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

Audit Committee Meeting
July 18, 2023
12:30 pm

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, May 23, 2023
(EXHIBIT A-1)

IV. **REVIEW AND TAKE ACTION**

A. FY24 Internal Audit Plan
(EXHIBIT A-2)

V. **REVIEW AND COMMENT**

A. Internal Audit FY2023 Q3 Audit Reports
(EXHIBIT A-3 David Fojtik)

B. Compliance Department Report
(EXHIBIT A-4 Demetria Martin)

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

VII. **RECONVENE INTO OPEN SESSION**

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

IX. **INFORMATION ONLY**

A. Compliance Department Binder
(EXHIBIT A-5)

B. Internal Department Binder
(EXHIBIT A-6)

X. **ADJOURN**

Veronica Franco

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

EXHIBIT A-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
AUDIT COMMITTEE MEETING
TUESDAY, May 23, 2023
MINUTES

Dr. Lois Moore, Committee Chair, called the meeting to order at 8:33 a.m. in Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

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

Committee Member in Absence: None

I. **DECLARATION OF QUORUM**

Dr. Moore called the meeting to order at 8:31 a.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, January 17, 2023

MOTION: SANTOS SECOND: MOORE

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

IV. REVIEW AND COMMENT

A. Internal Audit Report, presented by David Fojtik and included in the May 23, 2023, Audit Agenda Packet under Exhibit A-2.
B. Compliance Department Report, presented by Demetria Martin and Carrie Rys and included in the May 23, 2023, Audit Agenda Packet under Exhibit A-3.

V. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VI. ADJOURN-

MOTION: SANTOS **SECOND: MILLER**
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 9:18 a.m.

_____

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

August 31, 2023

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

Re: Fiscal Year 2024 Annual Audit Plan

Dear Mr. Young:

I am pleased to submit to you the Fiscal Year 2024 Annual Audit Plan. Previously, I had requested input as to possible areas of audit resource concentration from the Board of Trustees, Executive Staff, and others. This document serves as the primary work plan to carry out core auditing responsibilities in an efficient way established by Internal Audit. The plan was developed partially by utilizing the Enterprise Risk Assessment, which details specific risk profiles from each of the Center's Divisions.

The Fiscal Year 2024 Annual Audit Plan includes primarily reviews of financial controls and also provides for follow-up and special projects.

I hope you find this information useful and informative.

Respectfully submitted,

_____
David W. Fojtik, CPA, MBA, CIA, CFE
Director of Internal Audit

OFFICE OF THE INTERNAL AUDITOR

Fiscal Year 2024 Annual Audit Plan

Internal Audit's annual audit plan uses a risk assessment model based on auditable business entities in the comprehensive agency-wide business risk assessment tool, which mathematically prioritizes the entities in numerical order. The audit plan is enhanced with input from the Center's executive staff and department managers. The plan serves as the primary work plan to carry out the audit responsibilities in an efficient manner, and seek the priorities established by the office of the Internal Auditor at The Harris Center (THC).

Due to the continual request for audit services, the unknown extent of our report findings, and the required testing for the future planned audits, the Audit Plan should be kept fluid, so it can therefore be revised appropriately with approval from the Audit Committee.

Background

The Internal Audit Department is an independent, objective assurance consulting activity that issues its findings and recommendations to the Chief Executive Officer (CEO), THC senior management, the Audit Committee Members as well as to the Board of Directors.

The mission of the Internal Audit Department is to provide independent reports that show analyses, assurances, and recommendations concerning the adequacy and effectiveness of the Center's internal control structure, safeguarding and utilization of Center resources, and management's performance in carrying out assigned responsibilities. The scope of activities carried out by the Internal Audit Department may include:

- Evaluating and enhancing the Center's accounting policies and procedures that constitute its internal control structure.
- Assessing compliance with appropriate policies, laws and regulations.
- Evaluating the accuracy of reported data utilized by departmental and Center management in making operational decisions.
- Appraising the economy, efficiency, and effectiveness of the Center's organization, programs, functions and activities.
- Assessing efficiency of operations and developing recommendations for cost savings.
- Ascertaining that all Center revenue is maximized, safeguarded, and controlled.
- Ascertaining that all operational data is safeguarded and accurately maintained.
- Ascertaining how Center assets are accounted for and safeguarded from loss.
- Investigating allegations of financial fraud, waste and theft through various sources.

