Harris Center has updated the policy for receiving fixed assets and disposing of fixed assets, and the process includes one Purchasing Department employee who works in the Receiving process, while a second employee who performs Disposals. This audit review does not involve these workflows. These workflows are purposefully separated from the end-user fixed asset inventory tracking process.

In the past, Internal Audit reviewed the police reports of laptop thefts. All thefts are recorded in the Incident Report (IR) platform and the break-in details are also reported in the police reports, but the actual recovery of fixed assets is problematic as they are likely damaged or disassembled after the theft event. The Harris Center has a liability related to the loss of client data and consumer information, such as PHI, which can be worth many times more than the dollar value of a laptop business computer.

The process challenges arise when transfer paperwork is not properly obtained or not reviewed by the fixed asset designees (FAD) or their approving managers. Whenever any of the items are not effectively tracked, they may "go astray," but our experience has been that the FADs have located these wayward items. However, the effort to track items down requires a substantive part of their daily workday.

Internal Audit's concern is the inventory and record-keeping process over the fixed assets as the asset records in the corporate radar and other adjunct systems represent the key control to the inventory. Internal Audit relies on the accuracy of PowerBI fixed asset reports as an inventory control resource, and we have used these reports over the years to show anomalies that point out irregularities to investigate.

[1] Viewing FM.B.19 Property Inventory (policystat.com)

[2] Viewing FM.A.3 Asset Tracking and Depreciation (policystat.com)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 - Internal Audit generated the Fixed Assets Inquiry online report, dated 01/31/2024, and found 73 fixed assets, such as personal computers, scanners, cameras, and installed medical equipment that were still assigned to former and terminated employees.

Recommendation: Internal Audit recommends that the records containing names of former employees should be reassigned to show "general use" status if assets are not redeployed to another employee.

UPDATES

As of 06/04/2024, the Fixed Asset team ensured that all corrective activity had occurred to address this issue, and in Internal Audit's follow-up review found no laptops or other fixed assets assigned to former employees. This was accomplished by ongoing intensified emails sent by the FA team to the Fixed Asset Designees (FADs) to provide the required paperwork. Also, the FADs' supervisors and Internal Audit were added to these emails.

Note to Finding: The Fixed Asset Team is doing what it is empowered, by the agency, to do to keep the Fixed Asset inventory up to date. The Fixed Asset Team cannot make any updates to devices (location and employee assignment) without the proper paperwork, which is required by agency policy to authorize any updates.

Staff Comments – Internal Audit spoke with a number of fixed assets designees (FADs) who maintain the fixed assets inventory process. Here is a short list of additional comments from our conversations:

1. *Challenges include work environments where employees may trade or borrow laptops without the FAD's knowledge. but that type of exchange would occur after hours or weekends without the FAD's knowledge.*
2. *Another challenge is assigning a fixed location for equipment items when room numbers are updated during construction, or the equipment is a laptop used in the employee's home.*
3. *Whenever terminated employees leave employment, there is no automated process to identify the records that are no longer correct and require and amendment to show that or this laptop should be reassigned to "general use" or to "disposal" if it is no longer functional, or should be reassigned to another current employee in the business unit.*
4. *Fixed Asset Tags are placed in tough-to-read locations (back side, underneath side) of the equipment, which sometimes requires disassembling computer components to find Tag #.*
5. *There appears to be no tie-in to the Center's budgeting process or with the Ross financial system.*

***Management Response #1* (Fixed Asset Examiner):**

- ✓ *"Remove all ASSIGNED GENERAL USE designations as an employee assignment. Replace with either your (FAD) name or the unit manager's name.*
- ✓ *Remove all former employees and old unit staff data and replace it with the new staff names. If the position is vacant for now, replace that data with either your name or unit manager's name.*
- ✓ *Update locations if devices are moved or the Program relocates."*

CONCLUSION

Internal Audit's focus has been generally on the business controls used in this record-keeping process. In the past, Internal Audit used Corporate Radar inventory reports (based on AssetWin daily entries) to reconcile items in the database to actual asset numbers (e.g., "tags"). When Internal Audit can discern outmoded information, such as items reported for now defunct Center properties, Internal Audit reports the finding as a tracking anomaly, which left unattended leads to theft or other undesired outcomes.

Over the years, Internal Audit strongly recommended that end-user organizations should keep their record-keeping up-to-date by location and by employee name, which will require ongoing attention. Internal Audit has encouraged many end-users including Information Technology to maintain currency of their fixed asset accounting records, otherwise the Internal Audit team seeks the need for an audit.

