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

Audit Committee Meeting
May 23, 2023
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, January 17, 2023
(EXHIBIT A-1)

IV. **REVIEW AND COMMENT**

A. Internal Audit Report
(EXHIBIT A-2 David Fojtik)

B. Compliance Department Report
(EXHIBIT A-3 Demetria Martin)

V. **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.**

VI. **RECONVENE INTO OPEN SESSION**

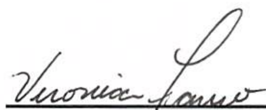
VII. **CONSIDER AND TAKE ACTION AS A RESULT OF THE EXECUTIVE SESSION**

VIII. **INFORMATION ONLY**

A. Internal Audit Binder
(EXHIBIT A-4)

B. Compliance Department Binder
(EXHIBIT A-5)

IX. **ADJOURN**



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, JANUARY 17, 2023
MINUTES

DRAFT

Dr. Lois Moore, Committee Chair, called the meeting to order at 12:35 p.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

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

Committee Member in Absence: Dr. R. Gearing, Mr. J. Lykes, Mrs. B. Hellums

I. DECLARATION OF QUORUM

Dr. Moore called the meeting to order at 12:35 p.m. noting that a quorum was present.

II. PUBLIC COMMENTS

There were no requests for Public Comment.

III. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 18, 2022

MOTION: SANTOS **SECOND: WOMACK**

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, October 18, 2022 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

IV. CONSIDER AND RECOMMEND ACTION

A. External Financial Report-Whitely Penn

MOTION: SANTOS **SECOND: WOMACK**

With unanimous affirmative votes,
BE IT RESOLVED External Financial Report-Whitely Penn, is approved and recommended to the Full Board.

V. REVIEW AND COMMENT

A. Internal Audit Report, presented by David Fojtik and included in the January 17, 2023, Audit Agenda Packet under Exhibit A-2.
B. Compliance Department Report, presented by Anthony Robinson and included in the January 17, 2023, Audit Agenda Packet under Exhibit A-3.

VI. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VII. ADJOURN-

MOTION: SANTOS **SECOND: WOMACK**
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 1:08 p.m.

DRAFT

____

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-2

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

Internal Audit

FY2023 Second Quarter Audit Reports

Presented By: David W. Fojtik, CPA, CFE, CIA, Director – Internal Audit

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FY 2023 2nd Quarter Reports

FY 2023 Q2 Audit Report Findings (to be discussed):

- Employer Retirement Plan Contributions Review
- Contracts with Service Agencies Audit
- Follow-up: HR Outstanding Invoices Review

FY 2023 Audit Reports In Progress (will be presented in FY2023 Q3 Reports)

- Directed Payment Program (DPP – Financial Services)
- Charity Care Program (CCP – Financial Services)
- Follow-up: New Hire Drug and TB Testing – (Human Resources)
- Travel Reimbursement Audit – (Financial Services)
- Accounts Receivable and Fee Collections Audit - (Financial Services)

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FY 2023 2nd Quarter Reports

Employer Retirement Plan Contributions Review:

Finding #1 – Internal Audit confirmed the employer contributions for two retirement accounts for one employee matched exactly on the employee's Lincoln Financial retirement report dated 12/31/22, and the contributions shown on the employee's pay stubs, dated December 2, and December 16, 2022.

The 12C pay stub with a December 30, 2022 check date shows the employee's deduction for 403b plan, and a company paid contribution in the 403b/401a Plan account. The contributions were included in the Lincoln Financial January 2023 retirement plan statement, after contribution payments were received. The contribution payments were applied to the employee's account on a trade date of January 11, 2023.

Management Response #1 (VP-Human Resources): There was a timing issue to produce the payment request at year end with holidays and internal issues. This should not be considered a regular occurrence. We have worked to address the issue going forward to not have a repeat in future periods.

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FY 2023 2nd Quarter Reports

Contracts with Service Agencies Audit:

Finding #1 – Internal Audit reviewed the Ultra Medical Cleaning account and we found a January 25, 2023 electronic funds transfer (EFT) paid for invoices, dated July 1, 2022 and July 19, 2022, which would normally be processed in the FY2022 budget period; these invoiced charges totaled $64,105.65. There were 34 invoices dated September 19, 2022 through January 1, 2023, which were paid January 25, 2023.

Exhibit I - Vendor invoices presented for initial payment paid later during the FY2023 budget fiscal year period

Vendor Payee	Vendor Inv.	(Ross) Inv. #	Invoice Date	Payment Date	Payment	Process Days	Invoice Amt
UltraMedical	31509	718556	7/01/2022	1/25/2023	EFT 104179	208	$1,326.75
UltraMedical	31510	718557	7/01/2022	1/25/2023	EFT 104179	208	$61,594.62
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Total Amount:							$64,105.65

Management Response #1 (Director of Facility Services): "These invoices were brought to the attention of the Facilities leadership team as not having been paid timely. Upon receipt of the invoices from Ultra, the Facilities team did process these invoices. In many circumstances, our vendors reconcile their invoicing at the end of their fiscal year, which differs from that of the agency, and we are provided the invoices that had not been billed to the agency timely. This is a challenge that our team works to address with our vendor partners."

Management Response #2 (VP-ERM): "I would need more information on the actual invoice detail and submission information from the vendor to make a specific response".

Management Response #3 (Facilities Coordinator): "Invoices were missed/sent late."

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FY 2023 2nd Quarter Reports

Contracts with Service Agencies Audit:

Finding #2 – Internal Audit reviewed the Allied Universal account and we found a November 16, 2022 check payment for two invoices, dated May 5, 2022 and August 18, 2022, which would normally be processed during the FY2022 budget period; these charges totaled $32,126.93. The Contract Term for CT142388 is listed as September 1, 2022 thru August 31, 2023.

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AlliedUniversal	13494434	715558	5/05/2022	11/16/2022	CHECK511590	195	$16,114.15
AlliedUniversal	13494442	715559	8/18/2022	11/16/2022	CHECK511590	90	$16,012.78
Total Amount:							$32,126.93

Source: Purchase Order & Invoice Review, online report, Financial Services, February 6, 2023

Management Response #1: (Director of Security): "Allied Universal experienced a high rate of attrition in a key position known as their "Client Manager" who is responsible for gathering data for the invoices as well as investigating and remedying our concerns/edits on invoices submitted for payment. From March 2022 through present day, they have had 5 staff members in that role (including 2 interim). The invoice review/edit/amendment process was challenging but seems to be improving now".

Management Response #2 (VP-ERM): "Each invoice is reviewed for accuracy. This process includes reports from our program leaders at each Agency location on number of guards reporting for duty and time of reporting. When a discrepancy is discovered in what we are billed compared to what we observed we communicate back to the vendor for correction of the security hours charged. This particular vendor has incurred numerous changes in leadership which has delayed the payment process as different persons would have to review the original requests".

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FY 2023 2nd Quarter Reports

Contracts with Service Agencies Audit:

Finding #3 - Internal Audit reviewed the online Accounting Accrual Tool report and selected account 576002 Utilities – Electric, and selected the account detail page to show electric utility charges accruals assigned to Unit **1827** (7011 Southwest Freeway). The report needs to show Unit **1817** (9401 Southwest Freeway).

Exhibit III – From the *Month End Automated Accrual Recommendation Tool* - Detail: 576002 UTILITIES – ELECTRIC

Unit	Account	Unit Description	August FY 2022	September FY 2023	October FY 2023	November FY 2023	December FY 2023
1827	576002	1827 7011 SOUTHWEST FREEWAY	$33,765.90	$32,233.44	$12.17	$28,409.61	$0.00

Management Response #1: (Manager of Accounting and Treasurer): "Upon further examination, it was discovered the wrong unit was being used by Accounts Payable (AP) to allocate monthly electricity invoices for 9401 Southwest Fwy. Immediately, the accounting department corrected this error and moved expenses to the correct unit (1817) and deactivated the old unit in the accounting software, Ross, to avoid future errors. (See Audit Report for complete response)".

Management Response #2 (Accounts Payable Supervisor): "This was an error from AP staff. I just requested the accounting department to inactivate 1827-576002 from Ross system to avoid any future mistake".

Management Response #3 (Controller): – "Agree".

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FY 2023 2nd Quarter Reports

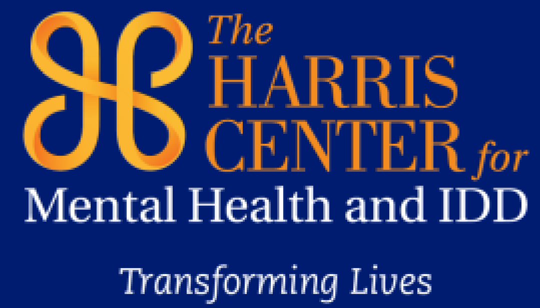
Follow-Up: HR Outstanding Invoices Audit:

Finding #1 – Internal Audit reviewed the CT142318 P-Recruitmen pool contract invoices and noted that the large number of invoices created in July and August 2022 processed after 90 or more days. The P-Recruitmen pool contract includes four (4) payees, including Elite Personnel and Burnett Specialty, whose firms created many invoices in July and August 2022, reflecting labor requirements in FY2022. The P-Recruitmen contract was approved for $324k, effective September 1, 2022 thru August 31, 2023. The current contract shows invoices created in July and August 2022 which totaled $55,589.07 (about 17.1%) and paid from the $324k NTE amount. The P-Recruitmen contract shows $36k remaining on this contract.

For invoices created in September and October, the majority of invoices were finalized within 60 days, and in November and December, the majority of these invoices were finalized within 45 days, or less. There is a marked reduction in A/P process days beginning in the early November, 2022 time period.

Management Response #1 (VP-Human Resources): “Ninfa Escobar has responsibility for the invoicing process related to our Talent Acquisition vendors. Good improvement has been made. We are assigning this work to our new OC Coordinator. Once completed, we expect that all invoices will be handled within 30 days”.

Management Response #2 (Chief Administrative Officer): “The HR Department has restructured accountability of the vendor payment process within the leadership team. We have observed a marked improvement in invoice processing since these changes within the department. We will continue to monitor the performance of these processes to ensure sustainability of the improvements”.



Thank You

EXHIBIT A-3

Transforming Lives

Compliance Department

FY23 Q2 Audit Reports

Date: March , 2023

Presented By: Anthony Robinson, VP – Enterprise Risk Management

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Summary of Audits Completed

Reporting Period: December 2022 – February 2023

Seven (7) Focus Reviews:

Two (2) Service Delivery Documentation Reviews

1. CPEP PATH Documentation Review
2. IDD ECI Service Delivery Documentation Review

Two (2) Plan of Improvement (POI) Follow-up Reviews

1. MH YES Waiver Program Documentation POI Follow- Up Review
2. MH TCOOMMI POI Follow-Up Focus Review

Three (3) Overlap of Time for a Server Review

1. MH NE Child and Youth Family Wellness Center
2. MH SWCAS
3. MH SECAS

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Summary of Audits Completed

Reporting Period: December 2022 – February 2023

Three (3) Routine Reviews

1. CPEP MCOT Routine Review
2. CPEP CRU Documentation Routine Review
3. CPEP PES Routine Review

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Q2 Key Compliance Take-Aways

1. Staff were not adhering to TAC Case Management documentation requirements when notating case management services despite receiving documentation training. Compliance has reeducated leadership on TAC requirements when documenting progress notes. Compliance will follow-up with the program to ensure the execution of the POI within the next one hundred eighty (180) days.
2. YES Waiver program was not including all elements when developing and updating the Wrap-Around Plan consistent with the YES Waiver Manual. Compliance will follow up with the YES Waiver program to ensure the documentation is completed per Health and Human Services (HHS) YES Waiver Manual Operational guidelines within the next one hundred eighty (180) days.
3. Service Delivery Documentation erroneously appeared to need a Co-signer to finalize notes due to the presence of a radio button in EPIC that must be unchecked when a cosigner is not needed. The program's leadership reported their intention to implement additional staff training when informed by Compliance. Program management is working with The Harris Center's IT Business Analyst to determine if the template can be modified to resolve future issues.
4. Safety plans were not initiated during the first encounters of persons served due to programmatic guidelines not aligning with The Harris Center's Policy and Procedure. The Harris Center's Policy on safety plans states, "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 a minimum." Compliance will follow up with the program to ensure the fulfillment of its POI obligations and HHS Information Item V standards within the next one hundred eighty (180) days.
5. CRU's management was unaware of some information pertaining to Crisis Information Item V requirements (Service delivery documentation). Compliance provided CRU's Program Manager with the HHS Crisis Information Item V and will follow up with program management within the next one hundred eighty (180) days to ensure the fulfilment of its POI obligations

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Q2 Key Compliance Take-Aways

6. Discrepancy with service times of Progress Note and Service Detail report in EPIC. Compliance will follow-up with the program in one hundred and eighty (180) days to monitor resolution.

7. TCOOMI management did not implement the recommendations noted in a previous POI. TCOOMI management reported understaffing as the primary cause of their inability to execute the recommendations. Compliance will follow up with the New Start-TCOOMMI program to ensure the program implements its POI within the next ninety (90) to one hundred eighty (180) days.

8. There is no overlapping services report currently in EPIC. Compliance brought this to the attention of Revenue Management and IT requesting the creation of the report be considered a high priority due to potential billing compliance issues.

External Reviews

The Harris Center for Mental Health and IDD
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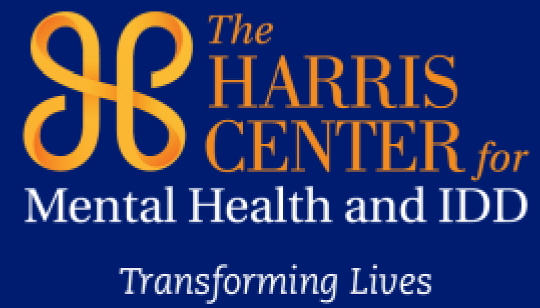
The following is a list of the external reviews (i.e. Governing Bodies, Managed Care Organizations MCO, etc.)

- Q4 2022 Superior Health Plan/The Harris Center Feedback December 8, 2022
- Health and Human Services (HHS) General Revenue- Community First Choice Review FY 2023 Report of Findings 1/23/2023
- Health and Human Services (HHS) Home and Community-Based Services Authority Review FY 2023 Report of Findings 1/23/2023
- Health and Human Services (HHS) Pre-Admission Screening & Resident Review (PASRR) Authority Review FY 2023 Report of Findings 1/23/2023
- Health and Human Services (HHS) Quality Assurance Authority Review FY 2023 Report of Findings 1/23/2023
- Health and Human Services (HHS) Texas Home Living Authority Review FY 2023 Report of Findings 1/23/2023
- Optum Behavior Health Solution/United Healthcare Community Documentation Review 1/27/2023
- ICF Qtr. 2 Audit Westbury, Applewhite, Pasadena Cottage A 2/1/2023
- Harris Center YES Waiver QM Remote Review Notification 2/17/2023
- ECI Administrative and Problematic Initial Report 2/24/2023



Thank You

EXHIBIT A-4

Executive Summary

EMPLOYER RETIREMENT PLAN CONTRIBUTIONS AUDIT (RETPLAN0123)

FINDINGS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit confirmed the employer contributions for two retirement accounts for one employee matched exactly on the employee's Lincoln Financial retirement report dated 12/31/22, and the contributions shown on the employee's pay stubs, dated December 2, and December 16, 2022.

The 12C pay stub with a December 30, 2022 check date shows the employee's deduction for 403b plan, and a company paid contribution in the 403b/401a Plan account. The contributions were included in the Lincoln Financial's January 2023 retirement plan statement, after contribution payments were received. The contribution payments were applied to the employee's account on a trade date of January 11, 2023.

Management Response #1 (VP - Human Resources): There was a timing issue to produce the payment request at year end due to a change in Benefits support. We have addressed the issue and do not expect this problem to occur in future periods.

Employer Retirement Plan Contributions Review

(RETPLAN0123)

INTERNAL AUDIT REPORT

April 18, 2023

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

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CURRENT PROCESS

The Harris Center allocates all employees a monthly contribution to the 401a base account in an amount equal to 5% of the employee salaries. The 5-5-5 Retirement Plan also provides a matching contribution for employees who voluntarily elect to deduct funds from their payroll for funding their 403b account. The 5-5-5 Retirement Plan provides 5% of employee salary allocation for the 401a base account, plus an equal amount contributed the 401a matching fund allocation based on the 403b account contribution from the employee's deduction.

The Lincoln Financial Group was selected in 2021 to assume fiduciary responsibilities over the Center's 5-5-5 Retirement Plan, which was revised to enhance its attractiveness to current and new employees. The advantage of the Lincoln Financial processing was that they were able to incorporate management of the 403b account, and then apply a corrected match amount in the employee's 401a match account.

The plan's revision established a monthly financial transaction (contribution) to the Plan Administrator in order to assure funds availability throughout the year, and avoiding any significant financial true-ups at the end of the calendar year, as it occurred prior to the revised 5-5-5 Retirement Plan administration.

This audit was performed to sample a small group of employees to determine that amounts deducted or company paid in the Kronos system are indeed matched in Lincoln Financial statement. For employees who elected to deduct a percentage or dollar amount of their pay to the 403b plan, it should be easy for the employee to verify that their 403b accounts likewise receives a regular once-a-month contribution. If the 403b option is funded each month, the payroll stub will show it clearly in the 401a match account, and categorized as "Company Paid Benefits" while all employee deduction amounts paid into the 403b voluntary savings accounts are categorized as "Deductions."

On the Lincoln Financial statements, the employee can select a number of ranges to see contributions. On this statement, the contributions made to the 401a account are categorized as "THC-1" and the contributions made to the 403b account are categorized as "THC-2" part of the account statement. The account comparisons can be made on the Lincoln Financial statements as 401a and 403b information is consolidated in the online statement.

The test need not be sophisticated but needs to be exact. The Auditor suggests comparing the payroll stubs (issued by pay periods) to dollar allocations shown in the monthly Lincoln Financial statements Because of the personal nature of guarding payroll and benefit information, the comparisons are few but should be illustrative as to how the processing has worked. To date, the Lincoln Financial system has been operating for 4 years without incident or complaint, but a query was presented to test the process.

SCOPE AND OBJECTIVES

Audit Scope: This audit will review the funding activity for the Harris Center's 5-5-5 Retirement Plan by comparing the Retirement Plan funds timely transfer to the Lincoln Financial Retirement Group.

Audit Objectives: The Audit is included in Internal Audit's Fiscal Year 2023 Annual Audit Plan, and our audit objectives were to:

1. Review the procedures used to ensure timely wire transfer of the 401a, 401a match and 403b funds from the Center's financial, banking and payroll systems to Lincoln Financial accounts.
2. Evaluate the Financial Services processes used to provide the monthly accruals to test that the amounts reflect any infrequent variations in employee payroll deductions.
3. Affirm that the Harris Center's 5-5-5 Retirement Plan eligibility, enrollment and participation rules are updated and accurate for employees' use in safeguarding their individual retirement benefits.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes may include the following:

1. Management does not acknowledge employee concerns regarding the Plan's funding needs.
2. Management does not educate employees on how to grow and safeguard retirement plan funds given the investors' risk appetites in their own accounts.
3. Management may pay excessively high administrative service fees without their knowledge.

FIELD WORK

Field Work: A high-level summary of audit work needed to address the audit objectives listed above:

1. Using Kronos Workforce Dimensions, select the "My Pay" option on the employee's profile. Select the Pay History for the pay period being reviewed to generate a "Pay Statement Review."
2. Under "Deductions" note the 403b/401a Plan account for a Current and YTD balance. This is the amount collected from the employee's pay for funding the 403b portion of the retirement plan.
3. Under "Company Paid Benefits" note the "401a Contrib" and the "403b/401a" account amounts. Note that the dollar amount in the "403b/401a" should be equal to or less than the amount in the "401a Contrib" since "401a Contrib" represents the 5% limit used in the 5-5-5 Retirement Plan.
4. Access the Lincoln Financial statement for the same time period. The Lincoln Financial website uses an additional process to verify the user, such as a two-factor authentication code.
5. Select "The Harris Center for Mental Health and IDD 401A Plan" to see company paid contributions. If an employee elected monthly deductions for the 403b Plan this account should show the two monthly contribution amounts, including one representing 5% of the employee's monthly salary, and the second representing the amount contributed to match the amount of the 403b account. Note: Contributions processed at the end of the prior calendar month should appear on the next month's Lincoln Financial statement.
6. Select "The Harris Center for Mental Health and IDD 403B Plan" to see employee deductions that were contributed to the employee's account in the time period. Note: Contributions processed at the end of the prior calendar month should appear on the next Lincoln Financial statement.

FINDINGS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit confirmed the employer contributions for two retirement accounts for one employee matched exactly on the employee's Lincoln Financial retirement report dated 12/31/22, and the contributions shown on the employee's pay stubs, dated December 2, and December 16, 2022.

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Management Response #1 (VP - Human Resources): There was a timing issue to produce the payment request at year end due to a change in Benefits support. We have addressed the issue and do not expect this problem to occur in future periods.

CONCLUSION

The Harris Center understands that employees need to be satisfied with their benefits, including their investment results from the 5-5-5 Retirement Plan. The Center has worked hard to develop a workable set of benefits, and the improvements in the retirement plan have been successful.

This audit was to verify that employer funds provided as contributions to the 401a base and 401a match accounts occurs without exception or delay, in accordance to the guidelines in the 5-5-5 Retirement Plan which was modified in 2019 which requires a monthly funding transaction to all the 5-5-5 Plan accounts.

After some initial adjustments, the amounts of the employee account accruals have been very accurate. We found that all the employer's contributions were readily captured in the Lincoln Financial statements albeit a delay in the year-end Lincoln retirement statement, when the payment transferred after the last day of the year. We found that all contributions were accounted for by calendar year-end.

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

CONTRACTS WITH SERVICE AGENCIES AUDIT (SERVICES0123)

FINDINGS, RECOMMENDATIONS & MANAGEMENT RESPONSES

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						Total Amount:	**$32,126.93**

Source: Purchase Order & Invoice Review, online report, Financial Services, February 6, 2023

Management Response #2 (Director of Security): Allied Universal experienced a high rate of attrition in a key position known as their "Client Manager" who is responsible for gathering data for the invoices as well as investigating and remedying our concerns/edits on invoices submitted for payment. From March 2022 through present day, they have had 5 staff members in that role (including 2 interim). The invoice review/edit/amendment process was challenging but seems to be improving now.

Management Response #2 (VP-ERM): Each invoice is reviewed for accuracy. This process includes reports from our program leaders at each Agency location on number of guards reporting for duty and time of reporting. When a discrepancy is discovered in what we are billed compared to what we observed we communicate back to the vendor for correction of the security hours charged. This particular vendor has incurred numerous changes in leadership which has delayed the payment process as different persons would have to review the original requests.

Finding #3 - Internal Audit reviewed accruals and we found electric utility charges accruals assigned to Unit **1827** (7011 Southwest Freeway) as shown in the Automated Accrual Recommendation report. The report needs to be updated to show that charges assigned to Unit **1817** (9401 Southwest Freeway).

Exhibit III – From the *Month End Automated Accrual Recommendation Tool* - Detail: 576002 UTILITIES - ELECTRIC

Unit	Account	Unit Description	August	September	October	November	December
			2022	2023	2023	2023	2023
1827	576002	1827 7011 SOUTHWEST FREEWAY	$33,765.90	$32,233.44	$12.17	$28,409.61	$0.00

Source: Automated Accrual Recommendation, online report, Financial Services, February 6, 2023

Management Response #3 (Director of Facility Services): This would be a function of the finance department which Facilities has not control or insight into, we submit utility bills for payment, account payables do the rest.

Management Response #3 (Accounting and Treasury Manager): Upon further examination, it was discovered the wrong unit was being used by Accounts Payable (AP) to allocate monthly electricity invoices for 9401 Southwest Fwy. Immediately, the accounting department corrected this error and moved expenses to the correct unit (1817) and deactivated the old unit in the accounting software, Ross, to avoid future errors. We also notified all key personnel to remove or deactivate 1827 from their relevant programs such as the travel system, expense reimbursement system, Citibank P-Card, Prospero, etc. Lastly, to address the comment above, it is a joint effort by both departments to ensure expenses are coded to the correct cost center. They are two sides of the same coin so to speak. AP relies on end users to notify them of the correct cost centers to use. End users, such as Facility Services, controls budgets and costs related to the units upon which they have been charged to maintain. Without end users notifying AP of where invoices should be coded, AP cannot be successful at their job.

Management Response #3 (Accounts Payable Supervisor): This was an error from AP staff. I just requested the accounting department to inactivate 1827-576002 from Ross system to avoid any future mistake.

Management Response #4 (Controller): Agree.

Contracts with Service Agencies Audit

(SERVICES0123)

INTERNAL AUDIT REPORT

April 18, 2023

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

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CURRENT PROCESS

The Harris Center contracts with two service agencies that perform daily activities: housekeeping, and security services. Internal Audit evaluated the activity level based on invoiced amounts from two firms who were employed to perform services at one or more of locations at The Harris Center.