Risk Assessment

Risk assessment is the identification and analysis of relevant risk to the achievement of an organization's objectives for the purpose of determining how risks can be managed.

Risk assessment implies an initial determination of operating objectives and systematic identification of those things that could prevent each objective from being fully attained. In other words, it is an analysis of what could go wrong.

Not all risks are equal. Some are more likely than others to occur, and, as such, will have greater impact than others if they occur. So, once risks are identified, their probability of occurrence and economic significance must be assessed.

Finally, having identified and assessed risk, management must decide how to deal with it. In some cases, the decision may be to control it; in others it may be to accept it.

The risk management process is ongoing. Internal and external factors constantly develop and present ongoing hazards to the Center's initial business plans. Change itself is a risk and management must adapt policies and procedures to manage these ever-changing risks to a more comfortable level, or at least, to approximate management's risk appetite. The appropriate response to the identified risk is widely known as the risk response process.

Each unit at the Agency faces its own challenges and each unit must assess how it will manage them to meet its objectives. A good internal control system can mitigate the risks, and Internal Audit can advise how to develop good internal controls.

The Internal Audit Department routinely assesses business risks throughout the Center. We seek input from the executive staff and management, and to discuss risks with the external auditors for wide range of risks and their likelihood or importance to mitigate.

The results of the management assessment are used to prepare a preliminary Audit Plan but Internal Audit takes the additional due diligence to deconstruct each of the submitted auditable business entities, to evaluate if any new risks have emerged.

The risk assessment model includes ten areas of factors that influence control variation. The model provides Internal Audit with an objective analysis for prioritizing auditable entities that are more profoundly affected by changes in the operating environment or are subjected to more uncontrolled levels of business risk. The following key risk criteria factors more heavily considered in the achievement of the Center's strategic objectives:

RISK ASSESSMENT MODEL

Nature of Operations

1) Significant Changes
2) Pressure Meeting Objectives
3) Clearly Defined Objectives
4) Strategic Value
5) Inherent Risks

Nature of Transactions

1) Number of Transactions
2) Complexity of Transactions
3) Accuracy of Information

Management

1) Attention Given by Management
2) Monitoring Activities

External Influences

1) Compliance With Regulations
2) Market Stability

Systems

1) Integrity: Reliance on Information Systems
2) Relevance: Ability to Satisfy Business Objectives
3) Access: Unauthorized Access and Transactions
4) Availability: Level of Support
5) Complexity: Relative Number of Transactions, Files, and Devices

Dollar Volume/Materiality

1) Materiality

Changes in Procedures/Personnel

1) Training/Experience
2) Adequacy of Staffing Levels
3) Segregation of Duties

Results of Prior Audits

1) Audit Findings
2) Follow-up

Time Since Last Audit

1) Time Since Last Audit

Opportunities to Achieve Operating Benefits

1) Opportunity Identification
2) Risk Assessment
3) Management Interest/Request

Center-Wide Updated Enterprise Risk Assessment Tool

The Director of Internal Audit reached out to the leadership team members to evaluate the Center-Wide Updated Enterprise Risk Assessment Tool. This process discussed tying the specific objectives of the Center's Strategic Plan to identified THC business entities. For example, the increased activity in telehealth services is a Strategic Plan Objective which touches the clinical unit, the revenue management and third-party billing aspects, and security issues for the Information Technology Department. Prior to this approach, the risk assessment was more limited to the business risks posed by just one department. The Center-Wide Updated Enterprise Risk Assessment views risk strategically and bases its foundation on creation of Strategic Plan showing the objectives and accomplishments.

Audit Focus Areas

The Business Risk Assessment model is a planning tool to determine the best investment for Internal Audit's time and activities. Departmental processes or activities with higher or moderate risks are prioritized in the Center's Business Risk Assessment Model. The Internal Audit Department's audit plan is structured on the outcome of this model. The objective of the audit plan is to prioritize limited resources of people and budget dollars, based on the model's outcomes, and management's need for vital information.