The Fixed Asset Examiner's role includes providing training for fixed asset designees (FADs) who require guidance, and provides one-on-one support for various employees in The Harris Center's facilities. The past few years introduced new laptop computers which were needed for the EPIC electronic healthcare records system (EHR). The overall fixed asset inventory has expanded to over 8,000 items.

The Fixed Asset Examiner represents Financial Services for the specific examination of the fixed assets. Internal Audit supports the Fixed Asset Examiner's role, but we cannot be a proxy to their departmental responsibilities. Internal Audit's role should show its independence and periodically intervene whenever the fixed asset designees have disputes with the Fixed Asset Examiner's office, which is not frequent nor a commonplace occurrence.

In the past, Internal Audit has performed physical on-site audits of fixed assets in collaboration with the Fixed Asset Management team's evaluations and reviews. The Harris Center's fixed asset management process requires all new IT items are tracked and delivered to end-users with discrete asset tags at their initial deployment to business units. When items are reassigned as loaners or designated to be disposal units, the need for the record-keeping and approvals are required before moving any fixed asset item.

Internal Audit works closely with the Fixed Asset Examiner to assure that their team can continue to reconcile the items to inventory, and the actual physical location of all fixed assets within the Center.

Respectfully submitted,

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Kirk D. Hickey

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Executive Summary

FOLLOW-UP AUDIT: TRAVEL REIMBURSEMENTS AUDIT (TRAVREIM0124)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Travel reports were reviewed between September 1, 2023 and March 7, 2024.

1) The six-month reimbursements totaled **1,145,215 miles** compared to **1,276,975 miles** reported in a prior six-month period from September 1, 2022 through February 28, 2023.

2) We determined that **95.7%** of the First Trip segment miles started from the employee's assigned Harris Center location and **88.2%** of Last Trip segment miles ended at their assigned Harris Center location.

3) Internal Audit noted that the current Center's travel policies rely on IRS business travel guidelines which require employees to compute mileage by subtracting "normal commute miles" to their assigned Center location.

4) The Harris Center paid out $775,079 to 635 employees in Travel Reimbursements during the period September 1, 2023 through February 28, 2024.

5) Internal Audit found 26 employees submitted at least $6,000 in mileage claims over this six-month period, however, per our review none of these individuals submitted reimbursements for excessive mileage.

Currently, although 4.3% of reimbursed travel reimbursements included starting from residential locations on the first trip of the day and 11.2% of last trip reimbursements ended at residential locations are immaterial in amount, these routes are not 100% compliant with current Travel Expense Reimbursement Policies and Procedures.

Internal Audit recommends the Travel Policies be revised to reflect compliancy.

Follow-Up Audit: Travel Reimbursements Audit

(TRAVREIM0124)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

All new employees are trained on the in-house online travel reporting application that records business mileage from The Harris Center's locations to consumer homes, and consumer family and group homes. The system was upgraded in 2018 to improve compliance with IRS rules for business travel reporting. Internal Audit reviewed the new FM18B Travel Reimbursement policy in May, 2022. The policy added a section to explain the Harris Center's position regarding the reimbursement of miles from an employee's home to a consumer's home, as IRS rules prohibit the reimbursement of "normal" commute mileage.

From FM18B Travel Reimbursement Policy (effective 05/22):

> G. When travel is required to a location in the field prior to the employee going to their assigned location, the employee will be able to claim mileage only in excess of the distance from their home to their assigned work location.
>
> Example: Home to assigned location is 10 miles
> Home to consumers home is 5 miles
> *Then no mileage reimbursement is allowed
>
> Home to assigned location is 10 miles
> Home to consumers home is 15 miles
> *Then mileage reimbursement is requested at 10 miles (roundtrip).
>
> The employee cannot claim mileage from their home to their primary work location.

The mileage application is used daily to record Origination Addresses and Destinations. The mileage should represent the mileages recorded between consumer homes or groups homes and business office locations so that mileage from the employee's home is minimized except for Out of County travel needs.

The mileage application uses data drop-downs generated from googlemaps.com to identify distances in order to calculate precise mileage. The application populates distances in rapid succession, which is key to its productivity and business controls. There is an option for users to override the drop-down mileage calculation method that requires entering a reason code such as "construction", or "road was closed." The overrides should not occur frequently but some employees tend to use them all too frequently.

There are training instructions for using the In-County Mileage Report application which are maintained by the Information Technology Department. There is a section H of The Harris Center's policy regarding exceptional approvals for on-calls should be noted:

From FM18B Travel Reimbursement Policy (effective 05/22):

> H. Employee's on-call beyond the person's normal shift shall be reimbursed point to point between the locations from which they were paged to the destination point of the page. It is expected that the on-call person should remain within a reasonable driving distance to the assigned location in order to respond to the on-call in a timely manner. Mileage reimbursement requested will be reviewed by the supervisor for appropriateness.