Ultra Medical Cleaning (aka Ultra Cleaning) is a local 15 year old firm that was founded by Kunal Puri, with headquarters in Stafford, Texas. The first currently employs 300+ workers and performs a variety of cleaning services including hospitals. The Harris Center has used this firm's services for many years.

Allied Universal provides security services for The Harris Center's various locations for last few years. The firm was founded in 1957 and operates in 96 countries with over 800,000 security professionals, valued at over $20 billion, and high growth as the demand for security and intelligence services grows. The Harris Center has used this firm's services for several years after they replaced the prior vendor.

We also looked at the utilities accounts for electricity service and water services in order to assess that the invoicing activity (documented on invoices) appears current, and that 'monthly' expenditures were fairly consistent in terms of the dollar value and that the sequencing of read dates occurred logically over time. Given that routine services are consistently provided without any lengthy interruption, it is imperative to verify that duplicate payments are not prepared in error.

In performing this audit, we also noted that some of the additional Board approvals had occurred while The Harris Center experienced some operational changes as the pandemic moved through our facilities.

SCOPE AND OBJECTIVES

Audit Scope: Audit will review invoices from service agencies at The Harris Center to assess them for consistency in providing services to the Center.

Audit Objectives: The Audit was included in Internal Audit's Fiscal Year 2023 Annual Audit Plan, and our audit objectives were to:

1. Review service agency's contracts for statement of work or service level agreement statements.
2. Evaluate agency's monthly billing to detect any anomalies, changes that increase or decrease the service level, and any suspension or termination in services at particular locations.
3. Review management's use of special controls over services performed by these service agencies.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes include the following:

1. Management does not acknowledge employee concerns or complaints about service providers.
2. Management does not educate employees on how to report issues of fraud, waste and abuse.
3. Management may pay excessively high service fees or pay for services that are not provided per the agency's contract specifications or do not meet contract requirements.

FIELD WORK

Field Work: A high-level summary of audit work needed to address the audit objectives listed above:

1. Identify two-three large service agencies who provide daily services throughout the year.
2. Obtain the service agency's contracts to review the statement of work or service level agreement (SLA) requirements.
3. Compare service expenditures for each service agency over time and measure fluctuations in all billed work that are observed in invoices following changes within The Harris Center operations.
4. Check for management and other Center-authorized approvals for change order authorizations or other agreements or surcharges that may result in temporary additional fees or expenditures.
5. Coordinate meetings with business process owners to assure that their agency's service provision meets their needs and business requirements.

FINDINGS, RECOMMENDATIONS & RESPONSES

Finding #1 – Internal Audit reviewed the Ultra Medical Cleaning account and we found a January 25, 2023 electronic funds transfer (EFT) paid for invoices, dated July 1, 2022 and July 19, 2022, which would normally be processed in the FY2022 budget period; these invoiced charges totaled $64,105.65. There were 34 invoices dated September 19, 2022 through January 1, 2023, which were paid January 25, 2023.

Exhibit I - Vendor invoices presented for initial payment paid later during the FY2023 budget fiscal year period

Vendor Payee	Vendor Inv.	Inv. #	Invoice Date	Payment Date	Payment	Process Days	Invoice Amt
UltraMedical	31509	718556	7/01/2022	1/25/2023	EFT 104179	208	$1,326.75
UltraMedical	31510	718557	7/01/2022	1/25/2023	EFT 104179	208	$61,594.62
UltraMedical	31757T	718561	7/19/2022	1/25/2023	EFT 104179	190	$175.00
UltraMedical	31770T	718562	7/19/2022	1/25/2023	EFT 104179	190	$175.00
UltraMedical	31772T	718563	7/19/2022	1/25/2023	EFT 104179	190	$478.00
UltraMedical	31775T	718564	7/19/2022	1/25/2023	EFT 104179	190	$356.28
						Total Amount:	**$64,105.65**

Source: Purchase Order & Invoice Review, online report, Financial Services, February 6, 2023

Management Response #1: (Director of Facility Services): These invoices were brought to the attention of the Facilities leadership team as not having been paid timely. Upon receipt of the invoices from Ultra, the Facilities team did process these invoices. In many circumstances, our vendors reconcile their invoicing at the end of their fiscal year, which differs from that of the agency, and we are provided the invoices that had not been billed to the agency timely. This is a challenge that our team works to address with our vendor partners.

Management Response #1 (VP – ERM): I would need more information on the actual invoice detail and submission information from the vendor to make a specific response.

Management Response #1 (Facilities Coordinator): Invoices were missed/sent late.

Finding #2 – Internal Audit reviewed the Allied Universal account and we found a November 16, 2022 check payment for two invoices, dated May 5, 2022 and August 18, 2022, which would normally be processed during the FY2022 budget period; these charges totaled $32,126.93. The Contract Term for CT142388 is listed as September 1, 2022 thru August 31, 2023.

Exhibit II - Vendor invoices presented for initial payment paid later during the FY2023 budget fiscal year period

Vendor Payee	Vendor Inv.	Inv. #	Invoice Date	Payment Date	Payment	Process Days	Invoice Amt
AlliedUniversal	13494434	715558	5/05/2022	11/16/2022	CHECK511590	195	$16,114.15
AlliedUniversal	13494442	715559	8/18/2022	11/16/2022	CHECK511590	90	$16,012.78
						Total Amount:	**$32,126.93**

Source: Purchase Order & Invoice Review, online report, Financial Services, February 6, 2023

Management Response #2 (Director of Security): Allied Universal experienced a high rate of attrition in a key position known as their "Client Manager" who is responsible for gathering data for the invoices as well as investigating and remedying our concerns/edits on invoices submitted for payment. From March 2022 through present day, they have had 5 staff members in that role (including 2 interim). The invoice review/edit/amendment process was challenging but seems to be improving now.

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Management Response #3 (Accounts Payable Supervisor): This was an error from AP staff. I just requested the accounting department to inactivate 1827-576002 from Ross system to avoid any future mistake.

Management Response #4 (Controller): Agree.

CONCLUSION

Internal Audit compared the vendor invoicing activities from prior calendar years to detect anomalies, but we did not observe any instances of double-billing, missed billings, or other obscured expenditures. However, we noted a number of lengthy periods from the vendor's initial invoice date to the final payment date called "Process Days" on the Purchase Order, where the Invoice Review shows that the payment is completed as the difference between the Invoice Date and the Payment Process Date.

Based on the vendors' invoice numbers and accounts payable process using number sequencing, it appears that invoices were issued to capture work activity from earlier time periods that were not previously billed to the Center. Internal Audit reviewed the invoices and did not observe instances of duplicated invoice entries, but rather we see invoices for work not invoiced in a more timely manner.

The "risk" of receiving the delayed invoices is that they take budget dollars out of the current budget. The UltraMedical #CT141583 purchase order from Fiscal Year 2022 shows it had $143,975.70 remaining at fiscal year-end, so it does not appear to be a lack of purchase order dollars. The FY2022 report shows funds were added and the contract was extended from 1/1/2021 until 8/31/2022, suggesting that the work conditions in the pandemic period called for these unique and exceptional operational changes.

The other "risk" we tested was the possible paying of duplicate invoices, but our comparison of the Vendor Invoice Numbers in both FY2022 and FY2023 purchase orders showed no duplicate payments. This shows that accounts payable processing is very robust, and thus it prevents this possible outcome.

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: HUMAN RESOURCES OUTSTANDING INVOICES REVIEW (FUHRINV0123)

FINDINGS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit reviewed the CT142318 P-Recruitmen pool contract invoices and noted that the large number of invoices created in July and August 2022 were processed after 90 or more days. The P-Recruitmen pool contract includes four (4) payees, including Elite Personnel and Burnett Specialty, whose firms created many invoices in July and August 2022, reflecting labor requirements in FY2022.

The P-Recruitmen contract was approved for $324k, effective September 1, 2022 thru August 31, 2023. The current contract shows invoices created in July and August 2022 totaled $55,589.07 (about 17.1%) and paid of the $324k NTE amount. The P-Recruitmen contract shows $36k remaining on this contract.

For invoices created in September and October, the majority of invoices were finalized within 60 days, and in November and December, the majority of these invoices were finalized within 45 days, or less. There is a marked reduction in A/P process days beginning in the early November, 2022 time period.

Exhibit I - Vendor invoices presented for initial payment paid later during the FY2023 budget fiscal year period

Vendor Payee	Vendor Inv.	Inv. #	Invoice Date	Payment Date	Payment	Process Days	Invoice Amt
Elitepersonnel	30010918	716154	7/13/2022	12/1/2022	EFT 104151	141	$3,084.70
Elitepersonnel	30011455	716153	8/3/2022	12/1/2022	EFT 104151	120	$2,856.89
Elitepersonnel	30011327	716160	7/27/2022	12/1/2022	EFT 104151	127	$3,198.09
Elitepersonnel	30011326	718561	7/27/2022	12/1/2022	EFT 104151	127	$1765.20
Elitepersonnel	30010919	716163	7/13/2022	12/1/2022	EFT 104151	141	$8,497.05
Elitepersonnel	30011715	718564	8/17/2022	12/1/2022	EFT 104151	106	$3,024.95
Elitepersonnel	30011454	716170	8/3/2022	12/1/2022	EFT 104151	120	$366.72
Elitepersonnel	30011328	716200	7/27/2022	12/7/2022	EFT 104153	133	$2,277.07
Elitepersonnel	30011716	716213	8/17/2022	12/7/2022	EFT 104153	112	$2,281.44
BurnettSpecial	B2073282	716501	8/12/2022	12/7/2022	Check 511747	117	$715.20
TheReservesn	6517923	717191	7/24/2022	12/21/2022	Check 511933	150	$1,113.38
TheReservesn	6519085	717192	7/31/2022	12/21/2022	Check 511933	143	$1,127.48
TheReservesn	6520183	717193	8/7/2022	12/21/2022	Check 511933	136	$1,901.73
TheReservesn	6521331	717194	8/14/2022	12/21/2022	Check 511933	129	$2,441.14
TheReservesn	6522577	717195	8/21/2022	12/21/2022	Check 511933	122	$2,196.36
TheReservesn	6523234	717196	8/28/2022	12/21/2022	Check 511933	115	$1,223.49
TheReservesn	6523690	717197	8/28/2022	12/21/2022	Check 511933	115	$2,715.45
BurnettSpecial	B2073344	716502	8/12/2022	12/7/2022	Check 511747	117	$1,192.00
BurnettSpecial	B2073603	716503	8/19/2022	12/7/2022	Check 511747	110	$1,192.00
BurnettSpecial	B2073609	716504	8/19/2022	12/7/2022	Check 511747	110	$953.60
BurnettSpecial	B2074318	716505	8/12/2022	12/7/2022	Check 511747	103	$1,192.00
BurnettSpecial	B2074556	716506	8/16/2022	12/7/2022	Check 511747	113	$1,192.00
ElitePersonnel	30010920	717286	7/13/2022	12/21/2022	EFT 104161	161	$7,614.49
ElitePersonnel	30011185	717454	7/20/2022	12/28/2022	EFT 104164	161	$1,466.64
						Total Amount:	**$55,589.07**

Source: Purchase Order & Invoice Review, online report, Financial Services, February 6, 2023

Management Response #1 (VP-Human Resources): Ninfa Escobar has responsibility for the invoicing process related to our Talent Acquisition vendors. Good improvement has been made. We are assigning this work to our new OC Coordinator. Once completed, we expect that all invoices will be handled within 30 days.

Management Response #1 (Chief Administrative Officer): The HR Department has restructured accountability of the vendor payment process within the leadership team. We have observed a marked improvement in invoice processing since these changes within the department. We will continue to monitor the performance of these processes to ensure sustainability of the improvements.

Follow-Up: HR Outstanding Invoices Review

(FUHRINV0123)

INTERNAL AUDIT REPORT

April 18, 2023

David W. Fojtik, MBA, CPA, CIA, CFE

Director, Internal Audit

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CURRENT PROCESS

The Harris Center for Mental Health and IDD maintains a well-established requisition and contract process for goods and services. The allocations are separated by individual contract number, and annual budgets are established prior to the spending period. For example, a budget for a contract is determined in May during the initial contract set up phase and available on September 1 of that same year.

Any additional contract funding increases should be identified by the "contract owner" who normally is the department head. Contracts specify an annual spending limit using a Not-To-Exceed or NTE amount, and any budget transfers of $50,000 or more require Board approval at the monthly Resource Meeting. All changes to the contract are listed in the purchase order header showing changes in the NTE or funds source, or due to any change in general ledger account number if there is a required reallocation.

The Financial Services online purchase order report (PowerBI reports) tracks invoicing activity and shows the remaining budget for the given purchase order; the contractor administrator should track when the available balance falls below the amount of funds needed to pay typical recurring charge or pay the typical invoiced amount from the vendor's organization for that specific contract number. The contract owner should frequently review status of all contracts (using the online purchase order and other tools) and make arrangements to curtail spending activity or seek additional funds to pay future invoices.

Internal Audit evaluation

Internal Audit began to review contracts which were managed by the Human Resources department which appeared to have no remaining funds (or low amounts of available funds) when viewing the department's Reporting Period 7 activity. Two of the FY2022 contracts (P-Recruitment and PreCheck) showed no available activity because more funding is needed and applied to these purchase orders.

The P-Recruitmen contract (actual name of this pooled contract) was created to provide funding sources for one or more vendor firms to provide recruitment services. We found that the largest contract firm in the P-Recruitmen pool contract is called Resource Staffing, a firm was recommended by a prior Director of Human Resources. This firm published a listing of the hourly rates for 147 different job titles, but Internal Audit could not match the listed position rates with the invoiced amounts issued to the Center.

Another firm Crag Energy Services has hired in early FY2021 to perform recruitment services with hourly rates from $64 per hour and up to $96 for overtime hours. These services were introduced when the number of departing employees was significantly high and there was a risk of curtailing daily services.

The PreCheck Inc. contract is used to pay for pre-employment verification services for newly hired employees, including a bundle price that provides a collection of prospective employee's record, in terms of motor vehicle records and criminal records. This contract has been used for a number of years and invoicing was paid by the Director of Human Resources corporate credit card (Bank of America). Previously the PreCheck charges were posted to Director of Human Resources on the Bank of America corporate card account.

SCOPE AND OBJECTIVES

Audit Scope: *This is a follow-up to the Human Resources Outstanding Invoices Issue Review audit*.

Last year, the Chief Executive Officer (CEO) asked Internal Audit to review outstanding invoices that are related to Human Resources Department projects used for recruiting new employees to fill the many immediate vacancies at The Harris Center.

Audit Objectives: The Chief Executive Officer asked Internal Audit to perform a follow-up review of the current invoicing activity, and to determine root causes for the current insufficient funding levels. Our audit objectives were to:

1. Obtain the list of contracts managed by Human Resources Department that appear to have been exhausted their Not To Exceed (NTE) amounts.
2. Identify all business contacts at the Harris Center who can identify one or more root causes for an apparent underfunding of budget dollars.
3. Obtain samples of invoices and email correspondence related to activities noted in the contracts.

AUDIT RISKS

Audit Risks: Possible factors that may contribute to worsened outcomes include the following:

1. Management does not adequately train contract owners on how best to estimate contract costs initially in Agreements or initial contracts, which may then require the subsequent change orders.
2. Management does not adequately train contract administrators on how best to estimate the remaining contract fund values or plan for budget transfers, if needed to pay for future invoices.

FIELD WORK

Field Work: A high-level summary of audit work is needed to address the audit objectives listed above:

1. Review the online Purchase Order report to identify the contracts that Human Resources has managed, and identify those contracts in which spending levels are accurate.
2. Review individual invoices to determine if additional notations or signatures are requested or required when the invoices were being processed, and if any split unit codes shared the expenses.
3. Contact the Accounts Receivables contacts at vendor firms with significant outstanding invoices and assess the financial value of these outstanding invoices to prepare for their prompt payment.
4. Examine if charges on invoices exceed labor rates outlined in the supplied Agreements or Contracts to assess probability of refunds for excessive fees paid during the processing of known invoices.
5. Estimate any identified duplicate charges based on billed charges exceed Bundle fees that were described and documented in the PreCheck Inc. contract.

FINDINGS, RECOMMENDATIONS & MANAGEMENT RESPONSES

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Management Response #1 (VP-Human Resources): The HR Department has restructured accountability of the vendor payment process within the leadership team. We have observed a marked improvement

in invoice processing since these changes within the department. We will continue to monitor the performance of these processes to ensure sustainability of the improvements.

CONCLUSION

In our prior audit, we found that some the contracts for services for onboarding and recruitment were underfunded relatives to the demand for hiring services after the primary COVID-19 pandemic period. Human Resources remedied the shortfalls with additional requests for Board approvals to revise these contracts sufficiently to continue their onboarding throughout the year.

In this audit, Internal Audit reached out to the HR contract administrators and we learned that the most recent staffing and reorganization occurred in late 2022. The new Vice President of Human Resources was hired, and it seems Human Resources rebuilt staff quickly and is poised for optimum performance. We observed that demand for many types of contracted services in the Human Resources Department had softened strongly, but in particular the onboarding process had slowed and staffs are stabilizing. Compared with last year's audit, Internal Audit found no funding issues with outstanding invoices so it seems that employee demand and manager request volumes for new hires have balanced out.

Internal Audit found the P-Recruitmen (pooled contract) and the PreCheck, Inc. accounts were both current in payment, and both showed adequate reserve balances at the six-month reporting month, which corresponds to February, 2023. We looked further to see if other services were following the anticipated levels of activity, and the associated invoicing that would accompany staff expansions.

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

EXHIBIT A-5

The Harris Center for Mental Health MH 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, 2022, through February 28, 2023.

Presenter: Anthony Robinson, Vice President of Enterprise Risk Management

Explanation of Reviews:
The following types of reviews were conducted by Compliance during the 2nd Quarter (Qtr.) of Fiscal Year (FY) 2023:

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.

Seven (7) Focus Reviews were conducted during the reporting period to ensure regulatory compliance in the following areas: Service delivery Documentation, Plan of Improvement (POI) Follow Up, and Overlap of Time for a Server.

Two (2) Service Delivery Documentation Reviews were conducted in accordance with The Compliance Department's Audit Schedule.

- Crisis Psychiatric Emergency Program (CPEP) Projects for Assistance in Transition from Homelessness (PATH) Service Documentation Review

- Individual with Developmental Disabilities (IDD) Early Childhood Intervention (ECI) Service Delivery Documentation Review

Two (2) Plan of Improvement (POI) Follow-Up Reviews were conducted in accordance with The Compliance Department's Audit Schedule.

- Mental Health (MH) Youth Empowerment Services (YES) Waiver Program Documentation POI Follow- Up Review

- MH New Start Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOOMMI)POI Follow-up Review

Three (3) Overlap of Time for a server Reviews were conducted in accordance with The Compliance Department's Audit Schedule

- MH Child and Youth Family Wellness Center

- MH Southwest (SW) Child and Adolescent Services (CAS)

- MH Southeast (SE) CAS

Routine Review – includes the following protocols (1) Requisites/Patient Services, (2) Services Compliance (3) Progress Note 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.

Three (3) Routine Reviews were conducted to ensure the programs are compliant with Texas Administrative Codes, Agency Policy and Procedure and programmatic guidelines.

- CPEP: Mobile Crisis Outreach Team (MCOT) Routine Review
- CPEP: Crisis Residential Unit (CRU) Documentation Routine Review
- CPEP: Psychiatric Emergency Services (PES) Routine Review

Other Compliance Activities:

Training/Meeting:

- December 20, 2022: Patient Satisfaction Surveys Meeting with Performance Improvement (PI) Meeting
- January 13, 2023: New Hire Training, *How to complete Deficiency Tracking.*
- January 31, 2023: Child and Adolescent Services (CAS) to Adult Mental Health(AMH) Transfers Meeting
- February 7, 2023: Running Reports in EPIC for PES and CRU programs Training.
- February 10, 2023: Compliance Department Meeting
- February 17, 2023: Compliance Staff Meeting

Other Responsibilities:

- Epic Deficiency Tracking (Ongoing)
- Maintenance of The Harris Center's policy and procedure process and platform (Ongoing) Bi-Weekly Policy Stat Meeting (Ongoing)
- Weekly Tracking for Audits, Deficiency Tracking and Policy Stat (Ongoing)

Q2 Audit Report Summary:

The chart below identifies the reviews conducted by Compliance for Q2 of FY 2023:

Review Type	Begin Date of the Review	Program Reviewed
Focus Review: Service Delivery Review	12/8/2022	PATH
Focus Review: Follow-Up Review	1/5/2023	YES Waiver
Focus Review: Service Delivery Documentation	1/6/2023	ECI
Routine Review	2/2/2023	MCOT
Routine Review	2/8/2023	CRU
Routine Review	2/10/2023	PES
Focus Review: Overlap in Time for a Server	2/14/2023	NE Child and Youth
Focus Review: Overlap in Time for a Server	2/14/2023	SWCAS
Focus Review: Overlap in Time for a Server	2/14/2023	SECAS
Focus Review: POI Follow-up Review	2/23/2023	New Start/TCOOMMI

Key Takeaways

1. <u>Focus Review: CPEP PATH Follow-Up Review:</u> Staff were not adhering to TAC Case Management documentation requirements when notating case management services despite receiving documentation training.

   Action Plan: Compliance has reeducated leadership on TAC requirements when documenting progress notes. Compliance will follow-up with the program to ensure the execution of the POI within the next one hundred eighty (180) days.

2. <u>Focus Review: YES, Waiver Documentation Follow-Up Review:</u> YES Waiver program was not including all elements when developing and updating the Wrap-Around Plan consistent with the YES Waiver Manual.

   Action Plan: Compliance will follow up with the YES Waiver program to ensure the documentation is completed per Health and Human Services (HHS) YES Waiver Manual Operational guidelines within the next one hundred eighty (180) days.

3. Focus Review: ECI Documentation Review: Service Delivery Documentation erroneously appeared to need a Co-signer to finalize notes due to the presence of a radio button in EPIC that must be unchecked when a cosigner is not needed. The program's leadership reported their intention to implement additional staff training when informed by Compliance.

   Action Plan: Program management is working with The Harris Center's IT Business Analyst to determine if the template can be modified to resolve future issues.

4. Routine Review: MCOT Routine Review: Safety plans were not initiated during the first encounters of persons served due to programmatic guidelines not aligning with The Harris Center's Policy and Procedure. The Harris Center's Policy on safety plans states, "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 a minimum."

   Action Plan: Compliance will follow up with the program to ensure the fulfillment of its POI obligations and HHS Information Item V standards within the next one hundred eighty (180) days.

5. Routine Review: CRU Routine Review: CRU's management was unaware of some information pertaining to Crisis Information Item V requirements (Service delivery documentation).

   Action Plan: Compliance provided CRU's Program Manager with the HHS Crisis Information Item V and will follow up with program management within the next one hundred eighty (180) days to ensure the fulfilment of its POI obligations.

6. Routine Review: PES Routine Review: There were discrepancies with service times of progress notes and the Service Detail report in EPIC. Action Plan: Compliance will follow-up with the program in one hundred and eighty (180) days to monitor resolution.

7. Focus Review: TCOOMMI Focus POI Follow-up Review: TCOOMI management did not implement the recommendations noted in its previous POI. TCOOMI management reported understaffing as the primary cause of their inability to execute the recommendations.

   Action Plan: Compliance will follow up with the New Start-TCOOMMI program to ensure the program implements its POI within the next ninety (90) to one hundred eighty (180) days.

8. Focus Review: MH Child and Adolescent Services (CAS) Duplicate/Overlap Services Focus Reviews: There is no overlapping services report currently in EPIC.

   Action Plan: Compliance brought this to the attention of Revenue Management and IT, requesting the creation of the report be considered a high priority due to potential billing compliance issues.

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. December 8, 2022: Q4 2022 Superior Health Plan/The Harris Center Feedback
2. Health and Human Services (HHS) General Revenue- Community First Choice Review FY 2023 Report of Findings 1/23/2023
3. Health and Human Services (HHS) Home and Community-Based Services Authority ReviewFY 2023 Report of Findings 1/23/2023
4. Health and Human Services (HHS) Pre-Admission Screening & Resident Review (PASRR) Authority Review FY 2023 Report of Findings 1/23/2023
5. Health and Human Services (HHS) Quality Assurance Authority Review FY 2023 Report of Findings 1/23/2023
6. Health and Human Services (HHS) Texas Home Living Authority Review FY 2023 Reportof Findings 1/23/2023
7. Optum Behavior Health Solution/United Healthcare Community Documentation Review 1/27/2023
8. ICF Qtr. 2 Audit Westbury, Applewhite, Pasadena Cottage A 2/1/2023
9. Harris Center YES Waiver QM Remote Review Notification 2/17/2023
10. ECI Administrative and Problematic Initial Report 2/24/202023

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Services Documentation Review
Comprehensive Psychiatric Emergency Program (CPEP) Division
Projects for Assistance in Transition from Homelessness (PATH)
Review Date: December 8-15, 2022

I. Audit Type:
Focus

II. Purpose:
At the request of the Program Director of PATH, Compliance conducted a review of service documentation to ensure compliance in accordance with Texas Administrative Code ***(TAC) 415.10 (a) (1-3) 415.6 (1-3), 301.361 (a) (1-14) (b), 306.263 (b) (1-13, 354.2607 (a) (1-10),*** and ***217.11 (D) (i - vi)*** and Health and Human Service Commission (HHSC) Service Standards for nurses.