The audit plan prioritizes audit focus on either agency-wide processes or departments with processes or activities having high or moderate residual risk. As such, the Center's audit function serves as a risk management tool through the development of improved control processes as a result of performance improvement and financial auditing, as well as a control with the performance of the revenue enhancement and compliance audits.

Audit Programs

Audit activities will vary as a result of the differences in the nature of operations, organizational structure, by management style and by the competence of employee capabilities, and by the concepts of operation control. Specific audit programs will be developed from each activity within the next fiscal year ending on August 31, 2023.

Audit programs will be custom-designed in regards to business services, compliance requirements, performance considerations, and any specialized skills or knowledge that is required for each auditable entity worthy of an audit project. All audit programs, work papers and reports are prepared in accordance with appropriate professional standards.

Special Audit Requests, Special Consulting Activities, and Follow-Up Audits

The Internal Audit Department will also provide assistance to management when they request special projects covering pertinent incidents found in their area of responsibility. These special projects are performed in addition to the normally scheduled audit work.

Internal Audit performs follow-up audits as needed to adequately address auditable issues that may arise usually due to a change in regulations, or on new risks, or in some cases because the auditable entity is a project in development that evolves over time and therefore introduces new risks.

SUMMARY OF FY2024 RISK ASSESSMENT WORKSHEET

Internal Audit maintains a population of auditable entities that change in terms of their risk profile as business conditions change at the Center. The Risk Assessment Worksheet shows the auditors auditable entities and follows a path of risk ratings for those entities, which can be a change in staffing, new computer system, or the time since the last audit.

Internal Audit's risk assessment worksheet is compatible to past worksheets. The process allows the auditor to assign a "9" to a high risk to assigning a "1" to a low risk, and when the scores are summarized, the entities with the highest overall risk ratings appear along the top of the worksheet. The business entity's total risk points are 243 points, so the ratio of 181 points/243 points = 74.49% represents a high-risk process (as shown below).

We found that many of the Center's complex units operate with more risks situated at the top of the Risk Assessment Worksheet. In order to keep our population of audit projects more robust, Internal Audit seeks to provide readers with a mix of operational, financial and compliance audits by including Agency Contracts with Service Agencies (91 points). The Audit Plan contains both high risk and low risk entities to add diversity and coverage of agency-wide issues. Additionally, we engage with process owners to identify any other higher risk processes that they would recommend for an internal process controls review.

Here are projects in the Risk Assessment Worksheet for the Fiscal Year 2024 Audit Plan sorted from a high to a lower number of Total Points and percentage of maximum score, which totals an overall 243 points possible in the current assessment model.

Audit Projects	***Total Points***	***Percentage***
Bank/Treasury/Investment Controls	152	62.5%
New Vendor Setups/Vendor Changes/Chase App.	129	53.1%
Third-Party Billings and Refunds	128	52.6%
Security Services	102	41.9%
Accounts Receivable and Fee Collections	176	72.4%
Bank Reconciliations	150	61.7%
Review of Checks/EFT/ACH Signature Levels	102	41.9%
Audit Follow Up/Special Audit Requests	Various	Various
Consulting Activities	Various	Various
Provide Assistance to External Auditors	60	24.7%

Internal Audit has discussed business unit changes with senior management in order to identify all changes in personnel, changes in system or workflows, or the possibility of potential losses due to a workflow with faltering business controls, or if administrative staff performance becomes ineffective due to the lack of solid policy and procedures.

FISCAL YEAR 2024 AUDITS

Approval is requested for the below listed project areas to be audited in Fiscal Year 2024. At any time starting any special request/project may warrant adjustments in the schedule. The list below does not represent any particular order because the sequence of the audits will depend upon the availability of the Center's schedules for internal or external staffs.