At this time there are discussions about developing a replacement in-county mileage reporting system, but as of this report's publication, these details have not been confirmed with Information Technology. Overall, the current system does its job, but there are always new process improvements to be made.

SCOPE AND OBJECTIVES

Audit Scope: The Director of Internal Audit requested this Travel Reimbursements Audit to assess that employees are complying with the Harris Center's prevailing travel policy and procedures.

Audit Objectives: Internal Audit reviewed the travel policy and procedures to:

1. Assure Financial Services internal processing of monthly mileage payments can occur on time.
2. Identify the frequency of discovering significantly high mileage reporting in our annual review.
3. Affirm that employees are reimbursed within a timely manner after submitting travel reports.

This audit subject has been reviewed in prior years with a review of the larger dollar claims by employees. This follow-up audit seeks to compare the observed employee reporting in terms of miles and dollars, and the policies and procedural best practice as outlined in the Center's Travel Reimbursement Policy.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management does not understand the employee mileage or travel reimbursement processes at The Harris Center well enough to address issues that arise when approving mileage claims.
2. Management does not prioritize interest in more frequent reviews of employee mileage claims.
3. Management does not investigate new methods that can improve the productivity of those employees who normally use personal vehicles to perform their daily work duties.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Review an ad-hoc annualized report from the IT contact that contains all monthly mileage reports submitted by employees for reimbursement from September 1, 2023 through February 29, 2024.
2. Examine the mileage reports for high mileage outliers, high dollar calculations, or other anomalies such as multiple overrides, explanations for routing changes or other recurring user comments.
3. Discuss instances of observed high mileage reports with mileage report approvers to understand if they see instances of mileage overrides that exceeded the normal googlemaps.com calculations, which can test excess mileage reporting which in turn creates liabilities for larger reimbursements.
4. Evaluate excessive override activity on the travel reports, to assess if they represent legitimate reasons for mileage calculation revisions (compared to mileages offered by googlemaps.com).
5. Rank employee claims by dollar amounts to determine the highest claims and compare with results in prior years for affirming legitimacy in the claims.

OBSERVATIONS, RECOMMENDATIONS AND MANAGEMENT RESPONSES

Observation #1 – Travel reports were reviewed between September 1, 2023 and March 7, 2024.

1) The six-month reimbursements totaled **1,145,215 miles** compared to **1,276,975 miles** reported in a prior six-month period from September 1, 2022 through February 28, 2023.

2) We determined that **95.7%** of the First Trip segment miles started from the employee's assigned Harris Center location and **88.2%** of Last Trip segment miles ended at their assigned Harris Center location.

3) Internal Audit noted that the current Center's travel policies rely on IRS business travel guidelines which require employees to compute mileage by subtracting "normal commute miles" to their assigned Center location.

4) The Harris Center paid out $775,079 to 635 employees in Travel Reimbursements during the period September 1, 2023 through February 28, 2024.

5) Internal Audit found 26 employees submitted at least $6,000 in mileage claims over this six-month period, however, per our review none of these individuals submitted reimbursements for excessive mileage.

Currently, although 4.3% of reimbursed travel reimbursements included starting from residential locations on the first trip of the day and 11.2% of last trip reimbursements ended at residential locations are immaterial in amount, these routes are not 100% compliant with current Travel Expense Reimbursement Policies and Procedures.

Internal Audit recommends the Travel Policies be revised to reflect compliancy.

CONCLUSION

Internal Audit has had several discussions about workplace changes and the impacts to the reimbursable in-county mileage tool that is used by employees using their own personal vehicle. In the current review, we looked at the mileage reported for the first six months of activity of FY2024 (through March 7, 2024).

Our evaluation included subtotaling the mileage by monthly reporting period and sorting reporting by employee names. We estimated that The Harris Center paid out $775,079 in reimbursement payments. This evaluation period was for the period beginning from September 1, 2023 through March 7, 2024.

We see the number of employees using their own personal vehicles growing as the number of consumer programs grow and the number of client appointments are rising. The employees who reported the highest mileage this year (viewed in the sample) work in the same business units as they did last year, and likewise reported high mileage, based on the needs of those business units as noted last year.

In a prior audit report, there was a discussion regarding possible “excessive mileage” being reimbursed to those employees who rely use in-county travel reporting. We found many trips which appear to show routine travel activity from employee’s home addresses to client locations. When the employee’s home is used, policy says that the mileage should be adjusted or reduced to meet the IRS “net” business travel rules, which state that only “excess” travel miles are reimbursable travel miles per IRS.