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 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling thirty (30) records using Compliance Encounter Documentation Review tool. Detailed data for this review is presented in the findings section below

IV. Audit Findings/History:
The program consistently documented the person's served mental status examination in the clinical record. Progress note documentation consistently evidenced the type of service(s) provided to the person's served. Progress notes were routinely individualized; there was no evidence of copying and pasting. Case management documentation did not consistently identify the goals and actions required to meet the person's served needs. Case Manager's documentation did not reflect efforts to assist persons served in gaining access to community resources. Case management documentation did not consistently demonstrate the steps needed to be considered case management services, i.e., referral, linking, advocacy, and monitoring. Nursing documentation did not evidence what services the persons served received. Nursing documentation did not evidence the persons served response towards treatment. Nursing documentation did not include the persons served health history.

No audits of this type have been previously conducted.

V. Recommendations:
Compliance recommends that the PATH program review the findings and continue to assess its processes for completing service documentation and ensure documentation is completed in accordance with TAC and HHS Service Standards. The PATH program is required to submit a Plan of Improvement (POI) focusing on areas of improvement. The Vice President (VP) of CPEP Division and the Program Manager/Director of PATH should return the signed report with management response and POI, acknowledging receipt of this report to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP)
Projects for Assistance in Transition from Homelessness (PATH)
Focus Review

Compliance Auditor(s): Marvin Williams

Review Date: December 8, 2022, to December 15, 2022

Purpose

At the request of the Program Director for PATH, Compliance conducted a Focus Review of service documentation to ensure documentation is completed in accordance with Texas Administrative Code ***(TAC) 415.10 (a) (1-3) 415.6 (1-3), 301.361 (a) (1-14) (b), 306.263 (b) (1-13, 354.2607 (a) (1-10), 217.11 (D) (I – vi)*** and Health and Human Service Commission ***(HHSC) Service Standards for Nurses.***

Method

Active records were randomly selected from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing* report in the Electronic Health Record (I) for persons served during 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling thirty (30) records using a Compliance Encounter Documentation Review Tool. Detailed data for this review is presented in the findings section below:

Findings

The strengths and areas of improvement identified during the review are as follows:

Strengths:

- The program consistently documented the persons served mental status examination in the clinical record. ***(§415.6 (2)***
- Progress note documentation consistently evidenced the type of service(s) provided to the person's served. ***(§301.361 (a)***

Areas of Improvement:

- Case management documentation did not consistently identify the goals and actions required to meet the persons served needs. ***(§306.263 (b) (4)***
- Case Manager's documentation did not reflect efforts to assist persons served in gaining access to community resources. ***(§306.263 (b) (2)***
- Case management documentation did not consistently demonstrate the steps needed to be considered case management services, i.e., referral, linking, advocacy, and monitoring. ***(§306.263 (b) (7)***
- Nursing documentation did not evidence what service the persons served received. ***(§217.11 (D) (ii)***

- Nursing documentation did not evidence the persons served response towards treatment. *(§217.11 (D) (v)*
- Nursing documentation did not include the persons served health history. ***HHSC Service Standards for Nurses***

History

No audits of this type have been previously conducted.

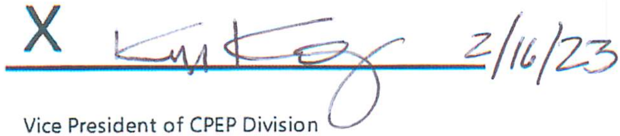
Recommendations

Compliance recommends that the PATH program review the findings and continue to assess its processes for completing service documentation and ensure documentation is completed in accordance with TAC and HHSC Service Standards for nurses. The PATH program is required to submit a Plan of Improvement (POI) focusing on areas of improvement listed in this report. The Vice President (VP) of the CPEP Division and the Program Manager/Director of PATH should return the signed report with a management response and POI to Compliance within seven (7) business days, by close of business February 21, 2023.

Management Response:

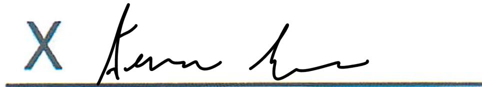
Recovery Plan/Case Management refresher training was provided on 1/27/23 and also management provided all clinical staff with the TAC notes guidelines to use as a reference. THE LVN was provided with training on documenting referrals and TAC notes guidelines were provided. Recovery Plan/Case Management refresher training was provided by the training department on 1/27/23. Management will monitor and discuss issues in monthly supervision with staff members.

Signature Page



Vice President of CPEP Division

Program Director/Manager



Compliance Manager

Projects for Assistance in Transition from Homelessness (PATH) Focus Review Plan of Improvement 2nd Qtr. FY 2023

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
§306.263 (b) (4)	1. Case management documentation did not consistently identify the goals and actions required to meet the persons served needs.	Dir.; Myra Smalls-Brayboy-Team Lead; Aaron Jones- Care Coordinator; Cynthia Moreno-Care Coordinator	Recovery Plan/Case Management refresher training will be provided and also TAC notes guidelines.	Recovery Plan/Case Management refresher training provided on 1/27/23	Management will monitor and discuss issues in monthly supervision with staff.
§306.263 (b) (2)	2. Case Manager's documentation did not reflect efforts to assist persons served in gaining access to community resources.	Omar Sesay, LPC-S, Program Dir.; Myra Smalls-Brayboy-Team Lead; Aaron Jones- Care Coordinator; Cynthia Moreno-Care Coordinator	Recovery Plan/Case Management refresher training will be provided and also TAC notes guidelines.	Recovery Plan/Case Management refresher training provided on 1/27/23	Management will monitor and discuss issues in monthly supervision with staff.
§306.263 (b) (7)	3. Case management documentation did not consistently demonstrate the steps needed to be considered case management services, i.e., referral, linking, advocacy, and monitoring.	Dir.; Myra Smalls-Brayboy-Team Lead; Aaron Jones- Care Coordinator; Cynthia Moreno-Care Coordinator	Recovery Plan/Case Management refresher training will be provided and also TAC notes guidelines.	Recovery Plan/Case Management refresher training provided on 1/27/23	Management will monitor and discuss issues in monthly supervision with staff.
§217.11 (D) (ii)	4. Nursing documentation did not evidence what service the persons served received.	Omar Sesay, LPC-S, Program Dir.; Valena Osei, LVN	Provided training on documenting referrals and also TAC notes guidelines.	1/27/2023	
§217.11 (D) (v)	5. Nursing documentation did not evidence the persons served response towards treatment.	Omar Sesay, LPC-S, Program Dir.; Valena Osei, LVN	Provided training on documenting referrals and also TAC notes guidelines.	1/27/2023	
HHSC Service Standards for Nurses	6. Nursing documentation did not include the persons served health history.	Omar Sesay, LPC-S, Program Dir.; Valena Osei, LVN	Provided training on documenting referrals and also TAC notes guidelines.	1/2/2023	

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Mental Health (MH) Division
Follow-Up Focus Review
Review Date: January 5, 2023, to January 9, 2023

I. Audit Type:
Follow-Up Focus Review

II. Purpose:
Compliance conducted a follow-up audit of the YES Waiver program to assess for implementation of the YES Waiver Manual procedures for the review conducted on September 16, 2021, to September 20, 2021.

III. Audit Method:
Active records were randomly selected from the *YES Waiver Inquiry Client Roster report* for the persons served during 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling ten (10) records using YES Waiver Review State Tool. Detailed data for this review is presented in the findings section below:

IV. Audit Findings and History:
During the review The YES Waiver program made improvements from the previous audit in the following areas: persons served/LAR received return calls from the Local Behavioral Health Authority (LBHA) within twenty-four hours or within (1) business day from registration on the Inquiry List. The first child and family team meetings were routinely held with the first thirty (30) days of the youth's enrollment.

The area(s) of improvement consist of several wraparound plans did not include at least one (1) needs statement for the youth and at least one (1) needs statement for the family.

The YES Waiver Policy Manual, Wraparound Provider Organization Responsibilities ***(YES Waiver Manual Page 85)*** states when developing the initial wraparound plan, during the first child and family team (CFT) meeting, the team will work to discuss, agree on and document needs statements for the participant and LAR and creating a family vision and team mission statement. Inconsistencies were observed in documenting the needs of the persons served and creating a family vision statement and team mission statement, some staff were completing during the first meeting and some staff were not. In response to the observation, Yes Waivers Leadership reported staff did not have to address or document the persons served needs during the buildup phase of completing the wraparound plan. It was also observed that clinical eligibility intake assessments were not held with the persons served within seven (7) business days of the initial demographic eligibility determination ***PCN (YES Waiver Manual Page 16)***

The Compliance Department conducted a comprehensive review of the YES Waiver program during 1st Qtr. of FY 2022 for services completed during 4th Qtr. of FY 2021 (June 1, 2021, to August 31. 2021

V. Recommendations:
Compliance recommends that the YES Waiver program review the finding(s) and continue to assess its processes to ensure documentation is completed in accordance with the YES Wavier Manual. The YES Waiver program is required to submit a Plan of Improvement (POI) and collaborate with Performance Improvement (PI) to assist with implementing program procedures. Compliance will review YES Waiver POI and PI processes in the next one hundred eighty (180) days. Signatures and a management response are required by the Vice President (VP) of MH Child and Adolescent Services and the Program Manager/Director of the YES Waiver Program. The signed report with management response and POI should be returned to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report: 2nd Quarter (Qtr.) of Fiscal Year (FY) 2023 Mental Health (MH) Division Youth Empowerment Services (YES) Waiver Program Documentation Follow-Up Audit

Compliance Auditor(s): Marvin Williams

Review Date: January 5, 2023 to January 9, 2023

Purpose

Compliance conducted a follow-up audit of the YES Waiver program to assess for improvements in the deficient areas reported in the comprehensive review conducted on September 16, 2021, to September 20, 2021.

Method

Active records were randomly selected from the *YES Waiver Inquiry Client Roster report* for the persons served during 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling ten (10) records using YES Waiver Review State Tool. Detailed data for this review is presented in the findings section below:

Findings

The strengths, areas of improvement, and observations identified during the review are as follows:

Strengths:

The YES Waiver program made improvements from the previous audit in the following areas:

- Persons served/LAR received return calls from the Local Behavioral Health Authority (LBHA) within twenty-four (24) hours or within one (1) business day from registration on the Inquiry List. ***YES Waiver Manual, page 72***
- The first child and family team meetings were routinely held within the first thirty (30) days of the youth's enrollment. ***YES Waiver Manual, Page 84***

Areas of Improvement:

- Several wraparound plans did not include at least one (1) needs statement for the youth and at least one (1) needs statement for the family. ***YES Waiver Manual, Page 85***

The HARRIS CENTER for Mental Health and IDD

Observations

The YES Waiver Policy Manual, Wraparound Provider Organization Responsibilities ***(YES Waiver Manual Page 85)*** states when developing the initial wraparound plan, during the first child and family team (CFT) meeting, the team will work to discuss, agree on and document needs statements for the participant and LAR and creating a family vision and team mission statement. Inconsistencies were observed in documenting the needs of the persons served and creating a family vision statement and team mission statement, some staff were completing during the first meeting and some staff were not. In response to the observation, Yes Waivers Leadership reported staff did not have to address or document the persons served needs during the buildup phase of completing the wraparound plan. It was also observed that clinical eligibility intake assessments were not held with the persons served within seven (7) business days of the initial demographic eligibility determination ***PCN (YES Waiver Manual Page 16)***

History

The Compliance Department conducted a comprehensive review of the YES Waiver program during 1st Qtr. of FY 2022 for services completed during 4th Qtr. of FY 2021 (June 1, 2021, to August 31, 2021

Recommendations

Compliance recommends that the YES Waiver program review the finding(s) and continue to assess its processes to ensure documentation is completed in accordance with the YES Wavier Manual. The YES Waiver program is required to submit a Plan of Improvement (POI) and collaborate with Performance Improvement (PI) to assist with implementing program procedures. Compliance will review YES Waiver POI and PI processes in the next one hundred eighty (180) days. Signatures and a management response are required by the Vice President (VP) of MH Child and Adolescent Services and the Program Manager/Director of the YES Waiver Program. The signed report with management response and POI should be returned to Compliance within seven (7) business days, by close of business on February 16, 2023.

Management Response:

[All wraparound plans, regardless of the family's stage in the build-up process will include the needs statement for the youth and family within the document. A notation of "N/A" or "Not evaluated at this time" will be documented as appropriate. The monthly internal audit conducted by YES Waiver staff will review wraparound plans to ensure the needs statement is documented accordingly. A review of this change has been discussed with Wraparound Facilitators. An ongoing training/education and review of the wraparound plans will be completed periodically.]

Signature Page

X *Lance Britt* 02/09/2023

Vice President of MH CAS Division

X [signature], MA, LPC-S

Program Director/Manager

X [signature]

Compliance Director/Compliance Manager

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Early Childhood Intervention (ECI)
Service Delivery Documentation Review
Review Date: January 6, 2023, to January 10, 2023

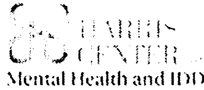
I. Audit Type:
Focus Review

II. Purpose:
Compliance conducted a review of ECI's service delivery documentation in accordance with Texas Administrative Code (TAC), 350.1111 (1-9), and agency policy and procedures (HIM9 A&B),

III. Audit Method:
Active records were randomly selected from the *Affiliated (AFF) Harris Center (HC) Encounter Data Outpatient (OP) Service Detail Listing* report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). The Compliance Department conducted a desk review, sampling ten (10) records, using the ECI Encounter Review Tool. Detailed data from this review is presented in the findings section below:

IV. Audit Findings/History:
The service delivery documentation consistently included the name of the child to whom the service was provided, consistently reflected the name of the ECI Contractor and the name and Discipline of the service provider and incorporated the beginning and end times of the service. The service delivery documentation included the method of service provision (individual or group) and consistently described how the provider engaged the family or routine caregiver in activities to meet the child's developmental needs, consistently evidenced coaching and instructions to the family or caregiver, consistently discussed how the service activities apply to children and families, included modeling intervention techniques within everyday learning opportunities, including a description of the opportunity for the caregiver's return demonstration, and evidenced that the family or other routine caregiver provided relevant new information about the child. However, the service delivery documentation was not entered into the EHR within two business days.***, HIM9B).*** During the review, Compliance observed that progress notes were not in a centralized location. The program specified three areas to locate progress notes due to staff scanning. It was communicated to the program that it would be beneficial to have a centralized location of service delivery documentation, reducing time spent searching for records, preventing unauthorized disclosure of sensitive service information, and ensuring that consumer information is kept confidential. Compliance also observed that seven (7) service delivery documents needed to be cosigned. It was discussed with the program manager, who said she would train the staff. Compliance requested a copy of the training record when it is completed.

V. Recommendations:
It is recommended that the ECI program continue to monitor service delivery documentation to ensure compliance with TAC and agency guidelines. The ECI program is not required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of MH and Program Director, including a management response addressing the present finding, and returned to the Compliance Department within seven (7) business days.



Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Early Childhood Intervention (ECI)
Service Delivery Documentation Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: January 6, 2023, to January 10, 2023

Purpose

Compliance conducted a review of ECI's service delivery documentation in accordance with Texas Administrative Code (TAC), 350.1111 (1-9), and agency policy and procedures (HIM9 A&B),

Method

Active records were randomly selected from the *Affiliated (AFF) Harris Center (HC) Encounter Data Outpatient (OP) Service Detail Listing* report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). The Compliance Department conducted a desk review, sampling ten (10) records, using the ECI Encounter Review Tool. Detailed data from this review is presented in the findings section below:

Findings

The strengths and areas of improvement identified during the review are as follows:

Strengths:

- The service delivery documentation consistently included the name of the child to whom the service was provided. ***TAC § 350.1111 (1)***
- The service delivery documentation consistently reflected the name of the ECI Contractor and the name and Discipline of the service provider. ***TAC § 350.1111(2)***
- The service delivery documentation regularly incorporated the beginning and end times of the service ***TAC § 350.1111(3).***
- The service delivery documentation included the method of service provision (individual or group) ***TAC § 350.1111 (4).***
- The service delivery documentation consistently described how the provider engaged the family or routine caregiver in activities to meet the child's developmental needs. ***TAC § 350.1111 (5).***
- The service delivery documentation consistently evidenced coaching and instructions to the family or caregiver. ***TAC § 350.1111 (5).***

- The service delivery consistently discussed how the service activities apply to children and families. ***TAC § 350.1111 (5 (B)).***
- The service documentation included modeling intervention techniques within everyday learning opportunities, including a description of the opportunity for the caregiver's return demonstration. ***TAC § 350.1111 (5 (C).***
- The service delivery documentation evidenced that the family or other routine caregiver provided relevant new information about the child ***TAC § 350.1111 (8).***

Areas of Improvement:

- The service delivery documentation was not entered into the EHR within two business days., ***HIM9B).***

Observations

During the review, Compliance observed that seven (7) service delivery documents needed to be cosigned. It was discussed with the program manager, who stated that she would train the staff. Compliance requested a copy of the training record when it is completed.

Staff and supervisors were notified of error. Co-Signature box not able to be unchecked on finalized note. Staff was informed to not make error on future notes. The attached document outlines the training implemented, and ongoing strategies to address these findings.

History

No reviews of this type were previously conducted.

Recommendations

It is recommended that the ECI program continue to monitor service delivery documentation to ensure compliance with TAC and agency guidelines. The ECI program is not required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of MH and Program Director, including a management response addressing the present finding, and returned to the Compliance Department within seven (7) business days, February 15, 2023.

Management Response:

All items were reviewed and discussed with leadership. Plan for correction addressed. It is noted discussed with compliance auditor service delivery documentation for ECI is same day, not within two business days like MH services.

Signature Page

X Lance Britt

Vice President of MH Division

X

Program Director/Manager

X

Compliance Director/Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department (Compliance)
Executive Summary Cover Sheet for the
Routine Review
Comprehensive Psychiatric Emergency Program (CPEP)
Mobile Crisis Outreach Team (MCOT)

I. **Audit Type:**
Routine Review

II. **Purpose:**
The purpose of this review is to assess the MCOT program to ensure compliance with completing service documentation in accordance with Texas Administrative Code (TAC), Agency Policies and Procedures, Health and Human Services (HHS) Information Item V Crisis Service Standards, and MCOT Organizational Guidelines and Training Manual.

III. **Audit Method:**
Active records were randomly selected by Compliance from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing report* in the Electronic Health Record (EHR) for persons served during 1st and 2nd Qtr. of FY 2023 (November 1, 2022 – January 31, 2023). Compliance conducted a desk review sampling thirty (30) service entries, and the documentation reviewed consisted of the Plan of Care (POC), Crisis Assessments, Progress Notes, Referrals, And Safety Plans. Detailed data for this review is presented in the findings.

IV. **Audit Findings:**
The areas identified as needing improvements where the safety plans were not consistently completed nor documented in the clinical record. *(HHSC Information Item V: II.D.6.b.i.ii.iii.iv.v.vi),* the Crisis Plans of care were not routinely updated. *(HHSC Information Item V: IV.G.3.b.i.ii.iii.c.iv.v.d),* and the program did not routinely provide services to every person served to assist in stabilizing the crisis behavior *(HHSC Information Item V: II.D.7a.i. ii.* However, the program identified strengths in these areas, the program consistently followed up on the initial crisis line call within twenty-four (24). *(HHSC Information Item V: II.1.c),* the program regularly documented the person served risk of harm evaluation in the crisis assessment *(HHSC Information Item V: II.D.5.a.i.ii.iii*), and the program frequently documented the person's served historical and current mental health information in the crisis assessment. *(HHSC Information Item V: II.D.5.d.i).* It was observed, during this review, the MCOT program was utilizing an older version of the agency's POC, policy and procedure, CS:21. b. This policy has been updated to include a new reference number identifying the current agency's policy and procedure on POCs and safety plans. The agency policy and procedure were updated in November 2021. The current policy and procedure for POC is ACC3A and ACC3B.

V. **Recommendations:**
Compliance recommends that the MCOT program review the findings and continue to assess its processes for completing service documentation to ensure documentation is completed in accordance with TAC, Agency Policy and Procedures, HHSC Information Item V Crisis Service Standards and should update MCOT Organizational and Training Manual guidelines.to the Agency's Policy and Procedure, regarding the completion of safety plans. The MCOT program is required to submit a Plan of Improvement (POI) addressing findings from this review The Vice President (VP) of the CPEP Division and the Program Manager/Director of MCOT should return the signed report with management response, acknowledging receipt of this report to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP) Division
Mobile Crisis Outreach Team (MCOT)
Routine Review

Compliance Auditor(s): Carla Reynolds

Review Date: February 2, 2023, to February 8, 2023

Purpose

The purpose of this review is to assess the MCOT program to ensure compliance with completing service documentation in accordance with Texas Administrative Code (TAC), Agency Policies and Procedures, Health and Human Services (HHS) Information Item V Crisis Service Standards, and MCOT Organizational Guidelines and Training Manual.

Method

Active records were randomly selected by Compliance from the *Affiliated Harris Center Encounter Data OP Service Detail Auditing report* in the Electronic Health Record (EHR) for persons served during 1st and 2nd Qtr. of FY 2023 (November 1, 2022 – January 31, 2023). Compliance conducted a desk review sampling thirty (30) service entries, and the documentation reviewed consisted of the Plan of Care (POC), Crisis Assessments, Progress Notes, Referrals, And Safety Plans. Detailed data for this review is presented in the findings section below:

Findings

The strengths and areas of improvement identified during the review are as follows:

Strengths:

- The program regularly followed up on initial crisis line calls within twenty-four (24). *HHS Information Item V: II.1.c*
- The program consistently documented the person served risk of harm evaluation in the crisis assessment. *HHS Information Item V: II.D.5.a.i.ii.iii*
- The program frequently documented the person's served historical and current mental health information in the crisis assessment. *HHS Information Item V: II.D.5.d. i*

Areas of Improvement:

- The safety plans were not consistently completed and documented in the clinical record. *HHS Information Item V: II.D.6.b.i.ii.iii.iv.v.vi* and Agency Policy and Procedures*, ACC3B*

- The Crisis Plan of Care was not regularly updated. *HHS Information Item V: IV.G.3.b.i.ii.iii.c.iv.v. d.*
- Person-served records evidenced that coordination of crisis services was not provided to every individual and did not 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)*

History

A previous audit was conducted of this type, from June 22, 2022, to June 27, 2022, 4th Qtr. FY 2022 for persons served during 3rd Qtr. FY 2022 (March 1, 2022 – May 31, 2022).

Observations

It was observed, during this review, the MCOT program was utilizing an older version of the agency's POC, policy and procedure, CS:21. b. This policy has been updated to include a new reference number identifying the current agency's policy and procedure on POCs and safety plans. The agency policy and procedure was updated in November 2021. The current policy and procedure for POC is ACC3A and ACC3B.

Recommendations

Compliance recommends that the MCOT program review the findings and continue to assess its processes for completing service documentation to ensure documentation is completed in accordance with TAC, Agency Policy and Procedures, HHSC Information Item V Crisis Service Standards and should update MCOT Organizational and Training Manual guidelines.to the Agency's Policy and Procedure, regarding the completion of safety plans. The MCOT program is required to submit a Plan of Improvement (POI) addressing findings from this review The Vice President (VP) of the CPEP Division and the Program Manager/Director of MCOT should return the signed report with management response, acknowledging receipt of this report to Compliance within seven (7) business days, by close of business March 14th, 2023.

Signature Page

Management Response:

MCOT Management outlined in the attached Excel spreadsheet how each area of improvement will be addressed to meet the recommendations of the compliance review. The plan of improvement documented will work to ensure documentation is completed in accordance with TAC, Agency Policy, and Procedures, HHSC Information Item V Crisis Service Standards and will update MCOT Organizational and Training Manual guidelines by May 31, 2023.

X Kim Kornmayer

Vice President of CPEP Division

X Sarah Strang

Program Director/Manager

X

Compliance Manager

The
HARRIS
CENTER for
Mental Health and IDD

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Services Documentation Review
Comprehensive Psychiatric Emergency Program (CPEP) Division
Crisis Residential Unit (CRU)
Review Date: February 8-21, 2023

I. Audit Type:
Routine

II. Purpose:
The purpose of this review was to assess CRU's internal operations and ensure services are in line with *Health and Human Services (HHS) Item V for Crisis Residential Service Standards*: ***V. D. 2. e. v. 1, V. D. 3. a. i, V. D. 3. b. v. 1, V.D. 3. b. iv. 1-12, V. D. 3. Vi. (1-5), V. D. 5. C. (i-iv), V. D. 4. b. i-iii, V. D. 4. c. i. (1-2), V. D.12.e. iv.***

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center CRU's IP Encounter Data* report in the Electronic Health Record (EHR) for persons served during 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling ten (10) records using a Compliance Crisis Residential Encounter Review Tool. Detailed data for this review is presented in the findings section below:

IV. Audit Findings/History:
The program consistently completed a physical health assessment with the person served. The Crisis Plan of Cares were regularly updated. The program consistently provided several treatment prevention services to assist the person served in crisis stabilization.
The physician did not see every person served at least once per week. Program documentation did routinely evidence that every person served received a unit orientation within twenty-four (24) hours after admission. The discharge planning process was not regularly initiated at the time of the person served admission into CRU services. Program documentation did not consistently evidence that each person served was educated about their medications. No audits of this type have been previously conducted.