1) **Review of Check/EFT/ACH Signature Levels** ***(****120 Hours Scheduled****)***
2) **Bank/Treasury/Investment Controls** ***(****120 Hours Scheduled****)***
3) **New Vendor Setups/Vendor Changes/Chase App.** ***(****40 Hours Scheduled)*
4) **3rd Party Billings and Refunds** *(150 Hours Scheduled)*
5) **Security Services** *(120 Hours Scheduled)*
6) **Accounts Receivable and Fee Collections** ***(****150 Hours Scheduled****)***
7) **Bank Reconciliations** ***(****80 Hours Scheduled****)***

Plus:

8) **Audit Follow Up/Special Audit Requests** – *(500 hours Scheduled*)
9) **Consulting Activities** – *(80 hours Scheduled)*
10) **Provide Assistance to External Auditors** – *(80 hours Scheduled)*

Total Direct Audit Hours	*1,440 Hours*
Indirect Hours (PTO, Training, Scheduling, Administration.)	*500 Hours*

There are 1,440 audit hours scheduled for Fiscal Year 2024, with emphasis on Financial Services. As strategic objectives and risk of new business entities increase, Internal Audit will continue to provide value by co-sourcing arrangements with external auditors and other experts who can enable Internal Audit to assess threats, prepare and execute audit plans, and acquire innovative skills through knowledge transfer. We remain a learning organization.

The Fiscal Year 2024 Annual Audit Plan consists of a variety of auditable entities. In practice, Internal Audit works on two or three audit projects concurrently because the fieldwork on any one audit project can be lengthy but not productive enough to satisfy the auditor's requirements. Sometimes the auditor asks for several meetings with the business process owner (which take time to schedule), and other auditees may be contacted to gain more of their specialized insight.

The Internal Audit Department audit projects can be charted for general planning purposes to show our commitment to audits identified by the Enterprise-Wide Risk Assessment Model and those that were shared with members of the Board of Directors, and the senior staff of THC. These proposed projects are subject to the Board of Trustees' review and approval. In addition, we will expect at least one or more Special Audit Request to be called during the year, and we will assist the external auditors as they review the agency's variety of business operations in preparing the Harris Center's *Comprehensive Annual Financial Report*.