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Executive Summary

SPECIAL AUDIT REQUEST: PETTY CASH AND CHANGE FUNDS AUDIT (SARPCF0124)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit performed unannounced petty cash audits and found the counted contents of currency agreed with the designated target cash balances that were listed in the Petty Cash Custodian Listing.

Internal Audit has noticed that the petty cash fund balances have decreased over the past years, and many petty cash custodians do not reconcile the petty cash funds timely due to fewer transactions that require petty cash as online purchases continue to reduce the usage of the current 17 petty cash funds.

The valuation of the funds in FY 2019 was $9,350.00 compared to the current total value of $4,150.00.

Current list of current petty cash and change fund locations located at The Harris Center

DIVISION	UNIT	UNIT NAME	LOCATION	TARGET	STATUS	Initials
Administration	1122	DSHS FF; HCS Support	9401 Southwest Fwy.	$2,000.00	*Agreed*	HH
Administration	2212	Northwest CSC Fee Coll'n	3737 Dacoma Street	$250.00	*Agreed*	AB
Adult MH	2213	Northeast Clinic	7200 North Loop East	$50.00	*Agreed*	RB
Adult MH	2214	Southeast Fee Collection	5901 Long Drive	$50.00	*Agreed*	SA
Admin.	2215	Southwest CSC Fee Coll'n	9401 Southwest Fwy.	$100.00	*Agreed*	SB
CPEP	2250	PATH	2627 Caroline Street	$250.00	*Agreed*	BF
IDD	3390	Westbury House	6125 Hillcroft Street	$400.00	*Agreed*	TW
Admin.	3636	Coffee House	3737 Dacoma Street	$50.00	*Agreed*	DG
Adult Forensic	9403	Jail Diversion Center	6160 South Loop East	$1,000.00	*Agreed*	GV
			Total All Cash and Change Funds:	**$4,150.00**	**TOTAL**	

Source: Accounts Payable report, October 2023 **** W/P = documented Petty Cash work paper***

Management Response #1 (Accounts Payable):

Special Audit Request: Petty Cash and Change Funds Audit

(SARPCF0123)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, CPA, MBA, CIA, CFE

Director, Internal Audit

TABLE OF CONTENTS

CURRENT PROCESS

From time to time the Director of Internal Audit staff completes an "unannounced" audit of the various petty cash and change funds operations throughout The Harris Center. The Director of Internal Audit has said that the administrative diligence displayed in the simple petty cash fund reflects the department's administrative health. In other words, the petty cash audit is a concise and easy test for efficiency.

The business controls of maintaining a petty cash funds box are basic math skills and demonstrate ability for consistent and reliable record-keeping. During the years of performing this audit, Internal Audit has found that most of the current cash custodians have strength in these skills, and generally perform well. The strong performers consistently perform above average, and weak performers show poor skills in the task. We saw custodians who viewed the role with less importance, and some are no longer employed at The Harris Center, which suggests that the role represents personal commitment to this role.

When Internal Audit began the unannounced petty cash and change funds reviews ten years ago, there were 47 individual custodians and today there are 17 petty cash custodians. The amount of currency in petty cash and change funds has decreased to $5,350.00 in total, down from $9,350.00 five years ago.

The Accounts Payable Supervisor plays a primary oversight role of the process. Custodians are sent email notices to perform a reconciliation every 90 days to avoid cash shortages. A cash box without sufficient currency is not effective if several purchases are needed. The reconciliation process takes a few minutes to prepare as the custodian brings all materials to the Accounts Payable Department contacts for funds replenishment. Internal Audit noted that the Accounts Payable Supervisor keeps track of these reconciliation dates, which showed most petty cash funds are fulfilled in 90 days.

Internal Audit finds that most of the successful cash custodians maintain a cash receipt book to record cash disbursements, which is helpful when staff members seek reimbursement for supplies and other purchases which they completed using their own personal credit card or cash. The cash receipt book is an effective record of disbursement activity.

The petty cash audit process includes counting all items in the cash box. Most of the petty cash boxes store smaller currency inventories, so there are fewer bills and coins to count. The emergence of using the p-card for purchases has grown and the controls are specifically outlined in the Center's p-card user policy and procedures. The Harris Center benefits from promoting the use of the p-card because it has the ability to generate the purchase history of transactions, items, business unit codes, vendors, etc.