V. Recommendations:
Compliance recommends that the CRU program review the findings and continue to assess its processes for completing service documentation and ensure documentation is completed in accordance with HHS Item V Standards. The CRU program is required to submit a Plan of Improvement (POI) focusing on areas of improvement listed in this report. The Vice President (VP) of the CPEP Division and the Program Manager/Director CRU should return the signed report with a management response and POI to Compliance within seven (7) business days,

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP)
Crisis Residential Unit (CRU) Bristow and Southmore
Routine Review

Compliance Auditor(s): Marvin Williams

Review Date: February 8, 2023, to February 21, 2023

Purpose

The purpose of this review was to assess CRU's internal operations and ensure services are in accordance with Health and Human Services (HHS) Information Item V standards for *Crisis Residential Services.*

Method

Active records were randomly selected from the *Affiliated Harris Center CRU's IP Encounter Data* report in the Electronic Health Record (EHR) for persons served during 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). Compliance conducted a desk review, sampling ten (10) records using a Compliance Crisis Residential Encounter Review Tool. Detailed data for this review is presented in the findings section below:

Findings

The strengths and areas of improvement identified during the review are as follows:

Strengths:

- The program consistently completed a physical health assessment with the person served. ***(HHS Item V: V. D.12.e.iv)***
- The Crisis Plan of Cares were regularly updated. ***(HHS Item V: V. D. 4. b. i-iii)***
- The program consistently provided several treatment prevention services to assist the person served in crisis stabilization. ***(HHS Item V: V. D. 4. c. i. (1-2).***

Areas of Improvement:

- Every person's served was not seen at least once per week by a physician. ***(HHS Item V: V. D. 2. e. v. 1)***
- Documentation did not routinely evidence that every person's served received unit orientation within twenty-four (24) hours after admission. ***(HHS Item V: V. D. 3. Vi. (1-5)***
- Discharge planning process was not regularly completed at the time of each person's served admission into CRU services. ***(HHS Item V: V. D. 5. C. (i-iv)***
- Program documentation did not consistently provide evidence that each person's served was educated about their medications. ***(HHS Item V: V. D.12.e.iv)***

History

No audits of this type have been previously conducted.

Recommendations

Compliance recommends that the CRU program review the findings and continue to assess its processes for completing service documentation and ensure documentation is completed in accordance with HHS Item V Standards. The CRU program is required to submit a Plan of Improvement (POI) focusing on areas of improvement listed in this report. The Vice President (VP) of the CPEP Division and the Program Manager/Director CRU should return the signed report with a management response and POI to Compliance within seven (7) business days, by close of business on March 16, 2023.

Management Response:

Staff at the Crisis Residential Unit are grateful for the feedback and have implemented a number of processes to strengthen a proud tradition of treatment programming and best practices on the unit. Here are some highlights in an endeavor to ensure excellence in provision of clients needs and ideal stewardship.

- Psychiatric Care: In March 2023 Nursing services implemented a change in tracking and scheduling a 7 day follow-up with unit psychiatrist each week by indicating this on a 'Daily Service Log' (DSL) used in tracking on the unit.
- Psychiatric Care: Turnover in psychiatric staff has necessitated ongoing recruitment and hiring of an additional psychiatrist. An ideal is to fill psychiatric vacancies by Summer of 2023 but availability of quality applications and onboarding requirements present some barrier.
- Admissions Orientation: Psych Tech's have been educated on documenting orientation in Epic as they complete admission date intake of new patients. This training occurred at a 3/2/23 all Psych Tech meeting. Program Director will audit to ensure implementation and monitor adherence.
- Discharge Planning: At a 3/8/23 team meeting unit Therapists and Care Coordinators were trained on the best practice of documenting discharge planning specifics at time of intake (within three days of admission). This audit item is a matter of documentation best practices, using language that reflects the discharge material that is historically covered as part of intake and crisis planning.
- Medication Education: The Medical Director will provide reminder and training to psychiatric staff cited in audit, new relief medical staff, and in general.

The HARRIS CENTER for Mental Health and IDD

Signature Page

Vice President of CPEP Division

Program Director/Manager
Signed by: Leo Kerr

Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Routine Review
Comprehensive Psychiatric Emergency Program (CPEP) Division
Psychiatric Emergency Services (PES)
Review Date: February 9-21, 2023

I. Audit Type:
Routine

II. Purpose:
The purpose of this review was to assess the PES program to ensure crisis services are provided in accordance with the Texas Administrative Code (TAC), Title 26 crisis services §301.351(2), §301.351(e), Title 25 Evaluation and Diagnosis (§415.5(f) §415.6(a)(1-5); Information Item V: Extended Observation unit (EOU) Eligibility Item V.3.a.b.c, Capacity to Consent Item V.4; Length of Stay Item V.6, Documentation Item V.IV. F.2, Item V. IV. Item V.IV.F.5., Item V. IV. F.5.a.iii, Item V. IV. F.5.a. iv. (1-3), F.5.(b-e), Item V. IV. F.5. f. i-iii (1-3) (h), Item V.IV.G.2. Item V.IV.N.2.a.i.ii, Item V. IV. H.c.(3)(4)(5), Item V.IV.Hd., Free Standing EOU Facility ItemV.IV.D.1.a.,b., Psychiatric Emergency Services Center (PESC) Facility ItemV.IV.D.2.a.i.,ii.,ItemV.IV.D.2.b.i.-v, Admission Status and Egress:ItemV.IV.D.5.a.i.-iii.,ItemV.IV.D.5.c.i.-iii.,ObservationAreaItemV.IV.D.7.a-b., ItemVIV.D.7.c.i.-iii., Staffing ItemV.IV.D.8.b.i.,ii., Item V.IV.D.8.b.iii.(1-5), Item V.IV.D.8.b.iv(2-3), Duties and Responsibilities.ItemV.IV.D.9 (a-f) and Agency policy and Procedures ACCB10B(1-5).

III. Audit Method:
Active records were randomly selected from the *Affiliated* (*AFF) Harris Center* (*HC) Psychiatric Emergency Services Encounter Data) Service Detail Listing* report in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). The Compliance Department conducted a desk review, sampling ten (10) records, using the Health and Human Services (HHSC) Tool, Information IV, and TAC to develop the PES Comprehensive Review Tool. Detailed data from this review is presented in the findings section below:

IV. Audit Findings/History:
A written process and procedures that clearly outline the eligibility criteria for admission into the Extended Observation Unit (EOU) were developed and implemented by the program. The discharge diagnoses were included in the After Visit Summary of the persons served. Discharge instructions were given consistently to the person served upon discharge. The program consistently documented crisis screening and assessment, the location of the service, and the behavioral description of the presenting problem. The crisis screening/assessment included: Lethality (e.g., suicide, violence), Substance use or abuse, Trauma, abuse, or neglect, the crisis outcome, the names and titles of staff members involved, and all actions, including referrals to address the problem. The prescribing professional assessed and documented the Persons served current and historical information, chief complaint, Psychiatric and medical information, Mental Status Exam, Substance Abuse, Medication history, allergies, and Labs. An up-to-date record of all medications currently prescribed, along with the name of the prescribing professionals. The reason for discharge was not included in the program's discharge documentation. The PES program did not include a summary of services received by the persons served since admission, and the persons served responses to each service provided. No reviews of this type were previously conducted.

V. Recommendations:
It is recommended that the PES program continue to monitor the program's documentation to ensure compliance with TAC, Item V, and Agency Policy and Procedures. The PES program is required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of CPEP and Program Director, including a management response addressing the present findings, and returned to the Compliance Department within seven (7) business days, March 17, 2023.

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP) Division
Psychiatric Emergency Services (PES)
Routine Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: February 10, 2023, to February 21, 2023

Purpose

The purpose of this review was to assess the PES program to ensure crisis services are provided in accordance with the Texas **Administrative Code** (**TAC**), *Title 26 crisis services §301.351(2), §301.351(e), Title 25 Evaluation and Diagnosis (§415.5(f) §415.6(a)(1-5)*; **Information Item V**: Extended Observation unit (EOU) Eligibility *Item V.3.a.b.c, Capacity to Consent Item V.4; Length of Stay Item V.6, Documentation Item V.IV. F.2, Item V. IV. Item V.IV.F.5., Item V. IV. F.5.a.iii, Item V. IV. F.5.a. iv. (1-3), F.5.(b-e), Item V. IV. F.5. f. i-iii (1-3) (h), Item V.IV.G.2. Item V.IV.N.2.a.i.ii, Item V. IV. H.c.(3)(4)(5), Item V.IV.Hd., Free Standing EOU Facility ItemV.IV.D.1.a.,b., Psychiatric Emergency Services Center (PESC) Facility ItemV.IV.D.2.a.i.,ii.,ItemV.IV.D.2.b.i.-v, Admission Status and Egress:ItemV.IV.D.5.a.i.-iii.,ItemV.IV.D.5.c.i.-iii.,ObservationAreaItemV.IV.D.7.a-b., ItemVIV.D.7.c.i.-iii., Staffing ItemV.IV.D.8.b.i.,ii., Item V.IV.D.8.b.iii.(1-5), Item V.IV.D.8.b.iv(2-3), Duties and Responsibilities.ItemV.IV.D.9* (a-f) and **Agency policy and Procedures** *ACCB10B(1-5)*.

Method

Active records were randomly selected from the Compliance Harris County (HC) *Affiliated* (*AFF) Psychiatric Emergency Services Encounter Data report* in the Electronic Health Record (EHR) for persons served during the 1st Qtr. of FY 2023 (September 1, 2022 – November 30, 2022). The Compliance Department conducted a desk review, sampling ten (10) records, using a PES Routine Review tool developed by Compliance. Detailed data from this review is presented in the findings section below:

Findings

The strengths and areas of improvement identified during the review are as follows:

Strengths:

- A written process and procedures that clearly outline the eligibility criteria for admission into the Extended Observation Unit (EOU) were developed and implemented by the program. ***Item V.3.a.b.c***
- The discharge diagnoses were included in the After Visit Summary of the persons served. ***ACCB10B(4)***

- Discharge instructions were given consistently to the person served upon discharge. ***ACCB10B (5).***
- The program consistently documented crisis screening and assessment, the location of the service, and the behavioral description of the presenting problem. ***§301.351(e)(4)(5).***
- The crisis screening/assessment included: Lethality (e.g., suicide, violence), Substance use or abuse, Trauma, abuse, or neglect, the crisis outcome, the names and titles of staff members involved, and all actions, including referrals to address the problem. ***§301.351(e)(6)(7)(8)(9)(10)***
- The prescribing professional assessed and documented the Persons served current and historical information, chief complaint, Psychiatric and medical information, Mental Status Exam, Substance Abuse, Medication history, allergies, and Labs. ***TAC §415.6(a)(1-5)***
- An up-to-date record of all medications currently prescribed, along with the name of the prescribing professionals, was found in the program documentation. Item ***V.IV.F.5.a. iv. (2)***

Areas of Improvement:

- The reason for discharge was not included in the program's discharge documentation ***ACCB10B (2).***
- The PES program did not include a summary of services received by the persons served since admission and the persons served responses to each service provided at discharge ***ACCB10B (3).***

History

No reviews of this type were previously conducted.

Recommendations

It is recommended that the PES program continue to monitor the program's documentation to ensure compliance with TAC, Information Item V, and agency policy and procedures. The PES program is required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of CPEP and Program Director, including a management response addressing the present findings, and returned to the Compliance Department within seven (7) business days, March 17, 2023.

Management Response:
[Insert Response Here]

Signature Page

X

Vice President of CPEP Division

X

Program Director/Manager

X

Compliance Director/Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department (Compliance)
Executive Summary Cover Sheet for the
Plan of Care (POC) Focus Review
New Start Program
Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

I. **Audit Type:**
Focus Review-POI Follow-up

II. **Purpose:**
To ensure the New Start-TCOOMMI program has made improvements to the areas that were identified as deficient based on their previous review. Texas Administrative Codes (TAC) 412.322(d)(1)(C), 412.322(e)(1) (A, B, D, F, G),412.322(e)(2) (A-E), 415.5(e),412.322(f)(1)(A), 412.322(f)(1)(C),412.322(f)(1)(D), agency policy and procedures, ACC3B.

III. **Audit Method:**
Active records were randomly selected from the *Affiliated Harris Center Mental Health Outpatient Treatment Plan* report in the Electronic Health Record (EHR) for persons served during the 1st and 2nd Qtr. of FY 2023 (November 1, 2022 – January 31, 2023). Compliance conducted a desk review, sampling fifteen (15) service entries using the *MH Plan of Care Review Tool*. The following documentation was reviewed: Plan of Care (POC).

IV. **Audit Findings:**
The areas identified as needing improvements were*,* the POCs were not regularly updated to reflect that the Contractor reviewed the plans every ninety (90) days before authorizing continued services. ***TAC §301.353(f)(1)(A*),** the POCs were not signed within ten (10) business days after the date of receipt of notification from the department or its designee that the individual is eligible and has been authorized for routine care services. ***TAC §301.353(e)(1) (A, B, D, F, G) (e)*,** the prescribing professionals did not routinely assess and document current historical psychiatric and medical information before initiating psychoactive medication to persons served. ***TAC §415.5(e),*** the Contractor did not document progress on all goals and objectives, any recommendation for continuing services, any change from current services, or any discharge from services. ***TAC §301.353(f)(1)(D),*** and the goals and objectives did not specifically address the individual's needs, preferences, experiences, cultural background, co-occurring substance use, or physical health disorder and were expressed in terms of overt, observable actions of the individual, using quantifiable criteria reflected the individual's self-direction, autonomy, and desired outcomes. ***TAC* §301.353** ***(e)(2)*** (***A-E***). However, the program identified strengths in these areas; the program consistently followed up on creating POCs in collaboration with the individual and/or legally authorized representative (LAR), if applicable). ***TAC* §301.353(d)(1(C)(A)(B),** and the Contractor regularly determined if the plan adequately addressed the needs of the Individual. ***TAC §301.353(f)(1)(C).*** During the review, Compliance was informed by Program Manager (PM) of the New Start- TCOOMMI program that the implementation of POCs in Continuity of Care (COC) was only being completed because they were required to link clients in the New Start- TCOOMI program to other services in the agency. However. TCOOMMI PGP-01.01, Program Requirements, section IV, states: The Local Mental Health Authority (LMHA) program staff are to ensure that the provision of COC includes the following elements; 1. Identification of medical, psychiatric or psychological treatment needs; 2. Develop and coordinate referrals based on identified educational, vocational, housing, transportation and other rehabilitative needs; 3. Determine compliance with medication and treatment objectives; 4. Develop and provide a copy of the treatment plan to the client; 5. Provide written monthly updates regarding the client's progress in treatment to include medication compliance to the Supervising Officer; 6. Coordinate and prepare the client for transition to community-based services to include transfer to non-TCOOMMI LMHA programs.

V. **Recommendations:**
Compliance recommends that the New Start-TCOOMMI program continue to follow the corrective measures currently in place within their Corrective Action Plan (CAP) and adjust its program processes to ensure documentation is completed in accordance with TAC and agency guidelines. Compliance also recommends that the New Start-TCOOMMI Program collaborate with Performance Improvement Department (PI) to resolve POC issues within their program. The Vice President (VP) of the MH Division and the Program Manager/Director of the New Start-TCOOMMI program should return the signed report with management response, acknowledging receipt of this report to Compliance within seven (7) business days.

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
New Start Program
Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)
Focus Review- POI Follow-up

Compliance Auditor(s): Carla Reynolds

Review Dates: February 23rd, 2023, – March 1, 2023

Purpose

The purpose of this review is to ensure the New Start-TCOOMMI program has made improvements to the areas that were identified as deficient based on their previous review. Texas Administrative Codes (TAC) 412.322(d)(1)(C), 412.322(e)(1) (A, B, D, F, G),412.322(e)(2) (A-E), 415.5(e),412.322(f)(1)(A), 412.322(f)(1)(C),412.322(f)(1)(D), agency policy and procedures, ACC3B.

Method

Active records were randomly selected from the *Affiliated Harris Center Mental Health Outpatient Treatment Plan* report in the Electronic Health Record (EHR) for persons served during the 1st and 2nd Qtr. of FY 2023 (November 1, 2022 – January 31, 2023). Compliance conducted a desk review, sampling fifteen (15) service entries using the *MH Plan of Care Review Tool*. The following documentation was reviewed: Plan of Care (POC). Detailed data from this review is presented in the findings section below:

Findings:

The strengths and areas of improvement are identified as follows:

Strengths:

- The program consistently created POCs in collaboration with the individual and/or Legally Authorized Representative (LAR), if applicable). ***TAC*** **§301.353(d)(1) (C) (A)(B) Improved from last review.**
- The provider regularly determined if the plan adequately addressed the needs of the Individual. ***TAC §301.353(f)(1)(C)***

Areas of Improvement:

- The POCs were not regularly updated to reflect that the provider reviewed them every ninety (90) days before authorizing continued services. ***TAC §301.353(f)(1)(A*****) No Improvement since the last review**
- The POCs were not signed within ten (10) business days after the date of receipt of notification from the department or its designee that the individual is eligible and has been authorized for routine care services. ***TAC §301.353(e)(1) (A, B, D, F, G) (e).*** **No Improvement since the last review**
- The prescribing professionals did not routinely assess and document current historical psychiatric and medical information before initiating psychoactive medication to persons served. ***TAC §415.5(e)***

- The Contractor did not document progress on all goals and objectives, any recommendation for continuing services, any change from current services, or any discharge from services. ***TAC §301.353(f)(1)(D)***
- The goals and objectives did not reflect the individual's self-direction, autonomy, and desired outcomes. ***TAC* §301.353 *(e)(2)* (*A-E)***

History

The Compliance Department conducted a POC review of the New Start program during the 3rd quarter (QTR.) of the fiscal year (FY) 2020 for services completed during the 2nd QTR. from (December 1, 2019 – February 29, 2020) sampling thirty (30) records and The Compliance Department conducted a POC review, during the 3rd OTR, FY 2022 for services completed during the 2nd QTR., from (December 1, 2021 -February 28th, 2022).

Observations

During the review, Compliance was informed by Program Manager (PM) of the New Start- TCOOMMI program that the implementation of POCs in Continuity of Care (COC) was only being completed because they were required to link clients in the New Start- TCOOMI program to other services in the agency. However. TCOOMMI PGP-01.01, Program Requirements, section IV, states: The Local Mental Health Authority (LMHA) program staff are to ensure that the provision of COC includes the following elements; 1. Identification of medical, psychiatric or psychological treatment needs; 2. Develop and coordinate referrals based on identified educational, vocational, housing, transportation and other rehabilitative needs; 3. Determine compliance with medication and treatment objectives; 4. Develop and provide a copy of the treatment plan to the client; 5. Provide written monthly updates regarding the client's progress in treatment to include medication compliance to the Supervising Officer; 6. Coordinate and prepare the client for transition to community-based services to include transfer to non-TCOOMMI LMHA programs.

Recommendations

Compliance recommends that the New Start-TCOOMMI program continue to follow the corrective measures currently in place within their Corrective Action Plan (CAP) and adjust its program processes to ensure documentation is completed in accordance with TAC and agency guidelines. Compliance also recommends that the New Start-TCOOMMI Program collaborate with Performance Improvement Department (PI) to resolve POC issues within their program. The Vice President (VP) of the MH Division and the Program Manager/Director of the New Start-TCOOMMI program should return the signed report with management response, acknowledging receipt of this report to Compliance within seven (7) business days, by close of business March 17th, 2023.

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Management Response:

Mgt will continue with monthly meetings regarding POCs to ensure compliance with documenting progress or that lack of at initial and updating of POC. As mentioned before, staff members work collaboratively in identifying goals of clients; however, we will continue to train staff on putting quotations for goals to reflect client's self-direction, autonomy, and desired outcomes. Mgt will continue to work on ensuring POCs are signed within 10 days of receipt. POCs that were in review were fairly new and none of them exceeded the 90-day timeframe, this is something that has been improved on since the last review. The prescribers routinely review medications at each visit with the clients, especially at intake since most of NS clients have received medications from other prescribers,

Signature Page

while incarcerated or at medical/psychiatric hospitalizations. POCs that are created at COC level are not seen by the prescriber at the time the initial plan is created since COC is for eligibility purposes.

X Lance Britt

Vice President of MH

3/17/2023

X Shannon Chenier, LPC

Shannon Chenier, LPC
Practice Manager IV
Signed by: ShannonCert

X

Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Duplicate/Overlaps Review
Mental Health (MH) Division
Child and Adolescent Services (CAS)
Review Date: February 14- March 7, 2023

I. **Audit Type:**
Focus

II. **Purpose:**
The purpose of this review was to assess the Mental Health (MH) Child and Adolescent Service programs service documentation for possible overlaps in time.

III. **Audit Method:**
Compliance ran the report, *AFF HC Encounter Data OP Services Details Report* in the Electronic Health Record (EHR) system to identify any instances of overlaps in services or duplicate services by the MHCAS programs during the 2nd Qtr. of FY 2023 (February 14, 2023- March 7, 2023). Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings/History:**
Of the records reviewed for the CAS programs the findings are in the following areas: Overlaps- providing services to different individuals during the same date and time. Place of service, Coding- unable to determine appropriate coding for encounters. Missing information from the progress note, based on progress note template. Progress note was not finalized within 48-hour. Expired and/or services not authorized on POC. Visit type does not match documented progress note. Type of contact/ place of contact/ person contacted. Use of incorrect pronouns within the progress note possible copy/paste. Another individual's name identified in progress note. The Compliance Department conducted a duplicate/overlap Desk Focus review for the MH Division CAS programs during the 3rd quarter (Qtr.) of fiscal year (FY) 2020.

V. **Recommendations:**
It is recommended the MHCAS program review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services and ensure that services are document in accordance with TAC, Agency guidelines, and other regulations. MHCAS programs should conduct this type of review monthly to monitor services for possible overlaps. The MHCAS programs are not required to submit a plan of improvement 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 close of business.

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Northeast Child and Youth Family Wellness Center
Duplicate/Overlap Services Focus Review

Compliance Auditor(s): Christopher Webb and Coneka Caleb

Compliance Review: February 14, 2023- March 7, 2023

Purpose

The purpose of this review was to assess the NE Child and Youth Family Wellness Center program for overlapping service documentation. In addition to this review, progress notes were reviewed to determine if they met the compliance requirements of the Texas Administrative Code (TAC) *§301.361 Documentation of Service Provision.*

Method

Compliance ran the *AFF HC Encounter Data OP Services Details Report* in the Electronic Health Record (EHR) system to identify any instances of overlaps in services or duplicate services by the NE Child and Youth Family Wellness Center program during the 2nd Qtr. of FY 2023 (February 14, 2023- March 7, 2023). Detailed data for the services reviewed are presented in the findings section below.

Findings

Of the records reviewed for NE Child and Youth Family Wellness Center program there were twelve (12) clear overlaps of time for services. There were also subsequent issues found with the progress notes in the following areas:

- Two (2) progress notes were missing the location where the service was provided, modality of service provision (i.e., individual or group) and the method of service provision. *§301.361 (a) (5, 7-8)*
- One (1) progress note was not completed within two business days after contact occurred. *§301.361 (b)*

Observations

In preparing for the review Compliance discovered that there is not currently a system in place for preventing and identifying overlapping services in the Epic system.

The HARRIS CENTER for Mental Health and IDD

History

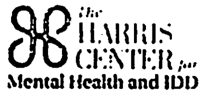
There are no previous reviews for duplicate/ overlap services.

Recommendations

It is recommended the NE Child and Youth Family Wellness Center program review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, document in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. NE Child and Youth Family Wellness Center program should continue to monitor services to ensure duplicate/overlap services are prevented. The NE Child and Youth Family Wellness Center program is not required to submit a plan of improvement 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 close of business April 12, 2023.

Management Response:

NE Child Youth and Family Wellness Center will collaborate with BO to minimize overlaps. Additionally, staff will be reminded to review progress notes for overlapping errors.