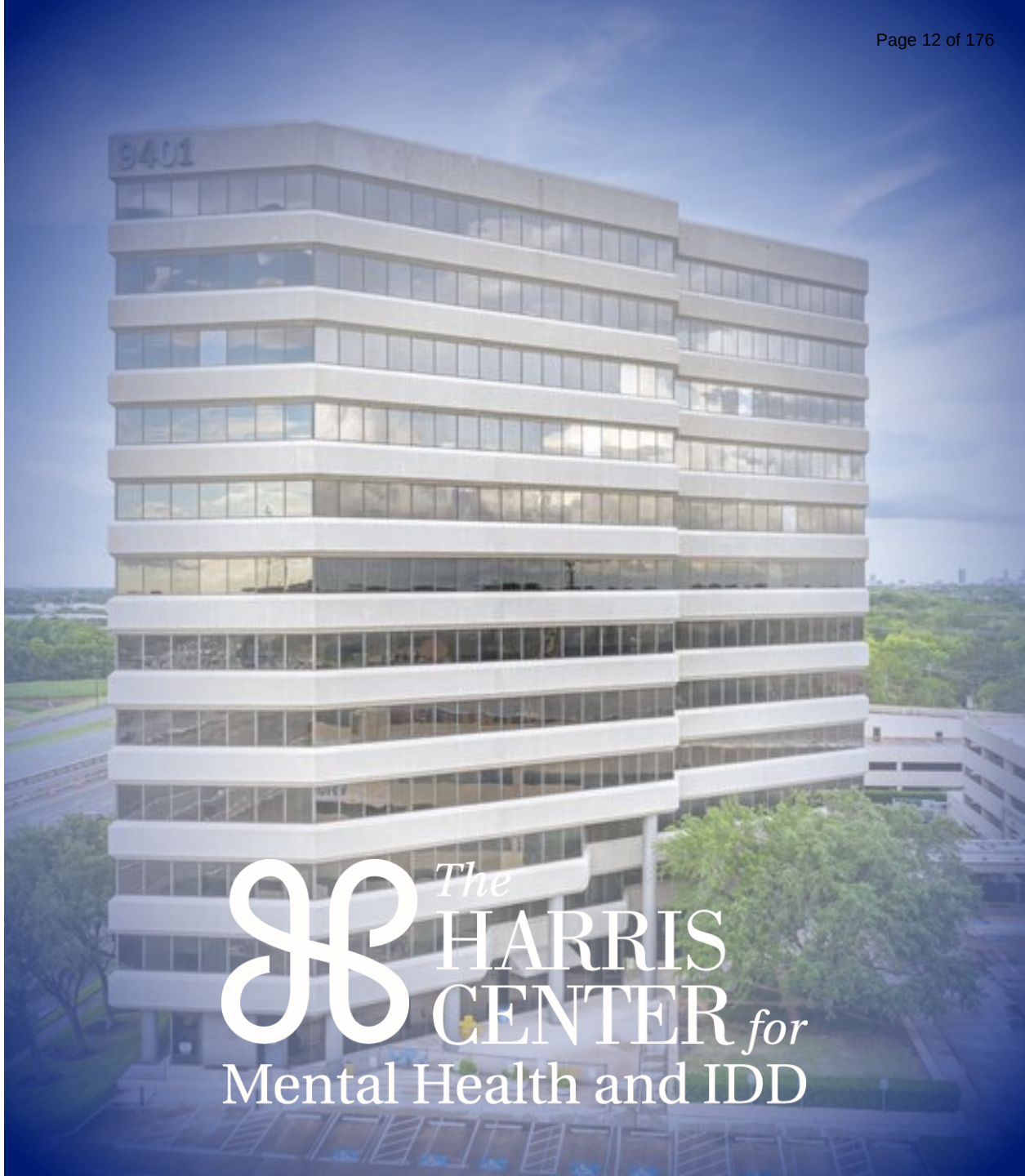
EXHIBIT A-3

FY2023 Q3 Audits

Internal Audit Department

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

July 18, 2023



FY2023 3rd Quarter Reports

The HARRIS CENTER for Mental Health and IDD

Agenda:

Current projects:

- Review and Approval of FY 2024 Proposed Audit Projects
- Follow-up: New Hire Drug and TB Testing Review – (Human Resources)
- Special Management Request: Agency Vehicle Sales Audit (Facility Services)

Pending projects to be presented at the October 17, 2023 Audit Committee Meeting:

- Directed Payment Program (Financial Services)
- Charity Care Program (Financial Services)
- Travel Reimbursement (Financial Services)
- Pharmacy Operations/Inventory Audit (Pharmacy)
- Other Special Management Requests: Accounting Controls

FY2023 3rd Quarter Reports

The HARRIS CENTER for Mental Health and IDD

Review and Approval of FY 2024 Proposed Audit Projects:

Approval is requested for the below listed project areas to be audited in Fiscal Year 2024. At any time starting any special request/project may warrant adjustments in the schedule. The list below does not represent any particular order because the sequence of the audits will depend upon the availability of the Center's schedules for internal or external staffs.

1) **Review of Check/EFT/ACH Signature Levels** ***(****120 Hours Scheduled****)***
2) **Bank/Treasury/Investment Controls** ***(****120 Hours Scheduled****)***
3) **New Vendor Setups/Vendor Changes/Chase App.** ***(****40 Hours Scheduled****)***
4) **3rd Party Billings and Refunds** *(150 Hours Scheduled)*
5) **Security Services** *(120 Hours Scheduled)*
6) **Accounts Receivable and Fee Collections** ***(****150 Hours Scheduled****)***
7) **Bank Reconciliations** ***(****80 Hours Scheduled****)***

- **Plus:**

1) **Audit Follow Up/Special Audit Requests** – *(500 hours Scheduled)*
2) **Consulting Activities** – *(80 hours Scheduled)*
3) **Provide Assistance to External Auditors** – *(80 hours Scheduled)*

FY2023 3rd Quarter Reports

The HARRIS CENTER for Mental Health and IDD

Follow-Up: New Hire Drug and TB Testing Review:

Finding #1 – Internal Audit found one employee hired September 26, 2022 had a background check performed, but had not completed a pre-employment drug and TB test.