Internal Audit starts an unannounced audit with printing out a Petty Cash Count Reconciliation Form. The form has spaces where currency can be counted by item (nickles, dimes, quarters) and the tally of bills and notes is clearly shown to match the target balance ($50, $100, etc.) of each petty cash fund. Any differences are listed on the form, even if the shortage/overages are *de minimus* (e.g., $.02 short). Most reconciliations routinely show zero amount differences. The primary policy and procedures are:

1. **Petty Cash Count Reconciliation Form (not numbered)** for counting out currency and test balances.
2. **Transfer Agreement for Petty Cash Form (BUS-F/B:16.001)** to list the current petty cash custodians.
3. **Petty Cash Reconciliation Form (BUS-F/B:16.002)** is used to obtain funds from Accounts Payables.
4. **Log of Petty Cash Disbursements Form (BUS-F/B:16.003)** is used to list individual petty cash fund disbursements paid out and the corresponding sales receipts to match the funds disbursements.

SCOPE AND OBJECTIVES

Audit Scope: The Special Audit Request: Petty Cash and Change Funds Audit has been added to Internal Audit's Fiscal Year 2024 Annual Audit Plan to assure that proper funds controls are in place.

Audit Objectives: This audit will review the Petty Cash Custodian procedures used to manage the petty cash and change funds function, and our audit objectives were designed to:

1. Show that policy and procedures are available for review by cash custodians.
2. Verify that fund balances on-hand agree with Accounts Payable's petty cash records.
3. Affirm that the petty cash custodians perform cash fund reconciliations periodically per policy, and that the funds are supplied expediently to the unit by Accounts Payables at reconciliation.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management does not acknowledge petty cash disbursement or employee reimbursement issues.
2. Management does not perform periodic reviews of the policies and procedures or evaluate the emergence of process improvements that may be identified during a review.
3. Management does not consider petty cash or change funds inventory tracking materially or see the process as important enough to be shown in periodic internal audit reports.

FIELD WORK

Field Work: A high-level summary of audit work needed to address the audit objectives listed above:

1. Obtain a Petty Cash Custodian listing report from Accounts Payable, which shows the petty cash custodian names, their locations, business unit codes and target balances ($50, $100 and so on).
2. Obtain a Petty Cash Count Reconciliation Form from Accounts Payable and count cash inventories by units and by the item denomination. Count all bills and coins and confirm overall balance found and consider counted currency counted as the funds cash on hand.
3. Determine that the counted currency balance meets the petty cash fund's target balance, per the Petty Cash Custodian listing report. Sign and date the Petty Cash Count Reconciliation Form and ask the custodian to sign and date the form as well, then leave a copy for cash custodian's records.
4. Report findings in an audit report noting zero difference and overages or shortages as determined at the time of the cash audit. Identify all root causes for any material shortages or overages and seek detailed explanations from the cash custodian.
5. Report the explanation with other contacts to assure greater success in the issue's resolution.
6. Report the custodian's use of cash disbursement slips or the use of other tracking tools that add traceability of expenditures or disbursements to unit employees. Provide recommendations as needed but understand that most procedural changes require agreement with the business unit's custodian, and with the business unit's management team.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit performed unannounced petty cash audits and found the counted contents of currency agreed with the designated target cash balances that were listed in the Petty Cash Custodian Listing.

Internal Audit has noticed that the petty cash fund balances have decreased over the past years, and many petty cash custodians do not reconcile the petty cash funds timely due to fewer transactions that require petty cash as online purchases continue to reduce the usage of the current 17 petty cash funds.

The valuation of the funds in FY 2019 was $9,350.00 compared to the current total value of $4,150.00.

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Adult Forensic	9403	Jail Diversion Center	6160 South Loop East	$1,000.00	*Agreed*	GV
			Total All Cash and Change Funds:	**$4,150.00**	**TOTAL**	

Source: Accounts Payable report, October 2023 **** W/P = documented Petty Cash work paper***

Management Response #1 (Accounts Payable):

CONCLUSION

Internal Audit has performed the petty cash audits for years and steadily observed the cash custodians' petty cash reconciliation process improve. In the initial review in 2013, we encountered 47 petty cash custodians but today the number of custodians is 17, according to the Accounts Payable Department's Petty Cash Custodian Listing report. The total amount of currency in all of these petty cash boxes has also been reduced to $5,350.00, suggesting that business needs for actual currency has diminished.

The Accounts Payable Department performs the primary oversight role and routinely reaches out to the various cash custodians to encourage reconciliations. The majority of petty cash custodians are shown to be reconciling their petty cash funds about every 90 days. Accounts Payable is actively in contact with the custodians to remind them to perform their reconciliations, and a majority comply with the request. Accounts Payable keeps up-to-date records and notations on changes in staff, to show the most current information on the cash custodians, and notes if newly-hired employees are assigned to represent the unit's petty cash custodian role.

In the ten (10) years of Internal Audit's performance of the petty cash and change funds audit, it seems that loss of funds through theft is *de minimus*. As the fund balances are low ($50 to $100 in many cases), it is less attractive for employees to borrow cash funds for personal reasons, such as a short-term loan. The emergence of the p-card process has alleviated maintaining large cash balances in office locations. Financial Services oversees the Center's larger change funds, which are heavily secured at headquarters and dubious disbursement activities have never been reported in such higher security locations.