Signature Page

X *Lance Britt*

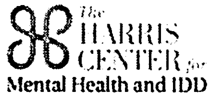
Vice President of MH Division

X *[signature]* 4-3-23

Program Director/Manager

X *Demetria Martin*

Compliance Manager



Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Southwest (SW) Child and Adolescent Services (CAS)
Duplicate/Overlap Services Focus Review

Compliance Auditor(s): Christopher Webb and Coneka Caleb

Compliance Review: February 14, 2023- March 7, 2023

Purpose

The purpose of this review was to assess the Southwest (SW) Child and Adolescent Services (CAS) program for overlapping service documentation. In addition to this review, progress notes were reviewed to determine if they met the compliance requirements of the Texas Administrative Code (TAC) *§301.361 Documentation of Service Provision, §301.353 Provider Responsibilities for Treatment Planning and Service Authorization,* and *Agency Policy and Procedure ACC3B Plan of Care.*

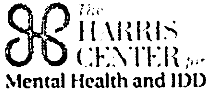
Method

Compliance ran the *AFF HC Encounter Data OP Services Details Report* in the Electronic Health Record (EHR) system to identify any instances of overlaps in services or duplicate services by the SWCAS during the 2nd Qtr. of FY 2023 (February 14, 2023- March 7, 2023). Detailed data for the services reviewed are presented in the findings section below.

Findings

Of the records reviewed for SWCAS there were ninety- five (95) clear overlaps of time for services. There were also subsequent issues found with the progress notes in the following areas:

- One (1) staff documented four (4) progress notes that overlapped time while providing two (2) separate services to the same individual.
- Twelve (12) progress notes were missing the modality of service provision (i.e., individual or group) and the method of service provision. *§301.361 (a) (7-8)*
- One (1) progress note documented the use of incorrect pronoun.
- Nine (9) progress notes were not completed within two business days after contact occurred. *§301.361 (b)*



- Nine (9) POCs were not developed within 10 business days after the date of receipt of notification from the department or its designee that the individual is eligible and has been authorized for routine care services. *§301.353 (e)*

Observations

In preparing for the review Compliance discovered that there is not currently a system in place for preventing and identifying overlapping services in the Epic system.

History

There are no previous reviews for duplicate/ overlap services.

Recommendations

It is recommended the SWCAS program review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, document in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. SWCAS program should continue to monitor services to ensure duplicate/overlap services are prevented. The SWCAS program is not required to submit a plan of improvement 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 close of business April 12, 2023.

Management Response:

PM Georgetta Medlock reviewed the attached report with its findings , comments were added and spreadsheet forwarded to Compliance. Although the review period was for the month of September 2022, PM appreciated the comments highlighting deficiencies for October 2022. PM reviewed the deficiencies noted, shared with SW CAS MD's and met with all SW CAS CTLs. All CTLs are aware of the concerns and the concerns will be addressed either individually during 1:1 supervision and/or with the team during team meetings . Additional recommendations made above will be followed i.e. collaborating with Business Office to clarify service dates and times.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

Recoverable Signature

X Georgetta M. Medlock 4-3-23

Program Director/Manager
Signed by: Georgetta Medlock

X Demetria Martin

Compliance Manager

Compliance Department (Compliance) Review Report:
2nd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Southeast (SE) Child and Adolescent Services (CAS)
Duplicate/Overlap Services Focus Review

Compliance Auditor(s): Christopher Webb and Coneka Caleb

Compliance Review: February 14, 2023- March 7, 2023

Purpose

The purpose of this review was to assess the SECAS program for overlapping service documentation. In addition to this review, progress notes were reviewed to determine if they met the compliance requirements of the Texas Administrative Code (TAC) *§301.361 Documentation of Service Provision*, *§301.353 Provider Responsibilities for Treatment Planning and Service Authorization,* and *Agency Policy and Procedure ACC3B Plan of Care.*

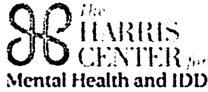
Method

Compliance ran the *AFF HC Encounter Data OP Services Details Report* in the Electronic Health Record (EHR) system to identify any instances of overlaps in services or duplicate services by the SECAS during the 2nd Qtr. of FY 2023 (February 14, 2023- March 7, 2023). Detailed data for the services reviewed are presented in the findings section below.

Findings

Of the records reviewed for SECAS there were one hundred and eighty (180) clear overlaps of time for services. There were also subsequent issues found with the progress notes in the following areas:

- Twelve (12) POCs were expired. *§301.353* and *ACC3B, Review of Plan of Care*
- One (1) progress note documented a Recovery Plan Objective that was not identified on POC. *ACC3B, Review of Plan of Care (a)*
- Fifteen (15) progress notes were missing the location where the service was provided, modality of service provision (i.e., individual or group) and the method of service provision. *§301.361 (a) (5, 7-8)*
- Sixteen (16) progress notes documented the use of incorrect pronouns.
- Nine (9) progress notes were not completed within two business days after contact occurred. *§301.361 (b)*



Observations

In preparing for the review Compliance discovered that there is not currently a system in place for preventing and identifying overlapping services in the Epic system.

History

There are no previous reviews for duplicate/ overlap services.

Recommendations

It is recommended the SECAS program review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, document in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. SECAS program should continue to monitor services to ensure duplicate/overlap services are prevented. The SECAS program is not required to submit a plan of improvement 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 close of business April 12, 2023.

Management Response:

This is the management response in reference to the Compliance overlapping audit.

1. *In reference to expired POCs the SECAS PM and CTLs work the POC tx plan report weekly as of Jan 2023 to keep track of lapsed POCs.*
2. *In reference to the (1) progress note that identified an objective that was not on the POC the CTL to retrain CC on documentation of notes, POC, including overlaps, completing all sections and correctly completing each section.*
3. *In reference to (15) notes missing the location where the service was provided this PM found that information to be incorrect. All MD notes cited clearly identified where the MD was located and where the pt was located. Billing is documented according to where the pt is located. When the MD documented "O = office" for the pt but the service was electronic it was clearly documented that the physician was virtual or providing the service via "Lifesize".*

The Harris Center for Mental Health and IDD

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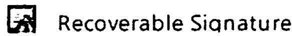
4. *In reference to (16) notes where the physician used the incorrect pronouns this PM also found this citation to be incorrect. Of all notes reviewed the gender of the note matched the gender listed in "Epic" in the demographic. If there is an instance where a different gender is noted in the chart it is documented that the pt identifies as that gender and wants that gender documented.*
5. *In reference to (9) notes that were not submitted in (2) business days the office supervisor runs the TOD report twice monthly. The PM and CTLs have been regularly reviewing TOD to improve submission within 2 business day timeframe. TOD is reviewed in supervision and is a continuous work in progress since the transition to Epic.*

X Lance Britt

Vice President of MH Division



Recoverable Signature

X Dana R.W. Brown, M.S., LPC 4-3-23

Dana R. W. Brown, M.S., LPC
Program Director/Manager
Signed by: Dana R.W. Brown, M.S., LPC

X Demetria Martin

Compliance Manager

Mental Health Rehabilitation (MHR) & Mental Health Targeted Care Management (MHTCM) Provider Review Feedback	
UM Completing Review:	Erin McLean, MA LPC
Quarter of Visit:	Q4 2022
Date Span Reviewed:	7/1/22-9/30/22
Date of Initial Feedback:	12/6/2022
Date of Feedback Meeting:	Thursday, December 8, 2022

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	OVERALL CHART AVERAGE
Member Name					
Please Indicate: Adult or Child/Adolescent	Child/Adolescent	Child/Adolescent	Child/Adolescent	Child/Adolescent	
OVERALL ***CHART*** COMPLIANCE	100.00%	93.48%	93.48%	93.48%	95.11%
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%	87.50%	87.50%	87.50%	90.63%
Reference:		TAC Rule 354.2607 (b)	TAC Rule 354.2607 (b)	TAC Rule 354.2607 (b)	
Example area of opportunity:		No name, signature or credentials of diagnosing clinician present	No name, signature or credentials of diagnosing clinician present	No name, signature or credentials of diagnosing clinician present	
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%
Reference:	TAC Rule 354.2609				
Example area of opportunity:	Barriers to Treatment section blank, but was able to see what needs were from client goals. Please continue to list needs in the barriers/needs section. No points taken.				
Section 3: Progress Notes (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)	100.00%	85.71%	85.71%	85.71%	89.28%
Reference:		TRR UM Guidelines	TRR UM Guidelines	TRR UM Guidelines	
Example area of opportunity:		Only received June and September wraparound plans- please provide July & August wraparound plans	No wraparound plan provided for September- please provide	No wraparound plan provided for September- please provide	
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?	Yes	N/A	N/A	N/A	
If no, was utilization above or below the average?					
	2.3 hours (LOC2 ~3 hours)	3.25 hours (LOC YES =n/a)	3.75 hours (LOC YES =n/a)	2.75 hours (LOC YES =n/a)	

Additional Comments from Reviewing UM Staff:

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%

% Met	Elements for Review	Expectations	Findings/Comments
	Notifications		
100.00%	**Your Rights in Local Authority Services Handbook** §4.107, §4.117(c)&(e), §4.119(a)&(d)	• Initial/Annual use of approved DADS rights handbook: Your Rights in Local Authority Programs	
100.00%	**LIDDA's Complaint & Appeal Process** §2.46(c)&(d), §2.307(c)(5)	• Complaint Process Notification	
100.00%	**Explanation of IDD Services and Supports** Publication No. DADS-245, Attachment A-1 2.71(D), Attachment A-7, LIDDA HB 6200, §2.305(b)(1), § 2.307(A)	• Initial/Annual Explanation of IDD Services and Supports-Publication NO. DADS-245 • IOP changes as necessary	
	Plan Development		
100.00%	**Service Coordination Assessment** §331.7(a)(1)(A)&(C)	• SC Assessment	
25.00%	**Person/Family Directed the Plan of Services and Supports** Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	See debriefing pages.
100.00%	**Discovery Process** **§L.331.11(a)**	• Discovery Process	
95.45%	**Plan of Services and Supports Content** Attachment A-11, §2.307(e)(1)(A), §2.307(e)(2), §331.5(33)(A)(B)&(C), §331.11(a)(2)	• Plan of Services & Supports (A) describes the desired outcomes to be achieved by the person (B) describes the services & supports to be provided, including service coordination; (C) identifies the frequency and duration of service coordination to be provided	See debriefing pages.
100.00%	**Service Coordination Plan** §331.5(33)(B)&(C), §331.5(36)(A),(B),(C)&(D), §331.7(a)(1), §331.11(d)(1)&(2)	• Based on SC Assessment • Describe one or more elements of SC & identifies frequency and duration.	

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%

Service Coordination & Service Delivery			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Revising Plan of Services & Supports §331.11(c)(1)&(2)**	• Revising Plan of Services & Supports when needs change	
90.67%	**Monitoring Services & Minimum Contact** §331.5(36), §331.11(b),(c),(d), §331.21 §331.11(b)(1)(A), §331.11(d)(1)	• Monitors delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	See debriefing pages.
100.00%	**Service Coordination Follow-up** §331.5(36)(A)-(D), §331.11 (d)(2)	• Service Coordination follow-up activities	
90.57%	**Reporting Progress Towards Outcomes** §331.21 (a)(3), §331.5(36)(A)-(D), §331.11(b)&(d)	• Reporting progress/lack of progress towards all outcomes at least every 90 days	See debriefing pages.
100.00%	**Ensuring GR Service Delivery** Attachment A-1, 2.7.2, Attachment A-3, §2.305(b)(1), §2.311(a); LIDDA HB 17230	• All IDD services offered and implemented in timely manner	
100.00%	**Providing Service Coordination** §2.307(d)(1)&(2)	• Service coordination offered to each Medicaid, Medicaid-ineligible person	

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%

CFC Functions			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**CFC Enrollment: Initial Eligibility Determination Activities** Attachment A-11, LIDDA HB 17130	• Complete ID/RC Assessment to determine LOC	
Not reviewed	**CFC Enrollment: SPT Meeting** Attachment A-11, LIDDA HB 17130	• Assign service coordinator • Schedule SPT and complete initial CFC service planning documents and activities • Identify joint meeting date	
Not reviewed	**CFC Enrollment: Documents sent for Joint Meeting with MCO** Attachment A-11 1.3, LIDDA HB 17230	• Complete Form 1040 and send service planning documents to MCO	
100.00%	**CFC Annual Reassessment** Attachment A-11 1.3, LIDDA HB 17200, 17230	• Communicate with MCO • Schedule SPT and complete annual CFC service planning documents and activities • Identify joint meeting date	
100.00%	**CFC Annual Service Planning** Attachment A-11 1.3, LIDDA HB 17230	• Complete Form 1040 and send annual service planning documents to MCO	

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%

Rights			
% Met	Elements for Review	Expectations	Findings/Comments
Not reviewed	**Rights Protection** §2.313(a)&(b)(1),(2)&(3)	• Rights Protection	
100.00%	**Guardianship** §4.107, §2.313	• Determine, at least annually, if the letters of guardianship are current • Make a referral of guardianship, if appropriate	
Not reviewed	**Financial Management (Consent)** §G.2.305(b)(9)	• Current consent to manage finances	
Not reviewed	**Behavioral Support Plan** §2.313(b),(c),(e),(f)	• BSP developed by qualified staff with SPT and approved by RPO • BSP consistent with Plan of Services & Supports • BSP reviewed and approved by SPT at least annually • BSP is monitored for effectiveness	
Not reviewed	**Psychotropic Medications** §2.313(d)	• Annual informed consent for medication prescribed by physician employed or contracted by LIDDA.	
Not reviewed	**Program Specific Training** §331.19 (b)(1)(G), §2.111	• Service Coordinators have trainings specific to providing service coordination to persons receiving CFC services or requiring Financial Assessments.	

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%

ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
Your Rights in Local Authority Services Handbook	40	0	140	NO corrections are required for this element	
LIDDA's Complaint & Process	8	0	52	NO corrections are required for this element	
Explanation of IDD Services & Supports	16	0	164	NO corrections are required for this element	
Service Coordination Assessment	6	0	14	NO corrections are required for this element	
Discovery Process	10	0	30	NO corrections are required for this element	
Person/Family Directed the Plan of Services & Supports	5	15	380	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Plan of Services & Supports Content	21	1	78	A SPECIFIC correction is required for each finding in this element	
Service Coordination Plan	15	0	45	NO corrections are required for this element	
Revising Plan of Services & Supports	4	0	36	NO corrections are required for this element	
Monitoring Services & Minimum Contact	136	14	420	A SPECIFIC correction is required for each finding in this element	
Service Coordination Follow-up	1	0	19	NO corrections are required for this element	
Reporting Progress Towards Outcomes	48	5	385	A SPECIFIC correction is required for each finding in this element	
Ensuring Service Delivery	10	0	30	NO corrections are required for this element	
Providing Service Coordination GR	4	0	56	NO corrections are required for this element	
CFC Enrollment: Initial Eligibility Determination Activities	2	0	18	NO corrections are required for this element	
CFC Enrollment: SPT Meeting	0	0	140	Not Applicable	
CFC Enrollment: Documents sent for Joint Meeting with MCO	0	0	120	Not Applicable	
CFC Annual Reassessment	20	0	140	NO corrections are required for this element	
CFC Annual Service Planning	15	0	105	NO corrections are required for this element	
Rights Protection	0	0	140	Not Applicable	
Guardianship	4	0	36	NO corrections are required for this element	
Financial Management (Consent)	0	0	20	Not Applicable	
Behavioral Support Plan	0	0	280	Not Applicable	
Psychotropic Medications	0	0	20	Not Applicable	
Program-Specific Training	0	0	1	Not Applicable	
PARTICIPANT GRAND TOTALS	**365**	**35**	**2869**	**PARTICIPANT GRAND TOTAL SCORE**	**91.06%**

Cecile Erwin Young
Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS
280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%	

In accordance with FYs 2022 and 2023 Performance Contract, for any item of non-compliance remaining uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after receiving a notice of deficiency, submit to HHSC a Corrective Action Plan (CAP).

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **March 10, 2023**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA’s request for reconsideration within 15 calendar days after receiving the request.

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GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD

01/23/23 - 01/26/23

General Revenue and CFC	91.06%	

In accordance with the FYs 2022 and 2023 Performance Contract, Attachment C. Article 3 and Article 4.1.1, the QA Debriefing page is shared at the time of the Exit Conference. The Authority Review report will be shared with the LIDDA and Contract Manager once the report has been finalized. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC specified remedies or sanctions after receipt of the CAP.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

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IDD Contracts Unit Intellectual and Developmental Disabilities Services, IDD-BH -Mail Code W-354

P.O. Box 149030

Austin, TX 78714-9030

Please extend our appreciation to your staff for their cooperation during this review. If you have any questions or require additional information, please contact:

Denice Cadena **Email:** **denice.cadena@hhs.texas.gov**

Denice Cadena, Contract Specialist, Facilitator
Charvey Betts, Contract Specialist
Sharon Cummings, Contract Specialist
Blake Hensley, Contract Specialist
Marselena Hernandez, Contract Specialist
Mercedes Hernandez, Contract Specialist
Tondria Jones, Contract Specialist
Kristina McClure, Contract Specialist
Donna Pendleton, Contract Specialist
Veronica Reyes, Contract Specialist

TEXAS Health and Human Services

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Executive Commissioner

GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP) See attachment for instructions to LIDDA						
Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	For G1, the outcome associated with the CFC service of PAS/HAB in the PDP dated 8/25/22 was not supported by the discovery information.	**Specific:**	G1-Assigned Service Coordinator will convene the SPT. During this meeting the discovery process will be utilized to gather information to support the CFC PAS/HAB person centered outcome. The PDP/CFC Assessment dated 8/25/22 will be revised to evidence the addition of this discovery information.	Kenyonika Johnson, Program Director or designee	5/9/2023
Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	For G4, the outcomes associated with the GR service of Behavior Supports, the CFC service of PAS/HAB "Wants to lose weight" and "Wants to cook nutritious meals independently," and the non-GR service of PCP were directed by someone else in the PDP and the CFC Assessment dated 6/23/22. For G4, the outcomes associate with the CFC service of PAS/HAB "Wants to budget her money independently" and the GR service of Community Supports in the PDP and the CFC Assessment dated 6/23/22 were not supported by the discovery information. For G4, the outcome associated with the non-GR service of Gastroenterologist was a service statement in the CFC Assessment dated 6/23/22.	**Specific:**	G4-Assigned Service Coordinator will convene the SPT. During this meeting, discovery information from the individual will be gathered to determine person centered outcomes for the GR service of Behavior Support, the CFC PAS/HAB service as well as the non-GR service of PCP. The PDP and CFC Assessment dated 6/23/22 will be revised accordingly. Also during this meeting, the discovery process will be utilized to gather information to support the CFC PAS/HAB person centered outcome "Wants to budget her money independently" and the GR service of Community Supports. The PDP and CFC Assessment dated 6/23/22 will be revised to evidence the addition of this discovery information. During this meeting, the discovery process will be utilize to develop an outcome for the non-GR service of Gastroenterologist that is person centered and not a service statement. The CFC Assessment dated 6/23/22 will be revised to relfect the updated outcome. Discussion to reflect the outcome of this meeting and changes to the PDP/CFC Assessment will be reflected in the Service Coordinator's progress note.	Kenyonika Johnson, Program Director or designee	5/9/2023

TEXAS Health and Human Services

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GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

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Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	For G5, the outcome associated with the GR service of Day Habilitation and one of outcomes associated with the CFC service of PAS/HAB "G5 would like to make important decisions on his own" in the PDP dated 6/15/22 were not supported by the discovery information. For G5, the outcome associated with the GR service of Respite did not justify the service in the PDP dated 6/15/22. For G5, one of the outcomes associated with the CFC service of PAS/HAB "G5 would like to learn to trust others" was a service statement in the PDP dated 6/15/22.	**Specific:**	G5-Assigned Service Coordinator will convene the SPT. During this meeting, the discovery process will be utilized to gather information to support the GR service of Day Habilitation and the CFC PAS/HAB outcome of "would like to make important decisions on his own". The PDP and CFC Assessment dated 6/15/22 will be revised to evidence the addition of this discovery information. During this meeting the outcome associated with the GR service of Respite will be revisited. Discovery information will be gathered and utilized to develop an outcome that is both person centered and justifies the use of this service. The PDP dated 6/15/22 will be revised to reflect this information. During this meeting, the discovery process will be utilized to develop an outcome for the CFC service of PAS/HAB (Socialization/Development of Relationships HAB) that is person centered and not a service statement. The CFC Assessment dated 6/15/22 will be revised to relfect the updated outcome. Discussion to reflect the outcome of this meeting and changes to the PDP/CFC Assessment will be reflected in the Service Coordinator's progress note.	Kenyonika Johnson, Program Director or designee	5/9/2023
Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	For CFC1, the outcomes associated with the CFC service PAS/HAB were directed by someone else in the CFC PAS/HAB Assessment dated 6/23/22. For CFC1, the outcome associated with the non-CFC service of PCP was a service statement in the CFC PAS/HAB Assessment dated 6/23/22.	**Specific:**	CFC1-Assigned Service Coordinator will convene the SPT. During this meeting, discovery information from the individual will be gathered to determine person centered outcomes for the CFC service of PAS/HAB. The CFC Assessment dated 6/23/22 will be revised accordingly. During this meeting, the discovery process will also be utilized to develop an outcome for the non-CFC service of PCP that is person centered and not a service statement. The CFC Assessment dated 6/23/22 will be revised to relfect the updated outcome. Discussion to reflect the outcome of this meeting and changes to the CFC Assessment will be reflected in the Service Coordinator's progress note.	Kenyonika Johnson, Program Director or designee	5/9/2023
Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	**A SYSTEMIC and MONITORING**	**Systemic:**	All Service Coordinators will participate in a refresher training on writing person centered outcomes. The training will include guidance on how to utilize the discovery process to ensure the outcomes reflect the individuals'/LARs' desires and preferences. Training will be evidenced by agenda and attendance log.	Kenyonika Johnson, Program Director or designee	Ongoing

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GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP) See attachment for instructions to LIDDA						
Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Person/Family Directed the Plan of Services and Supports Attachment A-11, §331.5(33)(A),(B)&(C), 331.11(a)	• Person/Family Directed the Plan of Services & Supports • Outcomes are Person Centered and reflect the Person's/LAR's preference.	**correction is required for each finding in this element**	**Monitoring:**	The assigned Program Director, Team Leader or designee will review at least (2) charts per program at least every fiscal quarter to ensure compliance addressing the outcomes; ensuring they are person centered and not service statements. Any findings will be documented on a review tool which will measure if the outcomes are person-centered or service statements. Program Director or designee will follow up to ensure appropriate corrections are made. Documentation to evidence the outcome of the reviews will be shared with the IDD SC Director. Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the SC Mentor.	Kenyonika Johnson, Program Director or designee	Ongoing
Plan of Services and Supports Content Attachment A-11, §2.307(e)(1)(A), §2.307(e)(2), §331.5(33)(A)(B)&(C), §331.11(a)(2)	• Plan of Services & Supports (A) describes the desired outcomes to be achieved by the person (B) describes the services & supports to be provided, including service coordination; (C) identifies the frequency and duration of service coordination to be provided	For G3, there was no evidence the non-GR services of PCP and Gynecologist were included in the PDP dated 9/25/22 with person-centered outcomes, although discovery information stated G3 received these services.	**Specific:**	G3-Assigned Service Coordinator will convene the SPT. During this meeting, the SC will confirm the discovery information from the individual to support and develop person centered outcomes for the non-GR services of PCP and Gynecologist. The PDP dated 9/25/22 will be revised accordingly. Discussion to reflect the outcome of this meeting and changes to the PDP will be reflected in the Service Coordinator's progress note.	Kenyonika Johnson, Program Director or designee	5/9/2023
Monitoring Services & Minimum Contact §331.5(36), §331.11(b),(c),(d), §331.21 §331.11(b)(1)(A), §331.11(d)(1)	• Monitors delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	For G2, there was no evidence of monitoring satisfaction with the GR services of Nursing and Employment Assistance from the perspective of the LAR during the third 90-day reporting period for the PDP dated 2/16/22.	**Specific:**	G2-This deficiency cannot be corrected as the timeframe to correct it has passed. Moving forward the Service Coordinator will monitor the satisfaction of the GR services of Nursing and Employment assistance from the perspective of the LAR at least once during each 90 day reporting period.	Kenyonika Johnson, Program Director or designee	5/9/2023
Monitoring Services & Minimum Contact §331.5(36), §331.11(b),(c),(d), §331.21 §331.11(b)(1)(A), §331.11(d)(1)	• Monitors delivery of and satisfaction with all services at least every 90 days • FTF contact at least every 90 days/in accordance with SC Plan	For G4, there was no evidence of monitoring delivery of and satisfaction with the non-GR services of PCP and Gastroenterologist and the GR services of Community Supports and Behavioral Supports during the first and second 90-day reporting periods for the PDP/CFC Assessment dated 6/23/22	**Specific:**	G4-This deficiency cannot be corrected as the timeframe to correct it has passed. Moving forward the Service Coordinator will monitor the delivery and satisfaction of the non GR services of PCP and Gastroenterologist as well as the GR services of Community Supports and Behavior Supports at least once during each 90 day reporting period.	Kenyonika Johnson, Program Director or designee	5/9/2023

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GENERAL REVENUE - COMMUNITY FIRST CHOICE REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP)
See attachment for instructions to LIDDA