Management Response #1 (Director, Talent Acquisition and Organizational Development): "Thank you for your patience – in meeting with my team, below are the dispositions. It would appear that we did in fact have one employee that we cannot locate a drug screen for (Employee #1-SB)."

Management Response Update: "Closing the loop on this; [the named] Employee has completed his drug test is clear." *Internal Audit Note: The employee hired on September 26, 2022 completed the drug testing procedure on or about April 20, 2023.*

FY2023 3rd Quarter Reports

Special Management Request: Agency Vehicle Auction Sale Audit:

Observation #1 – Internal Audit noticed that the Enterprise Leasing procedures include issuing a check for the sales of one or more vehicles, payable to The Harris Center for Mental Health and IDD. However, the actual mailing of the check has been directed to the Transportation Specialist by the Harris Center Mail Room.

The Transportation Specialist then forwards the check to Financial Services for posting and processing. From a control standpoint, however, this check should not be routed to the Transportation Specialist because she is the initial actor during the disposition process.

Management Response not required.

Questions

The HARRIS CENTER for Mental Health and IDD

@TheHarrisCtr @The-Harris-Center @TheHarrisCenterForMentalHealthandIDD

EXHIBIT A-4

Compliance Department

FY23 Q3 Audit Reports

Presented by: Demetria Luckett, Interim Compliance Director

July 2023

Summary of Audits Completed

Reporting Period: March 2023 – May 2023

Six (6) Focus Reviews:

1. Mental Health (MH): Southeast Community Service Center (SECSC) Duplicate/Overlap in Services Review
2. MH: Children Mental Health (CMH) Co-locations: Duplicate/Overlap in Services Review
3. Forensics: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Jr.: Plan of Care/Case Plan Review
4. MH Community Unit Probation Services (CUPS): Plan of Care/Progress Note Review
5. Intellectual Developmental Disability (IDD) Provider Services: Operational Review
6. Comprehensive Psychiatric Emergency Program (CPEP) Provider Service: Operational Review

Summary of Audits Completed

Reporting Period: March 2023 – May 2023

Four (4) Routine Reviews:

1. CPEP: Crisis Intervention Response Team (CIRT)
2. IDD: In-Home Respite
3. MH: Adult Mental Health (AMH) Northwest Community Service Center (NWCSC)
4. MH: AMH Southwest Community Service Center (SWCSC)

Q3 Key Compliance Take-Aways

Focus Review: Southeast Community Service Center and Children Mental Health Co-locations Duplicate Overlap Service Review: In efforts to continue mitigating the identified risk of not having systems in place to identify duplicate services, Compliance has continued to monitor documentation. Documentation strengths and areas of improvement were communicated to the Practice Manager and the identified duplicate services were provided for review and resolution.

A request was submitted by Quality Assurance and Revenue management's leadership to add a solution in Epic to identify services with overlapping times at time of entry, however; Epic reported this was not possible and recommended that the Haris center have a Reporting team develop a report to be used for after the fact auditing of documentation.

Action Plan: Compliance will continue to follow-up with the programs to ensure the execution of the Plan of Improvement (POI) within the next one hundred eighty (180) days concerning documentation findings. Compliance will follow- up with The Electronic Health Record Director on the development of the report to capture overlaps.

Focus Review: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Jr. Plan of Care/Case Plan Focus Review: Results are pending outcome of Review

Focus Review: Community Unit Probation Services Plan of Care/Progress Notes Focus Review: During the review, Compliance observed multiple notes were not completed within 24 to 48 hours. As a result, forty-eight (48) progress notes reviewed were not completed within 24 to 48 hours due to the needing a co-signer. Compliance discovered during the review service delivery documentation erroneously appeared to need a co-Signer to finalize notes to the presence of a radio button in Epic that must be unchecked when a co-signer is not needed. The Electronic Health Record Director was not able to provide a timeline for resolution; however has an optimization request with Harris Health to have the cosigner checkbox default to unchecked instead of checked.

Action Plan: Compliance recommended CUPS complete a Plan of Improvement (POI) to address the issues identified during the review. Compliance will follow up with the program to ensure the fulfillment of its Plan of Improvement (POI) obligations.