Respectfully submitted,

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Kirk D. Hickey

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Staff Internal Auditor
The Harris Center for Mental Health and IDD

Executive Summary

SPECIAL MANAGEMENT REQUEST: CYBERSECURITY AUDIT (SMRCYBER0124)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observations – Internal Audit met with the Center's Information Security Officer (ISO) to discuss the Center's stabilization following a cybersecurity attack on November 7, 2023.

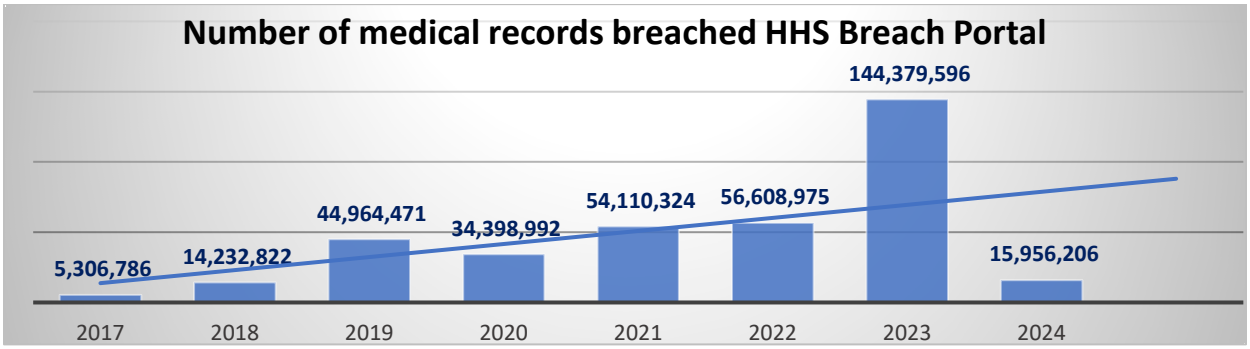
1) We learned that at the time a previously unidentified "bad actor" emerged and made their entry through the Center's Citrix Netscaler system, then pursued a systematic encryption of our data files, to make them unavailable to the Center's users. The attack was not a denial of service but instead was a ransomware attack propagated by BlackSuits, an organization known by other different names. During the initial attack, they quoted their ransom demands.

2) The Information Security Officer reported that granting system access quickly was essential to restoring the Center's operations and Information Technology consultants were brought in to assist. The Harris Center's response to this incident was enhanced significantly with the purchase of Crowdstrike Endpoint Managed Detection and Response platform, which provides greater monitoring than was provided in previous threat detection systems employed at the Center. The ISO's objective was to "reduce our attack surface" without shutting down service to end-users, which could have halted services in the Center's offices.

3) The attack encrypted thousands of patient records with varying amounts of sensitive information and the ISO stated that the volume necessitated notifying patients and/or patient families of this type of data breach, which is specified clearly in HIPAA regulations. Information Technology teams were able to restore service by changing the internet access swiftly. As an additional precaution, Information Technology organized a plan for reimaging the Center's laptop computers to assure additional protection to the end-users going forward.

Summary - No ransom was paid and the Center's operations continued with minor delays after the breach occurred.

Observation #2 – Internal Audit attended a Clearwater Security report on the HHS Breach Portal which counted 144.4 million medical records breached in CY2023 vs. 56.6 million in CY2022, a 155.0% increase. The report stated 76% of the reported medical breaches were due to hacking incidents.



Source: HHS Breach Portal (data pulled March 3, 2024), presented at recent Clearwater Security presentation, April 8, 2024

Management Response not required.

Special Management Request: Cybersecurity Audit

(SMRCYBER0124)

INTERNAL AUDIT REPORT

July 16, 2024

David W. Fojtik, MBA, CPA, CFE, CIA

Director, Internal Audit

TABLE OF CONTENTS

SCOPE AND OBJECTIVES

Audit Scope: This special management request audit is a review of management's progress since the cybersecurity attack that occurred in November 2023. Internal Audit will document and identify all strategies that the Information Security Officer's organization used to regain our operational stability. We added this special management request report to Internal Audit's Fiscal Year 2024 Audit Plan.

Audit Objectives: The special management request audit report has been approved for inclusion in Internal Audit's Fiscal Year 2024 Annual Audit Plan, and our audit objectives were designed to:

1. Review the previous audit report from FY2022 to view outstanding issues requiring resolution.
2. Evaluate the Information Security Officer's plans to invest in the Center's security infrastructure.
3. Determine that the Center's security profile has improved since the last cybersecurity audit.