Elements for Review	Expectations	Findings	CAP See attachment for instructions to LIDDA		Responsible LIDDA Manager(s)	Projected Completion Date
Reporting Progress Towards Outcomes §331.21 (a)(3), §331.5(36)(A)-(D), §331.11(b)&(d)	• Reporting progress/lack of progress towards all outcomes at least every 90 days	For G4, there was no evidence of reporting progress/lack of progress towards the outcomes associated with the GR services of Specialized Services, Behavioral Supports, and Community Supports during the fourth 90-day reporting period for the PDP dated 7/28/21. For G4, there was no evidence of reporting progress/lack of progress towards the outcomes associated with the GR service Community Supports and the non-GR service of PCP during the first and second 90-day reporting periods for the PDP/CFC	**Specific:**	G4-This deficiency cannot be corrected as the timeframe to correct it has passed. Moving forward the Service Coordinator will monitor the progress/lack of progress of the outcomes associated with the GR services of Behavior Supports and Community Supports as well as the non-GR service of PCP at least once during each 90 day reporting period. **Note: "Specialized Services" is not a service authorized on the PDP dated 7/28/21	Kenyonika Johnson, Program Director or designee	5/9/2023

The CAP must be submitted to the Contract Manager, within 30 calendar days, after receiving notice of any deficiency identified in the Report of Findings.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

For Hard Copy Submission: HHSC-IDD Services, Access and Intake-Mail Code W-354
Attn: Tom Best, Performance Contract Manager

TEXAS Health and Human Services

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Executive Commissioner

Home and Community-Based Services Authority Review
FY 2023 Report of Findings

280 - The Harris Center for Mental Health and IDD
01/23/23 - 01/26/23

OVERALL	92.10%

LIDDA Requirement for Providing Service Coordination			
% Met	Elements for Review	Expectations	Findings/Comments
Not Reviewed	**HCS Complaint/ Concern Resolution** §9.190(c), §9.190(d)	• Provider complaint process • Concern resolution	
100.00%	**Rights Protection & Guardianship** §9.190(e)(1), §9.190 (e)(18), §9.190(e)(17), §4.107, §2.313 **Rights Presentation** §9.190(e)(2); HCS HB 2160 & 16100 **Rights Documentation** §9.190(e)(2),(3),(4); HCS HB 2160 & 16000	**Rights and Guardianship** • Assist exercising the legal rights • Determine, at least annually, if the letters of guardianship are current; if appropriate • Make a referral of guardianship, if appropriate • Use of approved HHSC Rights publications and booklets for HCS • Document presentation of rights	
100.00%	**Consumer Record** §9.190(e)(5)	• Maintain required consumer record documentation	
59.09%	**Person/Family Directed Services** §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	See debriefing pages.
97.18%	**PDP Content** §9.190(b)(3-4), §9.190(e)(8), §41.404	• Full range of services and resources • Description of CDS back up plan, if required • Service backup plan approval prior to implementation, • Service backup plan review during monitoring and annually • Include a description CDS service component(s)	See debriefing pages.
100.00%	**HCS Program Enrollment** § 9.190(e)(8)	• Develop initial IPC with person	
	§ 9.190(e)(9)	• Required elements of the initial IPC	

Home and Community-Based Services Authority Review
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% Met	Elements for Review	Expectations	Findings/Comments
	HCS Program Enrollment (continued) §9.158(e)(1)	• Other SC enrollment responsibilities	
		• Provision of required enrollment documentation to program provider and FMSA, if applicable	
100.00%	**CDS requirements** §9.168(a-c), §9.190(e)(8)	• Inform about CDS Option, if applicable	
		• Presentation of CDS provider list, if applicable	
100.00%	**Review & Update the PDP** §9.190(e)(8)(A)	• PDP Review & Update • PDP Notifications & Revisions	
100.00%	**Renew & Revise the IPC** §9.190(e)(9)	• Participate in the renewal and revision of a person's IPC	
		• SC IPC responsibilities	
		• CARE entry of IPC agreement/disagreement	
Not Reviewed	**Behavior Support Plan** §9.190(e)(11)	• Notify SPT of intrusive interventions/ restrictions prior to implementation	
Not Reviewed	**Other PDP Changes** §9.190(e)(12)(A)(B)	• Changes to the PDP other than in relation to an IPC renewal or revision	

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OVERALL	92.10%

% Met	Elements for Review	Expectations	Findings/Comments
95.52%	**Service Coordination Monitoring** §9.190(e)(14)	• Monitor delivery of HCS program & Non-HCS program services and service coordination	See debriefing pages.
	§9.190(e)(41)	• Minimum face-to-face contact	See debriefing pages.
	§9.190(e)(16)	• Service Coordination follow-up	
	§9.190(e)(15)	• Document progress toward desired outcomes.	See debriefing pages.
100.00%	**Other SC Responsibilities** §9.161(c)(1-3)	• CARE Entry of ID/RC agreement/disagreement	
	§9.190(e)(19)	• Notify SPT when need for emergency services is identified	
	§9.190(e)(25)	• Manage provider transfers:	
	§9.190(e)(26)	• Be objective in assisting a person or LAR in selecting a program provider or FMSA;	
	§9.190(e)(27)	• SC assignment notifications	
	§9.190(e)(32)	• Ensure SPT offers choices and opportunities for accessing and participating in community activities and experiences available to peers without disabilities;	

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OVERALL	**92.10%**

% Met	Elements for Review	Expectations	Findings/Comments
	Other SC Responsibilities (continued) §9.190(e)(34)	• Ensure person is involved in planning the residential relocation, except in a case of an emergency;	
100.00%	**Understanding Program Eligibility and Services** **Explanation of IDD Services** **Verification of Freedom of Choice** §9.190(e)(42), IDD Services Broadcast 2019-57	At least annually, provide an oral and written explanation of: • Understanding Program Eligibility and Services • Explanation of IDD Services • Verification of Freedom of Choice	
80.00%	**Service Coordination Assessment** §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	See debriefing pages.
100.00%	**Community-based SPT Meetings** A-4, 2.2.1.1.B.4; HB 6820	• For a person transitioning from a nursing facility SPT meetings are held in the community	
Not Reviewed	**Program-Specific Service Coordination Training** §9.190(b)(2)	• HCS Service Coordinators receive program-specific training	

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ELEMENTS	MET	NOT MET	N/A	CAP REQUIREMENTS
HCS Concern Resolution	0	0	5	Not Applicable
HCS Rights Protection	41	0	39	NO corrections are required for this element
Individual Record	26	0	6	NO corrections are required for this element
Person/Family Directed the Plan	26	18	38	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
PDP Content	69	2	10	A SPECIFIC correction is required for each finding in this element
HCS Program Enrollment	32	0	43	NO corrections are required for this element
CDS Requirements	13	0	17	NO corrections are required for this element
Review & Update the PDP	9	0	36	NO corrections are required for this element
Review & Review the IPC	12	0	18	NO corrections are required for this element
Behavior Support Plan	0	0	5	Not Applicable
Other PDP Changes	0	0	10	Not Applicable
Service Coordination Monitoring	256	12	441	A SPECIFIC correction is required for each finding in this element
Other SC Responsibilities	18	0	56	NO corrections are required for this element
Annual Understanding Program Eligibility/Explanation of IDD Services/Verification of Freedom of Choice	12	0	8	NO corrections are required for this element
Service Coordination Assessment	4	1	0	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Community-Based SPT Meetings	2	0	8	Not Applicable
Program-Specific Training	0	0	0	Not Applicable
PARTICIPANT GRAND TOTALS	**520**	**33**	**740**	**PARTICIPANT GRAND TOTAL SCORE 92.10%**

TEXAS Health and Human Services

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Home and Community-Based Services Authority Review
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- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **March 10, 2023.**

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

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IDD Contracts Unit Intellectual and Developmental Disabilities Services, IDD-BH -Mail Code W-354
P.O. Box 149030
Austin, TX 78714-9030

Please extend our appreciation to your staff for their cooperation during this review. If you have any questions or require additional information, please contact:

Denice Cadena **Email:** **Denice.Cadena@hhs.texas.gov**

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Home and Community-Based Services Authority Review
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP)						
Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	For H2, the outcomes associated with the HCS services of RN, LVN, and Host Home were service statements in the PDP dated 6/29/22. For H2, the outcome associated with the HCS service of Dental in the PDP dated 6/29/22 was not supported by the discovery information.	**Specific:**	H2-Assigned SC for H2 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically RN, LVN, and HHCC. H2-Assigned SC for H2 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information to support the outcome of Dental.	HCS Program Director, Randi Garza or Designee	May 9,2023
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	For H3, the outcomes associated with the non-HCS service of PCP and the HCS service of Day Habilitation were not measurable and observable in the PDP dated 5/18/22. For H3 the outcome associated with the HCS service of Day Habilitation was a service statement in the PDP dated 5/18/22.	**Specific:**	H3-Assigned SC for H3 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop measuable observable outcomes. Specifically PCP, DH. H3-Assigned SC for H3 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically Day habilitation.	HCS Program Director, Randi Garza or Designee	May 9,2023
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	For H4, the outcomes associated with the non-HCS services of Orthopedic Specialist, Occupational Therapy, and ENT were service statements in the PDP dated 6/22/22. For H4, the outcomes associated with the HCS service of Host Home did not justify the service in the PDP dated 6/22/22. For H4, the outcomes associated with the non-HCS service of Home Health and the HCS service of Nursing in the PDP dated 6/22/22 were not supported by the discovery information.	**Specific:**	H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically Orthopedic Specialist, Occupational Therapy, and ENT. H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the outcome to justify the service in the PDP. Specifically HHCC. H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information to support the outcome of Home Health and Nursing.	HCS Program Director, Dana Sobers or Designee	May 9,2023

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Executive Commissioner

Home and Community-Based Services Authority Review
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP)

Elements for Review	Expectations	Findings	CAP See attachment for instructions to LIDDA		Responsible LIDDA Manager(s)	Projected Completion Date
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	For H5, the outcomes associated with the non-HCS service of PCP and the HCS service of LVN were service statements in the PDP dated 7/12/22. For H5, the outcomes associated with the HCS services of Dietary and RN were not measurable or observable in the PDP dated 7/12/22. For H5, the outcome associated with the non-HCS service of Psychiatry was directed by someone else in the PDP dated 7/12/22.	**Specific:**	H5-Assigned SC for H5 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically PCP, and LVN. H5-Assigned SC for H5 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop measuable observable outcomes. Specifically Dietary and RN. H5-Assigned SC for H along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes directed by the individual. Specifically Psychiatry.	HCS Program Director, Deandra Hines or Designee	May 9,2023
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	**A SYSTEMIC and MONITORING**	**Systemic:**	All HCS service coordinators will receive ongoing competency-based training on the TAC requirement of Person Directed Planning, including writing HCS/non-HCS person centered outcomes, and justifying all services evidenced by the discovery process - TAC 9.190 (e). Training will be evidenced through agenda and signature sheets. SCs will have continuous access to the Mentor for additional training and support.	HCS Program Director Randi Garza, Dana Sobers, and Deandra Hines or Designee	Ongoing

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Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	**correction is required for each finding in this element**	**Monitoring:**	The assigned Program Director, Team Leader or Designee will ongoingly monitor at least 2 HCS charts per team (for each of the 6 HCS teams) per fiscal quarter to ensure compliance addressing the specific issue identified. The monitoring tool will measure if outcome statements are preson centered and not service statements, supported by the discovery information, measurable, directed by the individual, and that they justify the service. Any findings will be documented, the specific issue addressed and shared with the Program Director or Designee who will provide corrections to the IDD Director. Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the Service Coordinatior Mentor.	HCS Program Director Randi Garza, Dana Sobers, and Deandra Hines or Designee	Ongoing
PDP Content §9.190(b)(3-4), §9.190(e)(8), §41.404	• Full range of services and resources • Description of CDS back up plan, if required • Service backup plan approval prior to implementation, • Service backup plan review during monitoring and annually • Include a description CDS service component(s)	For H4, the PDP dated 6/22/22 indicated that H4 received the non-HCS service of Audiologist annually, however there was no person-centered outcome associated with this service. For H4, there was no evidence the service coordination plan in the PDP dated 6/22/22 was based on the results from the Service Coordination Assessment dated 6/22/22. The service coordination plan indicated contact would be every 90 days, however the Service Coordination Assessment indicated a "high" level of need.	**Specific:**	H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop a person centered outcome for Audiology. H4- Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP to show evidence the PDP is based on the results of the Service Coordination Assessment.	HCS Program Director, Dana Sobers or Designee	May 9,2023

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Service Coordination Monitoring §9.190(e)(14)	• Monitor delivery of HCS program & Non-HCS program services and service coordination	For H4, there was no evidence of monitoring delivery of and satisfaction with the non-HCS services of Gynecologist, Audiologist, and Gastroenterologist during the first 90-day reporting period for the IPC with a begin date of 7/31/22. For H4, there was no evidence of monitoring satisfaction with the non-HCS services of Physical Medicine Specialist and Orthopedic Specialist during the first 90-day reporting period for the IPC with a begin date of 7/31/22.	**Specific:**	H4-Future documentation will evidence monitoirng of delivery and satisfaction of all HCS and Non-HCS services during the required 90-day period. H4-Future documentation will evidence monitoirng of satisfaction of all HCS and Non-HCS services during the required 90-day period.	HCS Program Director, Dana Sobers or Designee	May 9,2023
Service Coordination Monitoring §9.190(e)(14)	• Minimum face-to-face contact	For H5, there was no evidence of service coordination contact during the month of August 2022. The service coordination plan in the PDP date 7/12/22 indicated contacted frequency as monthly.	**Specific:**	H5-Future documentation will evidence montiroing based of the frequency indicated in the PDP.	HCS Program Director, Deandra Hines or Designee	May 9,2023
Service Coordination Monitoring §9.190(e)(15)	• Document progress toward desired outcomes.	For H4, there was no evidence of reporting progress/lack of progress towards the non-HCS services of Gynecologist, Physical Medicine Specialist, and Gastroenterologist during the first 90-day reporting period for the IPC with a begin date of 7/31/22.	**Specific:**	H4-Future documentation will evidence monitoirng of progress/lack of progress of all HCS and Non-HCS services during the required 90-day period.	HCS Program Director, Dana Sobers or Designee	May 9,2023
Service Coordination Assessment §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	For H3, the Service Coordination Assessment dated 5/18/22 identified the person had a "moderate" level of need for service coordination. However, the person had several unmet outcomes with a "high" level of need.	**Specific:**	H3-Assigned SC for H3 will complete the Service Coordination Assessment and mark the LEvel of Need correctly based on the findings of the assessment.	HCS Program Director Randi Garza, or Designee	May 9,2023

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CORRECTIVE ACTION PLAN (CAP)						
Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Service Coordination Assessment §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	A SYSTEMIC and MONITORING	**Systemic:**	All HCS Service Coordinators will receive ongoing Progress note documentation training to emphasize the importance of how to properly document delivery, progresss/lack of progress, and satisfaction of all services listed in the PDP monthly or at least once every 90 days. Service Coordination Assessment training will be completed for correctly scoring and marking the Level of Monitoring as well as making sure the PDP is based off the results of SC Assessment. All motniroing will be completed based off the frequency indicated in the PDP. Training will be evidenced through agenda and training documentation/handouts	HCS Program Director Randi Garza, Dana Sobers, and Deandra Hines or Designee	Ongoing
Service Coordination Assessment §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	correction is required for each finding in this element	**Monitoring:**	The assigned Program Director, Team Leader or Designee will ongoingly monitor at least 2 HCS charts per team (for each of the 6 HCS teams) per fiscal quarter to ensure compliance addressing the specific issue identified. The monitoring tool will measure delivery of, progress/lack of progress, and satisfaction with all services at least once every 90 days. The tool indicate if the Level of Monitoring was marked correctly and the PDP was based of the results of the SC Assessment. Any findings will be documented on a review tool with the specific issue addressed and shared with the Program Director or Designee who will provide corrections to the IDD Director.Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the Service Coordinatior Mentor.	HCS Program Director Randi Garza, Dana Sobers, and Deandra Hines or Designee	Ongoing
Community-based SPT Meetings A-4, 2.2.1.1.B.4; HB 6820	• For a person transitioning from a nursing facility SPT meetings are held in the community	A SYSTEMIC and MONITORING	**Systemic:**	All ECC Service Coordinators will receive ongoing training indicating SPT meetings are held in the community.	HCS/PASRR Program Director, Katrina Ware or Designee	Ongoing

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Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Community-based SPT Meetings A-4, 2.2.1.1.B.4; HB 6820	• For a person transitioning from a nursing facility SPT meetings are held in the community	**correction is required for each finding in this element**	**Monitoring:**	The assigned Program Director, Team Leader, or Designee will ongoingly use a monitoring tool to review at least 2 HCS charts (for the 1 ECC team), from a variety of ECC Coordinators per fiscal quarter to ensure the SPT meetings are held in the community. Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the Service Coordinatior Mentor.	HCS/PASRR Program Director, Katrina Ware or Designee	Ongoing

The CAP must be submitted to the Contract Manager, within 30 calendar days, after receiving notice of any deficiency identified in the Report of Findings.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

For Hard Copy Submission: HHSC-IDD Services, Access and Intake-Mail Code W-354
Performance Contracts
P.O. Box 149030
Austin, TX 78714-9030

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PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
FY 2023 REPORT OF FINDINGS

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01/23/23 - 01/26/23

OVERALL	94.36%	

TAC §303.601. Habilitation Coordination for a Designated Resident			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Habilitation Coordinator Assignment/ Service Coordinator Assignment** §303.601(a); 3100; 3230; 4200	·Habilitation coordinator assignment ·Diversion Coordinator review the person's admission within 45 days	
Not Reviewed	**Habilitation Coordinator Refusal** §303.504 (b); 4420; 5340	Refusal of Habilitation Coordination form	
100.00%	**Habilitation Coordination/Service Coordination/ECC Contact** §303.601 (b)(7); 3240; 5100	Meet face-to-face with the designated resident	
93.55%	**Service Planning Team Meeting** §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	See debriefing pages.
93.15%	**SPT Membership Requirements** §303.102 (61) (A)	·SPT includes all required members and participants	See debriefing pages.
88.00%	**Habilitation Service Plan Development** §303.601(b)(5); §303.601(b)(2); 5200	Develop and revise HSP	See debriefing pages.
66.67%	**Coordination with the Individual Profile** 5460.1	Individual Profile describes pertinent information identified by those who know the person best that service providers need to know and do to support the person	See debriefing pages.
85.71%	**Coordination of Specialized Services** §303.601 (3)(A)(B) §303.601 (4); §303.601 (5) 5510	·Assist with accessing needed specialized services; ·Coordinate other habilitative programs and services; ·Facilitate coordination of HSP and comprehensive care plan	See debriefing pages.
100.00%	**Community Living Options** §303.504 (b); §303.601(b)(9)(B); 2430.5	Address community living options initially and every six months on the Community Living Options (Form 1039); includes designated residents who refuse habilitation coordination	
100.00%	**Comprehensive Care Plan** §303.504 (a)(4)	Maintain current comprehensive care plan in the record:	
100.00%	**Habilitative Assessment** **5**200; 5340; 5340.2	Complete and distribute the Habilitative Assessment	

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% Met	Elements for Review	Expectations	Findings/Comments
96.67%	**Develop an HSP** §303.102 (23)(A) §303.102 (23)(B) §303.102(23)(C)	HSP-Habilitation Service Plan: · Is individualized and developed through a person-centered approach; · Identifies strengths, preferences, outcomes, psychiatric, behavioral, nutritional management, and support needs · Identifies amount, frequency, and duration of each service	See debriefing pages. See debriefing pages.
96.43%	**Monitoring & Coordination of HSP** §303.601 (b)(6)(A)-(B) §303.601 (b)(6)(C) §303.601 (b)(1,9A,10,11) 5850	Monitor and provide follow-up activities: ·Initiation, delivery and satisfaction with all specialized services ·Report progress toward desired outcomes ·Assess and reassess habilitation service needs quarterly ·Offer educational and informational opportunities semiannually ·Coordinate service and support access with the nursing facility ·Annual review of rights	See debriefing pages. See debriefing pages.
100.00%	**Integrated Activities** §303.602(a)(6)(A)(B)	Opportunities are provided for: ·Engaging in integrated activities with residents who do not have ID or DD ·In community settings with people who do not have a disability	
		§303.701. Transition Planning for a Designated Resident	
100.00%	**Transition Planning Responsibilities** §303.701; 5830	·Referral for Relocation Services ·Assign a ECC Service Coordinator	
75.00%	**Individual Participation in Transitioning** §303.701 (c)(2)	·When transitioning, the SPT ensures the person participates in SPT meetings to the fullest extent possible	See debriefing pages.
80.00%	**Transition Plan Development** §303.701 (b) (d) (e) (f) (g) 6100; 6200; 6300	Develop, plan, and revise the Transition Plan	See debriefing pages.
Not Reviewed	**Transition Plan Content** §303.701 (b); 6310	Transition Plan includes all required elements	
100.00%	**Transition Plan Implementation & Monitoring** 6200; 6300; 6530	Service Coordinator/Enhanced Community Coordinator (SC/ECC): ·Facilitates trial visits to HCS program providers, as requested ·Revises, implements, and monitors the Transition Plan, as necessary ·Manages transition into HCS services ·Develops and revises HCS PDP, as needed	

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% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Pre-Move Site Review** §303.701 (h); 3230	Conduct and document a pre-move site review of proposed residence in the community	
100.00%	**Essential Supports** §303.701 (h) 3230; 6530	Determine whether all essential supports in the transition plan are in place and resolve all barriers with the SPT before transition to the community	
96.55%	**Post-Move Monitoring** §303.702; 3240	Conduct required post-transition monitoring activities	See debriefing pages.
91.67%	**Post-Move Monitoring and Protecting Health** 3240; 6820	For one year after diversion/transition, the SC/ECC must: ·Inquire about health concerns ·Convene the HCS SPT to add services/revise the PDP when needed ·Ensure timely assessments, as necessary ·Record health care status to identify when changes in status occur ·Conduct HCS service planning and monitoring ·Review implementation plans and provider records ·Visit service delivery sites, as needed ·Monitor critical incidents ·Monitor a person while on suspension, upon request	See debriefing pages.
Not Reviewed	**Remaining in Nursing Facility** §303.701 (i)(A)(B)	Identify barriers to moving and steps the SPT will take to address those barriers.	
		3100 - 3200 Nursing Facility Diversions	
100.00%	**Nursing Facility Diversion Coordination** 3100	Identify, arrange, and coordinate access to community services as a diversion to NF admission; request a targeted NF HCS diversion slot, if appropriate	
		3100 - 3200 Community-based Service Enrollment	
100.00%	**Community-based Service Enrollment Responsibilities** 5830; 5840	Habilitation Coordinator facilitates assignment of Residential Relocation Specialist and ECC Service Coordinator to initiate enrollment into community-based services	
0.00%	**Community-based SPT Meetings** §303.701 (c)(1-3); 3240	The HCS SPT meets at least quarterly and ensures the person participates in the SPT meetings to the fullest extent possible	See debriefing pages.
75.00%	**Guardianship** §303.504 (a); §303.601 (b)(11)	·Determine, at least annually, if the letters of guardianship are current; if appropriate ·Make a referral of guardianship, if appropriate	See debriefing pages. See debriefing pages.

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OVERALL	94.36%	

ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
HC Refusal	0	0	30	Not Applicable	
HC Assignment	3	0	67	NO corrections are required for this element	
HC/SC/ECC Contact	47	0	0	NO corrections are required for this element	
SPT Meeting	87	6	7	A SPECIFIC correction is required for each finding in this element	
HSP Development & Revisions	22	3	7	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Coordination of Specialized Serves	6	1	24	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Community Living Options	8	0	72	NO corrections are required for this element	
Comprehensive Care Plan	3	0	7	NO corrections are required for this element	
Transition Planning	1	0	19	NO corrections are required for this element	
Habilitative Assessment	4	0	36	NO corrections are required for this element	
SPT Participation	68	5	0	A SPECIFIC correction is required for each finding in this element	
Develop an HSP	87	3	103	A SPECIFIC correction is required for each finding in this element	
Coordination & Monitoring of Servs	27	1	155	A SPECIFIC correction is required for each finding in this element	
Integrated Activities	6	0	14	NO corrections are required for this element	
Coordination w/ Individual Profile	2	1	1	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Transition Plan Development	4	1	139	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Transition Plan Content	0	0	120	Not Applicable	
Transition Plan Implementation & Monitoring	3	0	77	NO corrections are required for this element	
Pre-Move Site Review	4	0	36	NO corrections are required for this element	
Essential Supports	7	0	426	NO corrections are required for this element	
Post-Move Monitoring	28	1	34	A SPECIFIC correction is required for each finding in this element	
Monitoring and Protecting Health	11	1	128	A SPECIFIC correction is required for each finding in this element	
Remaining in NF	0	0	30	Not Applicable	
Nursing Facility Diversions Plan	2	0	18	NO corrections are required for this element	
Community-Based Services	2	0	78	NO corrections are required for this element	
Community-Based SPT Meetings	0	1	59	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
Guardianship	3	1	90	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element	
PARTICIPANT GRAND TOTALS	**435**	**26**	**1786**	**PARTICIPANT GRAND TOTAL SCORE**	**94.36%**

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PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW
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01/23/23 - 01/26/23

OVERALL	94.36%	

This review resulted in items of non-compliance with the FYs 2021 and 2023 Performance Contract. In accordance with Attachment D. Article 3 and Article 4.1.1 of the FY 2021 and 2023 Performance Contract, HHSC, IDD Services may require a Corrective Action Plan (CAP) for items of non-compliance at the time of the review exit conference. As a result of this review, a CAP is required to be submitted for all findings. The CAP must be submitted within 30 calendar days after receiving the notice of deficiency for approval by HHSC, IDD Services.