AUDIT RISKS

Audit Risks: Factors that may influence management's ability to provide sufficient strategy and responses for mitigating risks to the Center that may degrade the quality of the security profile.

1. Management did not assign sufficient resources to mitigate known infrastructural weaknesses.
2. Management did not keep records of transactions or documents with management approvals.
3. Management did not comply with the terms of one or more of the regulatory agencies or with meeting established HIPAA requirements.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the objectives listed above:

1. Meet department contacts and review current organizational charts and Internal Audit will schedule a meeting with the Center's Information Security Officer (ISO) and Chief Information Officer (CIO) to obtain their input about how the department responded (as stated in previous audit reports).
2. Review how ongoing scheduled infrastructure repairs and maintenance system security work is scheduled and documented.
3. Verify The Harris Center's infrastructure development and system maintenance projects and assess how they are budgeted for ongoing infrastructural improvements.
4. Affirm how the Center's infrastructure projects are monitored during the year and inquire as to how they work to provide needed protection against external intrusions from any malicious actors.
5. Discuss the possibility for ISO to re-perform the NIST compliance audit or comparable assessments to verify that the Center's infrastructure resources are improved and less vulnerable to cyberattacks.
6. Identify emerging trends in the cybersecurity attacks in the healthcare marketplace that are tracked by the ISO and evaluate how the cybersecurity team works with innovative technologies and strategies to improve user service levels and at the same time assure increased protection for the Center's data.

CURRENT PROCESS

In our previous audit reports, Internal Audit interviewed the Information Security Officer (ISO) about the plans to harden the Center's data systems infrastructure from system penetration by all external actors. The ISO has been employed in the role over ten (10) years at The Harris Center, and he clearly described the basic improvements that are employed that have enhanced the security profile of The Harris Center. The results of the FY2022 questionnaire for Cybersecurity showed us several main key issues, including:

1. Data loss and system inaccessibility via end user compromises are still our largest threat vector. Employees continue to be coaxed in responding to emails from external actors with malicious intentions who seek to gain access to The Harris Center's systems and databases for patient data. The Harris Center's patient data is believed to be a primary target because of its potential market value among the bad actors and other dark web operators. Improving our employees' training in proper response and handling of everyday phishing attempts is critical to reducing this vulnerability.

2. The largest operational threat concerning cybersecurity initiatives is supporting and securing the Center's mobile workforce who are leveraging hybrid (on-premise, cloud, vendor-hosted, and SaaS) technologies. Many employees are using powerful data devices such as iPhones, laptops and other internet-connected devices which can be misappropriated or stolen. The additional concern is protecting data assets including electronic patient healthcare information (ePHI). The landscape of technologies has changed in the past few years, and the rollout of additional IT equipment to the field to accommodate the EPIC system rollout introduces new challenges for management.

3. The Harris Center is following a well-rounded security project portfolio to address the changing IT landscape, which in turn affects the security posture of the Harris Center. The Information Security team continues to request funding for requested projects and seek securing and protecting new business initiatives at the Center, which may require rebalancing existing security projects' priority.

Since the last Cybersecurity audit, the Information Security department added staff and have worked to secure the Center's infrastructure and hardened the security profile. The COVID-19 pandemic required a quick response to enable hundreds of users to work from their home locations, but demand for IT help increased significantly in the short-term. Information Security performed a protective role in this period and Internal Audit had not observed any unusual or extended instances of outages in the past few years. Since then, our employees have returned to their work locations using a variety of devices and software platforms which keeps demand strong for Information Security's ongoing vigilance.

The Harris Center was hit with a cyberattack which allowed the attacker to "exfiltrate sensitive data by exploiting Citrix NetScalers", therefore the November 7, 2023 attack was not a Denial of Service (DoS). The attacker's intention was to seek a ransom payment, but to Internal Audit's knowledge was not paid. Information Security presented management's response to the Board of Directors in executive sessions. One of the Information Security Officer's recommendations was that "we need more financial resources for solutions and personnel, and faster procurement processes." The needs to procure remedial system hardware and software was slowed due to the Center's cumbersome procurement workflows, however, executive management worked hard to obtain procurement approvals for timely processing.

One recent improvement was that the Information Security team fortified the network by purchasing Crowdstrike software, which enables the IS team the ability to monitor changes in the "environment" well in advance of actual threat activity, which would provide better response time for the IS team.

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit met with the Center's Information Security Officer (ISO) to discuss the Center's stabilization following a cybersecurity attack on November 7, 2023.

1) We learned that at the time a previously unidentified "bad actor" emerged and made their entry through the Center's Citrix Netscaler system, then pursued a systematic encryption of our data files, to make them unavailable to the Center's users. The attack was not a denial of service but instead was a ransomware attack propagated by BlackSuits, an organization known by other different names. During the initial attack, they quoted their ransom demands.

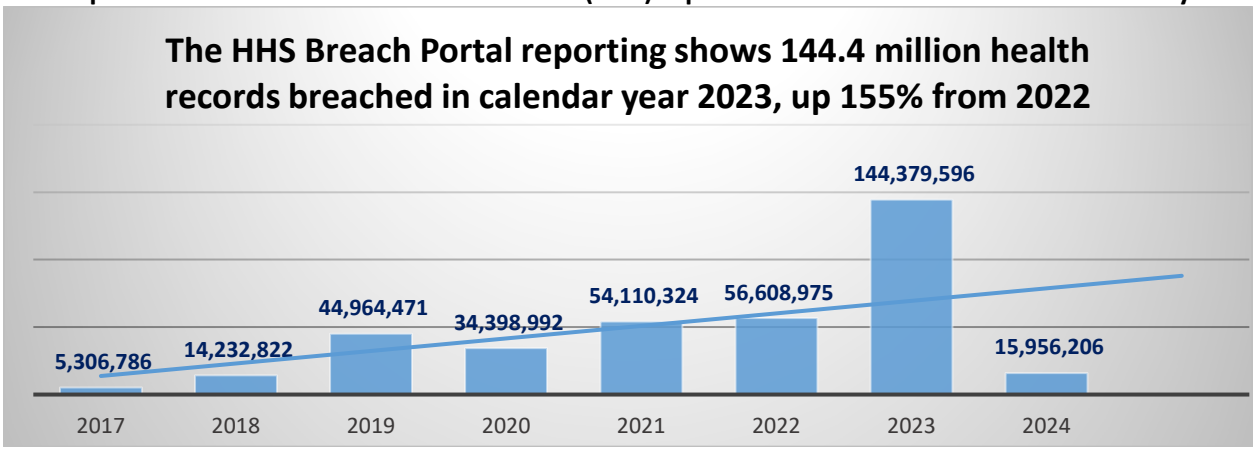
2) The Information Security Officer reported that granting system access quickly was essential to restoring the Center's operations and Information Technology consultants were brought in to assist. The Harris Center's response to this incident was enhanced significantly with the purchase of Crowdstrike Endpoint Managed Detection and Response platform, which provides greater monitoring than was provided in previous threat detection systems employed at the Center. The ISO's objective was to "reduce our attack surface" without shutting down service to end-users, which could have halted services in the Center's offices.

3) The attack encrypted thousands of patient records with varying amounts of sensitive information and the ISO stated that the volume necessitated notifying patients and/or patient families of this type of data breach, which is specified clearly in HIPAA regulations. Information Technology teams were able to restore service by changing the internet access swiftly. As an additional precaution, Information Technology organized a plan for reimaging the Center's laptop computers to assure additional protection to the end-users going forward.

Summary - No ransom was paid and the Center's operations continued with minor delays after the breach occurred.

Observation #2 – Internal Audit attended a Clearwater Security debrief which reported that the HHS Breach Portal reported 144.4 million medical records were reported as breached in calendar year 2023 compared to 56.6 million records in calendar year 2022, representing a 155.0% increase in quantity.

Department of Health and Human Services (HHS) reports show increased data breach activity.



Source: HHS Breach Portal (data pulled March 3, 2024), presented at recent Clearwater Security presentation, April 8, 2024

Management Response not required.

CONCLUSION

The Harris Center's Information Security Officer (ISO) role is tasked with planning and development of projects designed to fortify the Center's data systems and databases against external actors' intrusions and penetrations, which changed as cybersecurity threat detection tools and new technologies evolve.

While predicting new cybersecurity attacks is routine, this event demonstrated that attacks will occur with little advance notice, and thus require the ISO's immediate response by limiting access. The ISO said the senior management and members of the Board were supportive of the ISO's response and said that the new cybersecurity upgrades have immediately improved the Center's security posture.

The ISO noted that the only challenge in this response was working to restore service despite the speed of the Center's procurement process which may have delayed some of the intial restoration progress. Our data and service restoration was not delayed. The deployment of new technologies and services in continued response to the incident has been delayed by a lack of funding and the Harris Center's current procurement processes.

The Harris Center experienced a significant cybersecurity attack which exfiltrated sensitive data as part of a ransom demand. The event occured on November 7, 2023, but Information Technology had started to restore service immediately by changing internet access to computers and laptops. To further reduce vulnerability, the Information Technology group plans to reimage hundreds of laptop computers.

Respectfully submitted,

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