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **March 10, 2023**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

In accordance with the FYs 2022 and 2023 Performance Contract, Attachment D. Article 3 and Article 4.1.1, the PASRR Authority Review Report of Findings is shared at the time of the Exit Conference. The report will also be shared with the Contract Manager. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC, IDD Services specified remedies or sanctions after receipt of the CAP.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

For Hard Copy Submission:
IDD Contracts Unit Intellectual and Developmental Disabilities Services, IDD-BH -Mail Code W-354

P.O. Box 149030
Austin, TX 78714-9030

Please extend our appreciation to your staff for their cooperation during this review. If you have any questions or require additional information, please contact:

Denice Cadena **Email:** **denice.cadena@hhs.texas.gov**

Denice Cadena, Contract Specialist, Facilitator
Charvey Betts, Contract Specialist
Sharon Cummings, Contract Specialist
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Kristina McClure, Contract Specialist
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PRE-ADMISSION SCREENING & RESIDENT REVIEW (PASRR) AUTHORITY REVIEW FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

CORRECTIVE ACTION PLAN (CAP)						
Elements for Review	**Expectations**	**Findings**	**CAP See attachment for instructions to LIDDA**		**Responsible LIDDA Manager(s)**	**Projected Completion Date**
Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	For NF1, there was no evidence the SPT determined if the identified outcomes associated with Occupational Therapy and Physical Therapy were being addressed in the SPT meetings dated 4/12/22 and 7/12/22. For NF1, there was no evidence the PCSP for the SPT meeting dated 10/15/22 was entered into TMHP at any time.	**Specific:**	NF1, future STP meetings, HC will determine the identified outcomes associated with specialized services of Occupational Therapy and Physical Therapy. NF1, HC will enter PCSP form within 5 calendar days after the SPT meeting in TMHP.	Program Director, Katrina Ware or Designee	5/9/2023
Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	For NF3, there was no evidence the SPT determined if the identified outcome associated with Occupational Therapy was being addressed in the SPT meetings dated 8/10/22 and 11/21/22. For NF3, there was no evidence the SPT discussed NF3's completed Community Living Options (Form 1054) dated 7/19/22 or addressed the barriers to transitioning to the community in the SPT meeting dated 8/10/22.	**Specific:**	NF3, future STP meetings, HC will determine the identified outcomes associated with specialozed services of Occupational Therapy. NF3, future SPT meetings, HC will discuss Community Living Options (Form 1054) every 6 months from the initial meeting date. NF3, future SPT meetings, HC will discuss barriers preventing a transition to the community when discussing the Community Living Options (Form 1054) and document.	Program Director, Katrina Ware or Designee	5/9/2023
Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	**A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element**	**Systemic:**	All PASRR Habilitation Coordinators will receive training based on the TAC requirement for entering PCSPs in TMHP within the designated timeframe. Training will be evidenced through an agenda and attendance sheet.	Program Director, Katrina Ware or Designee	Ongoing
Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings		**Monitoring:**	The assigned Program Director, Team Leader, or Designee will review at least 2 PASRR charts for the 1 PASRR team, from a variety of HAB Coordinators per fiscal quarter, results of entering PCSPs form within 5 calendar days after the SPT metting in TMHP, by untilizing the PASRR unit cover sheet. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Program Director, Katrina Ware or Designee	Ongoing
SPT Membership Requirements §303.102 (61) (A)	·SPT includes all required members and participants	For NF1, there was no evidence the MCO service coordinator was invited to the SPT meeting dated 11/2/22.	**Specific:**	NF1, future SPT meetings, the assigned HC will notify the MCO at least 10 business days prior to SPT meeting to invite them to participate and document in progress note.	Program Director, Katrina Ware or Designee	5/9/2023

TEXAS
Health and Human Services

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QUALITY ASSURANCE AUTHORITY REVIEW
FY 2023 REPORT OF FINDINGS
280 - The Harris Center for Mental Health and IDD

Authority Functions	99.47%

01/23/23 - 01/26/23

Performance Contract			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Planning and Network Advisory Committee (PNAC)** Attachment A-1, 2.1.3 - 2.1.8	LIDDA ensures the PNAC performs its advisory functions according to its identified outcomes and reporting requirements	
100.00%	**Local Provider Network Development Plan** Attachment A-1, 2.1.1-2.1.2	LIDDA posts current IDD Services Local Service Plan	
100.00%	**CRCG Participation** Attachment A-1, Article 2 2.3.4 - 2.3.5	• LIDDA participation in CRCG/CRCGA • LIDDA shares information with CRCG/CRCGA on persons with multiagency service needs	
100.00%	**Separation of Provider and Authority Functions** Attachment A-1 2.5.1, Attachment A-6 1.1.3	• LIDDA ensures designated enrollment staff do not perform functions for the LIDDA's provider operations. • LIDDA ensures service coordinators do not perform provider functions.	
100.00%	**Provider Complaint Resolution** Attachment A-1 2.6.6	LIDDA has written procedures for responding to provider complaints/appeals	
100.00%	**Quality Management Plan** Attachment A-1 2.6.7. A-D	QM Plan includes the required methods.	
88.89%	**HCS & TxHmL Interest List Maintenance** Attachment A-1 2.7.1.B TAC 40 §D-9.157	• HCS & TxHmL Interest List Maintenance Process	See debriefing pages.
100.00%	**Permanency Planning** Attachment A-13 1.1.1- 1.1.2	Permanency Plan contains the following elements: • Information for Permanency Planning • Support Planning Information • Action Plans • Participant Information	

TEXAS
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Authority Functions	99.47%

% Met	Elements for Review	Expectations	Findings/Comments
Administrative			
100.00%	**Internal Interest List** Attachment A-1 2.10.3	LIDDA has written procedures for processing requests for services not immediately available using HHSC required documentation	
100.00%	**Emergency Plan** Attachment A-1 2.10.6	LIDDA has an emergency plan that meets the contract requirements.	
Data			
97.22%	**Accurate and Timely Critical Incident and data reporting** A-1 2.9.4.J; C 2.4.7.4-5	• Accurate and timely data reporting • Timely and Accurate Critical Incident Reporting	See debriefing pages.
100.00%	**Priority Population** Attachment A-1, Article 2.7.2	LIDDA ensures individuals who receive services are qualified to receive services.	
TLETS			
	Texas Law Enforcement Telecommunication System (TLETS) LIDDA HB 19240 Attachment A-1, Article 2.3.7	• TLETS Implementation	See debriefing pages.
CLOIP			
Not Reviewed	**Community Living Options Information Process** Attachment F-4 §F.2.253, §F.2.274 §G.2.309 (a) HB 10300	• CLOIP Implementation	
OBI			
	Outpatient Biopsychosocial Services (OBI) Program Attachment A-2	• OBI Implementation	

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Authority Functions	99.47%

% Met	Elements for Review	Expectations	Findings/Comments
	Service Provision		
100.00%	**Ensuring Quality of Service Provision in all programs** Attachment A-1 2.7.2	LIDDA shall supervise and ensure provision of IDD services	
100.00%	**Ensuring Meaningful Access to LIDDA Programs, Services, Activities** Attachment A-1, 2.8.5	LIDDA must provide meaningful access to its programs, services & activities and ensure adequate communication through language assistance services	
Not Reviewed	**Ensuring Eligibility Determination** Attachment A-1 2.7.1.a LH 6500	LIDDA shall provide screening, eligibility determination services	
	Human Resources		
% Met	Elements for Review	Expectations	Findings/Comments
91.30%	**Service Coordinators Qualifications & Training** §331.17(b-f); §331.19 (b) (1-8) & (c) Ch 4, L §4.560 (a-b), §C.2.111,§K.4.505, §K.4.507, §C.4.121, C §49.304(b-c), G §2.315 (h)(1-5); TxHmL-N §9.583 (g)(1-2); HCS-D §9.190(b)(1-2)	• Qualifications and training requirements for service coordination supervisor and service coordinators assigned to individuals in the GR, TxHmL, HCS, and PASRR samples.	See debriefing pages.
100.00%	**PASRR Habilitation Coordination Qualifications & Training** §303.501 (1-3), §303.502(a)(1)(A-B) 40 §C.4.121, L §4.560 (a-b), G §2.315(h)(1-5), §303.502 (2)(A-B) 40 §K.4.505 §K.4.507, C §49.304(b,c,f), 303.703(b)(1)(A-B)	• Qualifications and training requirements for habilitation coordinators assigned to individuals PASRR samples.	

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Human Resources			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**PASRR Evaluation Staff Qualifications & Training** §331.17(b-f), §331.19 (b) (1-8) & (c), 4, L §4.560 (a-b), §C.2.111, §K.4.505, §K.4.507, §C.4.121, C §49.304(b,c,f), G §2.315 (h)(1-5); TxHmL-N §9.583 (g)(1-2); HCS-D §9.190(b)(1-2) §303.703(b)(1)(A), §303.303(c)(1)(A)	• Qualifications and training requirements for staff who are completing PASRR Evaluations.	
100.00%	**ECC Coordinator Qualifictions and Training** §331.17(b-f), §331.19 (b) (1-8) & (c), Ch 4, L §4.560 (a-b), §C.2.111, §K.4.505, §K.4.507, §C.4.121, C §49.304(b-c), G §2.315 (h)(1-5); TxHmL-N §9.583 (g)(1-2); HCS-D §9.190(b)(1-2) §303.703(b)(1)(A-B), §303.303(c)(1)(A)	• Qualifications and training requirements for ECC service coordinators assigned to individuals in the GR, TxHmL, HCS, and PASRR programs.	
Not Reviewed	**PASRR Diversion Staff Qualifications & Training** §331.17(b-f); §331.19 (b) (1-8) & (c), Ch 4, L §4.560 (a-b), TAC 40 §C.2.111, §K.4.505 §K.4.507, §C.4.121, C §49.304(b-c), G §2.315 (h)(1-5); HCS-D §9.190(b)(1-2) §303.703(b)(1)(A-B), §303.303(b)(3) & (c)	• Qualifications & training requirements for staff who are completing PASRR Diversions.	

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Human Resources			
% Met	Elements for Review	Expectations	Findings/Comments
Not Reviewed	**Professional Staff Qualifications & Training** 40 – Ch 4, L §4.560 (a-b), §C.2.111 §K.4.505, §K.4.507, §C.4.121, C §49.304(b,c,f), G §2.315 (h)(1-5)	• Qualifications and training requirements for employed and contracted professional staff assigned to individuals in the GR sample.	
100.00%	**Direct Support Staff Qualifications & Training** 40 §G.2.315(h)(4)(A)&(B), §G.2.315(h)(5)(A)&(B), §G.2.315(e)(1-2), §C.4.121, §L.4.560 (a)(1)-(7), §L.4.560 (b), §K.4.505, §K.4.507, C §49.304(b,c,f)	• Qualifications and training requirements for direct support staff assigned to individuals in the GR sample.	
100.00%	**Enrollment Staff Qualifications & Training** Attachment A-6, 1.1.2 §331.17(b-f); §331.19 (b) (1-8) & (c), §4.560 (a-b), §C.2.111, §K.4.505, §K.4.507, §C.4.121, §49.304(b-c), G §2.315 (h)(1-5); TxHmL-N §9.583 (g)(1-2); HCS-D §9.190(b)(1-2) LIDDA Handbook: 13100	• Training requirements for designated enrollment staff.	
100.00%	**Crisis Intervention Specialist Qualifications and Training** 1.3.1A, 1.3.2 A-B, 42 Code of Federal Regulations, §483.430(a), LIDDA Handbook: 19000, 40 §C.4.121, L §4.560 (a-b), G §2.315(h)(5)(A) & (B), G §2.315 (h)(1); §K.4.505, §K.4.507, C §49.304(f), C §49.304(c)(5), C §49.304(b)	• Qualifications & training requirements for staff who are providing Crisis Intervention Specialized Services.	
	Collaborative Care Case Manager DSW Training Attachment A-2	• Training requirements for staff who are providing Collaborative Care Case Management.	

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Human Resources and other requirements			
% Met	Elements for Review	Expectations	Findings/Comments
100.00%	**Protected Health Information & Record Retention** Attachment C. 5.2 (9); Attachment C 5.18.	LIDDA safeguards protected health information of persons served	
100.00%	**Additional Items of Non-Compliance**		
100.00%	**Federal & Texas LEIE Compliance** TAC 40 Part 1, Subchapter C §49.304(f)	• LEIE Compliance	

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ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS
Planning and Network Advisory Committee (PNAC)	1	0	0	NO corrections are required for this element
Local Provider Network Development Plan	1	0	0	NO corrections are required for this element
CRCG Participation	1	0	0	NO corrections are required for this element
Provider Complaint Resolution	1	0	0	NO corrections are required for this element
Quality Management Plan	1	0	0	NO corrections are required for this element
HCS & TxHmL Interest List Maintenance Process	16	2	0	A SPECIFIC, SYSTEMIC, and MONITORING correction is required for each finding in this element
Permanency Planning	15	0	0	NO corrections are required for this element
Internal Interest List	1	0	0	NO corrections are required for this element
Emergency Plan	1	0	0	NO corrections are required for this element
Accurate/Timely Critical Incident and CARE Reporting	35	1	0	A SPECIFIC correction is required for each finding in this element
Priority Population	7	0	0	NO corrections are required for this element
Data Verification	0	0	24	Not Applicable
Texas Law Enforcement Telecommunication System (TLETS)	N/A	N/A	N/A	
Community Living Options Information Process	0	0	8	Not Applicable
Outpatient Biopsychosocial Services (OBI) Program	N/A	N/A	N/A	
Ensuring Quality of Service Delivery (ALL programs)	92	0	0	NO corrections are required for this element
Ensuring Meaningful Access to LIDDA	23	0	0	NO corrections are required for this element
Ensuring Eligibility Determination	0	0	0	Not Applicable

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ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
Service Coordinators Qualifications & Training	0	0	2	Not Applicable	
Habilitation Coordination Training and Qualifications	40	0	1	NO corrections are required for this element	
PASRR Evaluator Qualifications and Training	0	0	2	Not Applicable	
ECC Staff Qualifications & Training	63	0	1	NO corrections are required for this element	
PASRR Diversion Coordinator Checks	0	0	2	Not Applicable	
Professional Staff Qualifications & Training	0	0	2	Not Applicable	
Direct Support Staff Qualifications & Training	40	0	1	NO corrections are required for this element	
Enrollment Staff Qualifications & Training	63	0	1	NO corrections are required for this element	
Crisis Intervention Specialist Qualifications and Training	18	0	1	NO corrections are required for this element	
Collaborative Care Case Manager DSW Training	N/A	N/A	N/A		
Federal & Texas LEIE Compliance	19	0	0	NO corrections are required for this element	
Protected Health Information	125	0	0	NO corrections are required for this element	
Additional Items of non-compliance	1	0	0	NO corrections are required for this element	
PARTICIPANT GRAND TOTALS	**566**	**3**	**47**	**PARTICIPANT GRAND TOTAL SCORE**	**99.47%**

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Authority Functions	99.47%	

In accordance with FYs 2022 and 2023 Performance Contract, for any item of non-compliance remaining uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after receiving a notice of deficiency, submit to HHSC a Corrective Action Plan (CAP).

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **March 10, 2023**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

In accordance with the FYs 2022 and 2023 Performance Contract, Attachment C. Article 3 and Article 4.1.1, the QA Debriefing page is shared at the time of the Exit Conference. The Authority Review report will be shared with the LIDDA and Contract Manager once the report has been finalized. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC specified remedies or sanctions after receipt of the CAP.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

For Hard Copy Submission:
IDD Contracts Unit Intellectual and Developmental Disabilities Services, IDD-BH -Mail Code W-354
P.O. Box 149030
Austin, TX 78714-9030

Please extend our appreciation to your staff for their cooperation during this review. If you have any questions or require additional information, please contact:
Denice Cadena **Email:** **Denice.cadena@hhs.texas.gov**

Denice Cadena, Contract Specialist, Facilitator
Charvey Betts, Contract Specialist
Sharon Cummings, Contract Specialist
Blake Hensley, Contract Specialist
Marselena Hernandez, Contract Specialist
Mercedes Hernandez, Contract Specialist
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Kristina McClure, Contract Specialist
Donna Pendleton, Contract Specialist
Veronica Reyes, Contract Specialist

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QUALITY ASSURANCE AUTHORITY REVIEW
FY 2023 - Corrective Action Plan

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CORRECTIVE ACTION PLAN (CAP)
See attachment for instructions to LIDDA

Elements for Review	Expectations	Findings	CAP See attachment for instructions to LIDDA		Responsible LIDDA Manager(s)	Projected Completion Date
HCS & TxHmL Interest List Maintenance Attachment A-1 2.7.1.B TAC 40 §D-9.157	• HCS & TxHmL Interest List Maintenance Process	For T2, there was no evidence of an Identification of Preferences (Form 8648) or other documentation to support the HCS Interest List date of 10/28/08 in the HHSC data system.	**Specific:**	T2-Files were searched for the origianl Identification of Preference (Form 8648) supoortting the Interest list date on 10-28-2008 but were not located. The LIDDA will meet with the Individual/LAR to verbally verify the date in CARE.	Practice Manager, T. M. Huckleberry or designee	5/9/2023
HCS & TxHmL Interest List Maintenance Attachment A-1 2.7.1.B TAC 40 §D-9.157	• HCS & TxHmL Interest List Maintenance Process	**A SYSTEMIC and MONITORING correction is required for each finding in this element**	**Systemic:**	The Interest List staff will be re-trained with guidelines from the current Interest List Manual, with emphasis on completion of the IOP form and accomanying documentation of such in a service note	Practice Manager, T. M. Huckleberry or designee	initial training will be completed by 5/9/2023 and ongoing training will be conducted yearly for all staff.
HCS & TxHmL Interest List Maintenance Attachment A-1 2.7.1.B TAC 40 §D-9.157	• HCS & TxHmL Interest List Maintenance Process		**Monitoring:**	Based on random sample of 30 individuals PER MONTH on the interest list, staff will verify that the person's record contains documenation supporting the request to add the person's name to the Interest list. IOP (Form 8648) forms are store in EPIC post 2021 and Laserfiche pre-2021. Verification of IOP will be entered into progress note. If IOP form does not exist, family will be contacted, IOP form will be confirmed and uploaded into record system and progress note will be updated. In the case of non-compliance with stated procedures, staff will be retrained and placed under supervisory monitoring to	Practice Manager, T. M. Huckleberry or designee	ongoing
Accurate and Timely Critical Incident and data reporting A-1 2.9.4.J; C 2.4.7.4-5	• Accurate and timely data reporting • Timely and Accurate Critical Incident Reporting	For NF5, there was evidence of an open R0NR assignment in the HHSC data system, even though NF5 was not refusing services.	**Specific:**	NF5-Completed. R0NR assignment in CARE has been closed and updated to reflect current assignment of R01HProgram Director, Coneka Caleb, Team Leader or Designee	Program Director, Katrina Ware, or Designee	5/9/2023

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OVERALL	98.93%

40 TAC, Chapter 9, Subchapter, Texas Home Living Program Principles for LIDDA			
% Met	**Elements for Review**	**Expectations**	**Findings/Comments**
100.00%	§9.567 Process for Enrollment	LIDDA must offer TxHmL Program services in accordance with §9.567 of this subchapter (relating to Process for Enrollment).	
100.00%	§9.583(b) Process Enrollment Request	(b) LIDDA must process enrollments in the TxHmL Program in accordance with §9.567 of this subchapter (relating to Process for Enrollment).	
100.00%	§9.583(c) Objective Program Provider Selection Process	(c) A LIDDA must have a mechanism to ensure objectivity in the process to assist an individual or LAR in the selection of a program provider and a system for training all LIDDA staff who may assist an individual or LAR in such process.	
100.00%	§9.583(d) Complaints	(d) A LIDDA must ensure that an individual or LAR is informed orally and in writing of the processes for filing complaints as follows: (1) the telephone number of the LIDDA to file a complaint; (2) the toll-free telephone number of HHSC to file a complaint; and (3) the toll-free telephone number of DFPS (1-800-647-7418) to report an allegation of abuse, neglect, or exploitation.	
100.00%	§9.583(e)(1-5) Consumer Record §9.558(c) Current IPC	(e) A LIDDA must maintain for each individual for an IPC year: (1) a current IPC; (2) a current PDP; (3) a current ID/RC Assessment; and (4) current service information.	
100.00%	§9.583(f) Copy Consumer Record	(f) For an individual receiving TxHmL Program services and CFC services within the LIDDA's local service area, the LIDDA must provide the individual's program provider a copy of the individual's current PDP, IPC, and ID/RC Assessment.	
90.39%	§9.583(h) Service Coordinator Assurances §9.583(r)(1)(2) CDS Option Enrollment §9.583(s) CDS Option documentation	(h) A LIDDA must ensure that a service coordinator: (1) initiates, coordinates, and facilitates the person-directed planning process to meet the desires and needs as identified by an individual and LAR in the individual's PDP, including: (A) scheduling service planning team meetings; and (B) documenting on the PDP whether, for each TxHmL Program service or CFC service identified on the PDP, the service is critical to meeting the individual's health and safety as determined by the service planning team;	
		(2) coordinates the development and implementation of the individual's PDP;	See debriefing pages.

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% Met	Elements for Review	Expectations	Findings/Comments
90.39%	§9.583(h) Service Coordinator Assurances	(3) coordinates and develops an individual's IPC based on the individual's PDP;	
		(4) monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	See debriefing pages.
		(4) coordinates the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	
		(5) records each individual's progress;	See debriefing pages.
100.00%	§9.583(i) Notification	(i) A LIDDA must ensure an individual or LAR is informed of the name of the individual's service coordinator and how to contact the service coordinator.	
100.00%	§9.583(j) Service Coordinator Obligations	(j) A service coordinator must: (1) assist the individual or LAR in exercising the legal rights of the individual as a citizen and as a person with a disability; (2) assist the individual's LAR or family members to encourage the individual to exercise the individual's rights;	
		(5) ensure that the individual and LAR participate in developing a personalized PDP and IPC that meet the individual's identified needs and service outcomes and that the individual's PDP is updated when the individual's needs or outcomes change but not less than annually;	
		(6) ensure that a restriction affecting the individual is approved by the individual's service planning team before the imposition of the restriction;	

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% Met	Elements for Review	Expectations	Findings/Comments
	§9.583(j) Service Coordinator Obligations (continued)	(10) in accordance with HHSC instructions, manage the process to transfer an individual's TxHmL Program services and CFC services from one program provider to another or transfer from one FMSA to another, including: (A) informing the individual or LAR who requests a transfer to another program provider or FMSA that the service coordinator will manage the transfer process; (B) informing the individual or LAR that the individual or LAR may choose: (i) to receive TxHmL Program services and CFC services from any program provider that is in the geographic location preferred by the individual or LAR and whose enrollment has not reached its service capacity in the HHSC data system; or (ii) to transfer to any FMSA in the geographic location preferred by the individual or LAR; and (C) if the individual or LAR has not selected another program provider or FMSA, provide the individual or LAR a list of and contact information for available TxHmL Program providers and FMSAs in the geographic locations preferred by the individual or LAR.	
100.00%	§9.583(k) PDP/IPC Changes	(k) When a change to an individual's PDP or IPC is indicated, the service coordinator must discuss the need for the change with the individual or LAR, the individual's program provider, and other appropriate persons as necessary.	
100.00%	§9.583(l) PDP/IPC Updates	(l) At least 30 calendar days before the expiration of an individual's IPC, the service coordinator must: (1) update the individual's PDP in conjunction with the individual's service planning team; and (2) if the individual receives a TxHmL Program service or a CFC service from a program provider, submit to the program provider: (A) the updated PDP; and (B) if CFC PAS/HAB is included on the PDP, a copy of the completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form.	

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% Met	Elements for Review	Expectations	Findings/Comments
Not Reviewed	§9.583(m) Service Suspensions	(m) A service coordinator must: (1) review the status of an individual whose services have been suspended at least every 90 calendar days following the effective date of the suspension and document in the individual's record the reasons for continuing the suspension; and (2) if the suspension continues 270 calendar days, submit written documentation of the 90, 180, and 270 calendar day reviews to HHSC for review and approval to continue the suspension status.	
100.00%	§9.583(n) Oral and Written Notification of SC Obligations	(n) A service coordinator must: (1) inform the individual or LAR orally and in writing, of the requirements described in subsection (j) of this section: (A) upon receipt of HHSC approval of the enrollment of the individual; (B) if the requirements described in subsection (j) of this section are revised; (C) at the request of the individual or LAR; and (D) if the legal status of the individual changes; and (2) document that the information described in paragraph (l) of this subsection was provided to the individual or LAR.	
100.00%	§9.583(s) CDS Choice	(s) If an individual or LAR chooses to participate in the CDS option, the service coordinator must: (1) provide names and contact information to the individual or LAR regarding all FMSAs providing services in the LIDDA’s local service area; (2) document the individual’s or LAR’s choice of FMSA on Form 1584; (3) document, in the individual’s PDP, a description of the services provided through the CDS option; and (4) document, in the individual’s PDP, a description of the individual’s service back-up plan.	
100.00%	§9.583(v) Explanation of Eligibility and Services	Understanding Program Eligibility Explanation of Services and Supports Verification of Freedom of Choice Program specific fact sheets, if applicable	
100.00%	§C.4.117, §C.4.117(e), §C.4.119(d), §C.4, §9.583(j)(1) Rights	Rights Notifications	

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% Met	Elements for Review	Expectations	Findings/Comments
	§C.4.117, §C.4.117(e), §C.4.119(d), §C.4, §9.583(j)(1) Rights (continued)	Guardianship Determine, at least annually, if the letters of guardianship are current; or make a referral of guardianship, if appropriate.	
100.00%	§2.554(a)(c) Service Coordination Assessment	Service Coordination Assessment determines frequency of service coordination	
Not Reviewed	§9.583(h)(2) Program-Specific Service Coordination Training	TxHmL Service Coordinators receive program-specific training	

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ELEMENTS	Met	Not Met	N/A	CAP REQUIREMENTS	
§9.567 Process for Enrollment	4	0	6	NO corrections are required for this element	
§9.583(b) Process Enrollment Request	13	0	25	NO corrections are required for this element	
§9.583(c) Objective Program Provider Selection Process	2	0	3	NO corrections are required for this element	
§9.583(d) Complaints	17	0	0	NO corrections are required for this element	
§9.583(e)(f) Consumer Record and Copy Consumer Record	41	0	3	NO corrections are required for this element	
§9.583(h) Service Coordinator Assurances	254	27	242	A SPECIFIC correction is required for each finding in this element	
§9.583(i) Notification	3	0	1	NO corrections are required for this element	
§9.583(j) Service Coordinator Obligations	27	0	28	NO corrections are required for this element	
§9.583(k) PDP/IPC Changes	2	0	3	NO corrections are required for this element	
§9.583(l) PDP/IPC Updates	18	0	6	NO corrections are required for this element	
§9.583(m) Service Suspensions	0	0	10	Not Applicable	
§9.583(n) Oral and Written Notification of SC Obligations	3	0	22	NO corrections are required for this element	
§9.583(s) CDS Choice	3	0	7	NO corrections are required for this element	
§9.583(v) Explanation of Eligibility and Services	13	0	7	NO corrections are required for this element	
§C.4.117, §C.4.119 Rights Protection	30	0	19	NO corrections are required for this element	
§2.554(a)(c) Service Coordination Assessment	5	0	0	NO corrections are required for this element	
§9.583(h)(2) Program-Specific Training	0	0	0	Not Applicable	
PARTICIPANT GRAND TOTALS	**435**	**27**	**382**	**PARTICIPANT GRAND TOTAL SCORE**	**98.93%**

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

TEXAS HOME LIVING AUTHORITY REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
01/23/23 - 01/26/23

OVERALL	98.93%

In accordance with §9.582(c), for any item of non-compliance remaining uncorrected by the LIDDA at the time of the review exit conference, the LIDDA must, within 30 calendar days after receiving a notice of deficiency, the LIDDA must submit to HHSC IDD Services a Corrective Action Plan (CAP).

The CAP must include the following:

- The date by which the deficiency will be corrected, which date may not exceed 90 days after the day of the exit conference or the date identified in the notice of deficiency, unless HHSC, IDD Services approves an additional amount of time prior to the expiration date;
- Identification of the party responsible for ensuring the deficiency is corrected;
- The actions that have been or will be taken to correct the deficiency, and
- A description of the systematic change and monitoring system implemented to ensure the deficiency does not re-occur, including the frequency of the monitoring and the party responsible for monitoring.

The CAP is due to HHSC IDD Services no later than **March 10, 2023**.

Within 10 business days of receiving this report, the LIDDA may request a reconsideration of findings based on the evidence originally reviewed by HHSC, IDD Services. The reconsideration request must be in writing via email to the Review Facilitator. Submission of new or additional information will not be considered. Requests for reconsideration will not affect the CAP due date HHSC, IDD Services will respond via email to the LIDDA's request for reconsideration within 15 calendar days after receiving the request.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

TEXAS HOME LIVING AUTHORITY REVIEW
FY 2023 REPORT OF FINDINGS

280 - The Harris Center for Mental Health and IDD
01/23/23 - 01/26/23

OVERALL	**98.93%**

In accordance with the FYs 2022 and 2023 Performance Contract, Attachment C. Article 3 and Article 4.1.1, the TxHmL Authority Review Report of Findings is shared at the time of the Exit Conference. The report will also be shared with the Contract Manager. If remedies or sanctions are required, the Contract Manager shall send to the LIDDA notice of the LIDDA's alleged noncompliance and HHSC IDD Services specified remedies or sanctions after receipt of the CAP.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov

For Hard Copy Submission:
IDD Contracts Unit Intellectual and Developmental Disabilities Services, IDD-BH -Mail Code W-354
P.O. Box 149030
Austin, TX 78714-9030

Please extend our appreciation to your staff for their cooperation during this review. If you have any questions or require additional information, please contact:
Denice Cadena **Email:** **Denice.Cadena@hhs.texas.gov**

Denice Cadena, Contract Specialist, Facilitator
Charvey Betts, Contract Specialist
Sharon Cummings, Contract Specialist
Blake Hensley, Contract Specialist
Marselena Hernandez, Contract Specialist
Mercedes Hernandez, Contract Specialist
Tondria Jones, Contract Specialist
Kristina McClure, Contract Specialist
Donna Pendleton, Contract Specialist
Veronica Reyes, Contract Specialist

Cecile Erwin Young
Executive Commissioner

TEXAS HOME LIVING AUTHORITY REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

Elements for Review	Expectations	Findings	CAP See attachment for instructions to LIDDA		Responsible LIDDA Manager(s)	Projected Completion Date
§9.583(h) Service Coordinator Assurances	(2) coordinates the development and implementation of the individual's PDP;	For T3, the outcomes associated with the non-TxHmL service of PCP and the TxHmL service of Dental in the PDP dated 6/6/22 were not supported by the discovery information. For T3, the outcome associated with the CFC service of PAS/HAB in the PDP dated 6/6/22 was developed by someone other than the individual.	**Specific:**	T3 The SPT meeting with the individual/LAR, the SC will update the PDP, to revise the discovery information to support the outcome of non TXHML services of PCP and the TXHML services of Dental. T3 The SPT meeting with the individual/LAR, the SC will address discovery information to support outcomes for the non-TXHML service of PCP and the TXHML service of Dental to make them an outcome.	*Program Director, Deandra Hines or Designee*	*9-May-23*
§9.583(h) Service Coordinator Assurances	(2) coordinates the development and implementation of the individual's PDP;	For T4, the outcome associated with the non-TxHmL service of PCP was a service statement in the PDP dated 5/18/22.	**Specific:**	T4 The SC will convene an SPT meeting with the individual/LAR to address updating/changing the outcome for the non-TXHML service of PCP to make them a person-centered outcome. This will be evidence by a revision of the PDP	*Program Director, Deandra Hines or Designee*	*9-May-23*
§9.583(h) Service Coordinator Assurances	(2) coordinates the development and implementation of the individual's PDP;	For T5, the outcome associated with the CFC service of PAS/HAB was a service statement in the PDP dated 7/26/22.	**Specific:**	T5 The SC will convene an SPT meeting with the individual/LAR to discuss updating/changing the outcome for the CFC service of PAS/HAB to make it a person centered outcome. This will be evidence by a revision of the PDP.	*Program Director, Deandra Hines or Designee*	*9-May-23*
§9.583(h) Service Coordinator Assurances	(4) monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	For T2, there was no evidence of monitoring satisfaction for any services from the perspective of the person during the first 90-day reporting period for the IPC with a begin date of 6/28/22. For T2, there was no evidence of monitoring satisfaction with the non-TxHmL service of PCP, the TxHmL service of Dental and the CFC/CDS service of PAS/HAB from the perspective of the person during the second 90-day reporting period for the IPC with a begin date of 6/28/22.	**Specific:**	T2 Future documentation will evidence monitoring satisfaction/dissatisfaction of the non-TXHML and TXHML services monthly or at least once every 90 days from the perspective of the individual. T2 Future documentation will evidence monitoring satisfaction/dissatisfaction of the non-TXHML service of PCP, and the TXHML service of Dental and CFC/CDS service of PAS HAB services monthly or at least every 90 days from the perspective of the individual.	*Program Director, Deandra Hines or Designee*	*9-May-23*

Cecile Erwin Young
Executive Commissioner

TEXAS HOME LIVING AUTHORITY REVIEW
FY 2023 - Corrective Action Plan

280 - The Harris Center for Mental Health and IDD

Elements for Review	Expectations	Findings	CAP See attachment for instructions to LIDDA		Responsible LIDDA Manager(s)	Projected Completion Date
§9.583(h) Service Coordinator Assurances	(4) monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	For T5, there was no service coordinator contact for the months of August and September 2022. The service coordination plan in the PDP dated 7/26/22 stated contact frequency as monthly.	**Specific:**	T5 Future documentation will evidence monitoring based of the frequency indicated in the PDP.	*Program Director, Deandra Hines or Designee*	*9-May-23*
§9.583(h) Service Coordinator Assurances	(5) records each individual's progress;	For T2, there was no evidence of reporting progress/lack of progress towards the outcomes associated with the TxHmL services of Dental from the perspective of the person during the second 90-day reporting period for the IPC with a begin date of 6/28/22.	**Specific:**	T2Future documentation will evidence monitoring progress/lack of progress of the TXHML service of Dental from the perspective of the individual.	*Program Director, Deandra Hines or Designee*	*9-May-23*

The CAP must be submitted to the Contract Manager, within 30 calendar days, after receiving notice of any deficiency identified in the Report of Findings.

For Electronic Submission: iddperformance.contracts@hhs.texas.gov
For Hard Copy Submission: HHSC, IDD Contracts Unit, IDD/BH-Mail Code W-354
P.O. Box 149030
Austin, TX 78714-9030

January 27, 2023

The Harris Center for Mental Health and IDD
9401 Southwest Fwy
Houston, TX 77074-1407
Sent via email: wayne.young@theharriscenter.org; veronica.franco@theharriscenter.org
Attn: Wayne Young, CEO; Veronica Franko, Executive Administrative Assistant

Dear Wayne,

On behalf of Optum Behavioral Health Solutions/UnitedHealthcare Community and State, thank you for taking the time to meet with us on 10/27/2022 to provide information about your agency and discuss your billing and practice patterns. This letter is to identify next steps after our meeting.

Based on our discussion, we will continue to monitor your practice patterns and claims. We would also like to review some of your cases through our audit process. Optum Behavioral Health Solutions/UnitedHealthcare Community and State conducts reviews of providers as part of our effort to fulfill contractual provisions between Optum Behavioral Health Solutions/UnitedHealthcare Community and State and contracted providers. Your contract specifies an agreement for review of documentation. The review is also a forum for education on maintaining records based on the Optum Behavioral Health Solutions/UnitedHealthcare Community and State standards for treatment record documentation.

For the review you will need to submit records for **10** Optum Behavioral Health Solutions/UnitedHealthcare Community and State members. Please include the requested information indicated in the table on the following page.

In accordance with the HIPAA guidelines, reasonable precautions should be taken to avoid inadvertent disclosures. Therefore, records must be shipped in a manner that prevents unauthorized disclosure (this includes using appropriately sized envelopes or mailing containers that are adequately sealed).

By **2/27/2023** please mail, upload, or fax the information outlined in the table below, including:

- Face Sheet
- Biopsychosocial Assessments
- Diagnostic Assessments
- Functional Assessments
- Initial Treatment Plan(s)
- All Treatment Plan Reviews
- **Most recent 6 months of Progress Notes** (if member has discharged, the last 6 months of notes prior to discharge date)
    - Psychotherapy
    - Skills Training and Development
    - Targeted Case Management
    - Psychosocial Rehabilitation
    - Medication Management
- Evidence of Coordination of Care
- Discharge Plan/Summary
- Program Description:
    - Comprehensive program descriptions and clinical policies for all levels of care

The requested records can be sent by one of the methods listed below:

- By Electronic Communication Gateway (ECG), allowing you to upload the requested medical records (one complete file upload per member- zip files cannot be accepted):
  - Will require registration which can be facilitated by Practice Specialist

- By a trackable method to the address below (paper records only):
  USPS:
  OHBS Practice Management
  Attn: PO Box 30780
  4050 South 500 West
  Salt Lake City, UT 84130-0780

  FedEx/UPS
  OHBS Practice Management
  Attn: PO Box 30780
  4050 South 500 West
  Salt Lake City, UT 84123

- By secure fax to (248) 733-6135 (paper records only, one complete fax submission per member record)

When sending by mail, please include the **full** address exactly as it is listed above to ensure delivery to the correct person.

Thank you for your cooperation. If you have any questions or need any additional information, please feel free to contact me at (763)340-7633 or bryan.c.adkins@optum.com.

Sincerely,

Bryan Adkins, LCSW
Clinical Practice Specialist | Public Sector Practice Management
Optum Behavioral Health
bryan.c.adkins@optum.com
Phone: (763)340-7633
Fax: (844)291-8752

Please submit the following records for each member and date of service indicated in the table below:

Member Number	Member Last Name	Member First Name	Member Date of Birth	Requested Information
xxxx05190	[redacted]	[redacted]	10/31/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx17548	[redacted]	[redacted]	1/5/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx82249	[redacted]	[redacted]	7/22/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx27881	[redacted]	[redacted]	12/14/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*

xxxx35166			10/2/20xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx29793			10/13/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx85897			11/7/20xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx02445			6/14/20xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx26870			9/9/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*
xxxx15401			2/10/19xx	Full patient chart for date of service **8/3/2021-1/27/2023.** See above for specifics. *Note: We are requesting the most recent 6 months of Progress Notes*

TEXAS
Health and Human Services

Form 3701
October 2020

Preliminary Findings Based on Survey, Inspection or Investigation

Facility/Agency/Program Provider Name	Entrance Date	Exit Date
Westbury	1/31/2023	2/1/2023

Physical Street Address	Purpose of Visit
5707 Warm Springs	☒ Survey ☐ Complaint ☐ Other (describe)

City	ZIP Code	County
Houston	77035	Harris

Facility/Agency/Program Provider Type	Facility ID/Vendor No.
☐ ADC ☐ ALF ☐ HCSSA ☐ SNF/NF ☒ ICF/IID ☐ HCS ☐ TxHmL	003721

Administrator/Manager/Program Director Name	Contract Number and Component Code (HCS/TxHmL only)
Omar Flaherty, QIDP	

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. **Note:** If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Potential Noncompliance
☐	☐	
☐	☐	
☐	☐	
☒	☒	No deficiencies Cited
☐	☐	
☐	☐	
☐	☐	
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Signature – Administrator/Program Director or Designee	Date
Omar Flaherty	2-1-23
Signature – Team Leader or Surveyor	**Date**
Austin Patrick	2/1/2023

Form 3701
October 2020

Preliminary Findings Based on Survey, Inspection or Investigation

Facility/Agency/Program Provider Name	Entrance Date	Exit Date
Applewhite	1·10·2023	1·12·2023
Physical Street Address: 526 Applewhite	Purpose of Visit: ☑ Survey ☐ Complaint ☐ Other (describe) ____	
City: Katy	ZIP Code: 77450	County: Harris
Facility/Agency/Program Provider Type: ☐ ADC ☐ ALF ☐ HCSSA ☐ SNF/NF ☑ ICF/IID ☐ HCS ☐ TxHmL	Facility ID/Vendor No.: 456407 / 3688	
Administrator/Manager/Program Director Name	Contract Number and Component Code (HCS/TxHmL only)	

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. **Note:** If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Potential Noncompliance
☐	☐	
☐	☐	No Deficiencies cited
☐	☐	
☐	☐	
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Signature – Administrator/Program Director or Designee	Date
Lily Pan	1-12-23
Signature – Team Leader or Surveyor	Date
Crystal Harris	1·12·23

Form 3701
Page 2
October 2020

Continued from the previous page.
Use this sheet if there are additional preliminary areas of potential noncompliance.

Facility/Agency/Program Provider Name	Entrance Date	Exit Date

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. **Note:** If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Potential Noncompliance
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Signature – Administrator/Program Director or Designee	Date
Signature – Team Leader or Surveyor	Date

TEXAS
Health and Human
Services

Form 3701
October 2020

Preliminary Findings Based on Survey, Inspection or Investigation

Facility/Agency/Program Provider Name: Pasadena Cottage	Entrance Date: 1/10/23	Exit Date: 1/12/23
Physical Street Address:	Purpose of Visit: ☒ Survey ☐ Complaint ☐ Other (describe)	
City: Pasadena	ZIP Code: 77502	County: Harris
Facility/Agency/Program Provider Type: ☐ ADC ☐ ALF ☐ HCSSA ☐ SNF/NF ☒ ICF/IID ☐ HCS ☐ TxHmL	Facility ID/Vendor No.: 007807	
Administrator/Manager/Program Director Name:	Contract Number and Component Code (HCS/TxHmL only):	

This list contains preliminary areas of potential noncompliance with federal and/or state requirements, based on findings from the entrance and exit dates listed above. **Note:** If the visit was to an assisted living facility, refer to the attached checklists.

State	Federal	Brief Description of Potential Noncompliance
☐	☐	
☐	☐	No deficiencies cited
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☐	☐	
☐	☐	
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Signature – Administrator/Program Director or Designee	Date
Lily Pan	1/12/23
Signature – Team Leader or Surveyor	**Date**
[signature]	1/12/23

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 17, 2023

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

Dear Wayne Young,

Texas Health and Human Services (HHSC) will conduct the annual Youth Empowerment Services (YES) Waiver program review for Harris Center for Mental Health and IDD on March 20, 2023. Due to the current situation surrounding the COVID 19 pandemic, and out of an abundance of caution for your team and ours, this review will be conducted remotely. This review is necessary to comply with the Center for Medicare and Medicaid Services requirements to provide quality and financial oversight of waiver administration and operations.

The YES Quality Management team will conduct an entrance conference prior to the initiation of the remote review to answer any questions you and your team may have. This call is scheduled for March 13, 2023 at 9:00 am and will take place via video or telephone conference line. The sample of individuals selected will also be provided during the entrance conference. The attached document request list identifies items that must be made available to the YES Quality Management team via remote access to your Electronic Health Record or by electronic transmission (i.e., PDF documentation submitted by e-mail.)

HHSC personnel will review clinical and administrative records and provide technical assistance and consultation to program staff regarding the YES Waiver. The remote review is intended to ensure that requirements are met in the following areas: inquiry list management, eligibility; freedom of choice; qualifications of service providers; administrative procedures; health, safety, and welfare; billing and reimbursement; and service plans using the Wraparound planning process.

Please contact me at linda.gonzalez@hhs.texas.gov should you have any questions prior to the date of the site review.

Sincerely,

Linda Gonzalez, YES Waiver, Program Specialist
Health and Human Services Commission
Medical and Social Services, Behavioral Health Services

Cc: Stella Olise, Practice Manager, 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, Manager YES Waiver, HHSC
Chera Tribble, YES Waiver Liaison, HHSC
Rashida Broussard, Manager BHMP QM, HHSC
Simona Haqq, Quality Improvement Lead, HHSC
Eva Mendoza, QM Program Specialist, HHSC
Renee West, HHSC, Contract Manager

ADMINISTRATIVE AND PROGRAMMMATIC REVIEW

INITIAL REPORT

Date:2/24/23

Provider: MHMR of Harris County

Program Name	Contract Number	Award Amount	Contract Period
The Harris Center for Mental Health and IDD	HHS000640200031	$14,029,725.00	**9/1/2022-8/31/2023**

Date of Review: **1/17/23-1/19/23**

Scope of Review: Administrative and Programmatic
12/1/21-11/31/22

HHS ECI Reviewers:

- **Meaghan Ramgoolam, ECI**
- **Jessica Mitchell, ECI**

Exit Conference Participants:

- **Stephanie Meads, Harris Center**
- **Jannette Olguin, Harris Center**
- **Camelia Lee, Harris Center**
- **Rhonda Mcdonald, Harris Center**
- **Joseph Gorczyca, Harris Center**
- **Keena Pace, Harris Center**
- **Britt Lance, Harris Center**
- **Wayne Young, Harris Center**
- **Janene Roch, ECI**
- **Jessica Mitchell, ECI**
- **Meaghan Ramgoolam, ECI**

Summary of Review

Purpose & Authority: Contract # **HHS000640200031** 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

ADMINISTRATIVE REVIEW

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 **40** complete records within a 12-month review scope. Of the **40** reviewed, some requirements were out of scope or were not applicable to the child whose record was being reviewed.

Of the **40** records reviewed, compliance requirements were met for the area(s) identified below:

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 **0%** of procedures noted as out of compliance.

Compliance requirements were met for the areas identified below:

- A review of the IFSP did occur every six months or more frequently, if conditions warranted or if the family requested it.
- The periodic IFSP review did document the degree to which progress toward achieving the outcomes identified in the IFSP is being made, and changes or no changes in service.
- 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.

IFSP: Transitions

Records were reviewed to determine if the transition plan is completed in accordance with ECI 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:

- 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.

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 **40** TKIDS data entry items were reviewed from all client records with **0%** noted as out of compliance.

Requirement: ECI Contract, Section XXXVIII.A

Annual Verification of Third-Party Coverage:

Records were reviewed to ensure third-party coverage is verified at least annually. A sample of **40** records were reviewed from the monthly verification reports, with **0%** noted as out of compliance.

FINDINGS

ADMINISTRATIVE REVIEW

Of the personnel records reviewed, compliance requirements were not met for the area(s) identified below:

Finding #1: 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 **24%** out of compliance.

Requirement: 26 TAC §350.309

Corrective Action: The program must provide a written corrective action plan, including management oversight to ensure only qualified personnel provide services or work on the ECI program. Submit a plan using the attached template with specific timelines for implementation to ensure compliance with this requirement.

PROGRAM REVIEW

Of the **40** client records reviewed, compliance requirements were not met for the area(s) identified below:

Finding #2: 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 **2%** procedures noted as out of compliance.

Findings of non-compliance include:

- Prior written notice was not provided to the family for the evaluation and consent was obtained.
- Prior written notice of the IFSP meeting was not provided to the family.
- Informed written consent was not obtained from the family before providing any ECI services.

Compliance requirements were met for the areas identified below:

- A copy of the ECI Parent Handbook was provided to the family.

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.

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: 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 **3%** of procedures noted as out of compliance.

Findings of non-compliance include:

- Oral and written explanation was not provided to the parent during the pre-enrollment process and other times when parental consent is required as reflected in documentation.

- The required program forms in Spanish or other appropriate language based on needs were not provided.

Compliance requirements were met for the areas identified below:

- Contractor did provide the family rights publication (parent handbook) in the appropriate language.
- 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

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.

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 #4: 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 **7%** of procedures noted as out of compliance.

Findings of non-compliance include:

- The interdisciplinary team did not provide a review of nutrition status, assistive technology and an autism screening (as warranted) as part of the assessment.

Compliance requirements were met for the areas identified below:

- 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.
- The Eligibility Statement did document the child eligibility decisions of the interdisciplinary team or did reflect supporting documentation.
- 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 #5: 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 **1%** procedures noted as out of compliance.

Findings of non-compliance include:

- The initial IFSP was not conducted within 45 days from the date of referral receipt.
-

Compliance requirements were met for the areas identified below:

- 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 contain all the following: the service, discipline of the provider, frequency, intensity, location, method, start and end date, and payments sources.
- 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 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)

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 #6: 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 **5%** procedures noted as out of compliance.

Findings of non-compliance include:

- The IFSP did not include measurable outcomes expected to be achieved for the child and family.

Compliance requirements were met for the areas identified below:

- 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.

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 #7: 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:

- Services were not provided by qualified personnel.
- Services were not 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 not delivered according to the IFSP.

Compliance requirements were met for the areas identified below:

- Case management services provided included assisting the family in identifying available services or making referrals to address identified needs.
- Case management services included 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 delivered within 28 days of the parental signature on the IFSP.

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: The program must provide a written corrective action plan, including management oversight to ensure service planning is reflective of the child and family's needs. Submit a 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 #8: 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 **4%** of procedures noted as out of compliance.

Findings of non-compliance include:

- Documentation of each service did not contain 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 did not include a description of the contact, the child's progress, and family or routine caregiver participation in the activities.

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

Individual child findings reflect specific findings of noncompliance for an individual client. Individual child findings are listed in an attachment to this report. Within six months of receipt of the final monitoring report, Contractor 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 comprehensive administrative and programmatic review is recommended at this time. In six to eight months a follow-up onsite review will be conducted to ensure that all corrective action plans have been implemented successfully and that all individual child findings have been cleared.