Focus Review: Intellectual and Developmental Disabilities Provider and Comprehensive Psychiatric Emergency Program Provider Operational Review: Minor Identified deficiencies were corrected within 24hrs.

Action Plan: Compliance will review the facilities annually to ensure they comply with state and federal regulations.

Q3 Key Compliance Take-Aways

Routine Review: Crisis Intervention Response Team (CIRT): Overall, no deficiencies were discovered during the review; however, Compliance was made aware of a crisis mental health emergency call, where the individual was told by HCSO or HPD dispatcher that no one was available to respond to the call due to not having enough available staff. In further review, the CIRT program has seventeen (17) staff who provide crisis community-based services, and at any given time, The Program Director communicated there may be one (1) to four (4) Harris Center staff members working to assist Harris County Sheriff's Office (HCSO) and Houston Police Department (HPD) to address emergency crisis mental health calls during each work shift.

Action Plan: This information has been brought to the attention of the Harris Center's COO and the Division's VP who are in communication with HPD and HCSO to address the staffing issues.

Routine Review: ID Network Management In-home Respite Routine Review: Overall there were no deficiencies found with the contracted services. The Contractor provided evidence to support contractual obligations. However, Compliance noted the ID Network Management did not provide evidence of monitoring the Contracted Service provider's performance. The Program has began corrective actions to ensure monitoring takes place quarterly.

Action Plan: Compliance will follow up with the program in one hundred and eighty (180) days to ensure the ID Network Management has executed it's plans to track and monitor the contractor's performance.

Routine Review: Northwest Community Service Center (NWCSC) and Southwest Community Service Center (SWCSC): During the review it was noted encounters coded as Routine Case Management did meet TAC case management documentation standards; however did not align with Operational guidelines.

Action Plan: Compliance will follow up with the program to ensure the fulfillment of its Plan of Improvement obligations and reassess the Program's Operational Guidelines within the next one hundred and eighty (180) days

External Reviews

The following is a list of the external reviews (i.e., Governing Bodies, Managed Care Organizations MCO, etc.)

1. Texas Health And Human Services Commission: Substance Use Disorder Compliance Group Routine Inspection Facility License 4554: Site 4708 03/07/2023
2. Texas Health And Human Services Commission: Substance Use Disorder Compliance Group Routine Inspection Facility License 4554: Site 4555 03/09/2023
3. Health and Human Services Commission (HHSC) QM Annual Yes Waiver 03/23/2023
4. HHSC BHS Quality Management Desk Review 4/13/2023
5. U.S. Department of Housing and Urban Development (HUD): Community-wide COVID Housing Program (CCHP)- The Harris Center Dennis St. (Covid -19), Project No. 2020-0048 4/24/2023
6. Harris County American Rescue Plan: Final Report Monitoring Summary and Quality Improvement Plan 04/25/2023
7. Be Well Texas Quality Monitoring 5/ 2023

Thank you.

EXHIBIT A-5

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Duplicate/Overlap Service Review:
Southeast Community Service Center (SECSC)
Mental Health (MH) Division
Review Dates: March 7- 19, 2023

I. **Audit Type:**
Duplicate/Overlap Service Focus Review

II. **Purpose:**
The purpose of this review was to assess the SECSC program for overlapping service documentation. Additionally, 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, §306.263 MH Case Management Services Standards,* and *Agency Policy and Procedure ACC3B Plan of Care.*

III. **Audit 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 SECSC staff during the 3rd Qtr. of FY 2023 (March 7- 19, 2023). Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Compliance discovered two hundred and eighty-three (283) clear overlaps of time for services. There were also subsequent issues found with the progress notes. Forty-three (43) Plans of Care (POC) were not written to authorize routine care services, three (3) POCs were not developed within ten (10) business days after delivery of services, two (2) POCs were not signed by credentialed staff members, six (6) 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, twenty (20) progress notes were not completed within two (2) business days after contact occurred, and two (2) progress notes did not identify the steps necessary to accomplish the goals required to meet the individual's identified needs by using a referral.

There are no previous reviews for duplicate/ overlap services.

V. **Recommendations:**
The SECSC program should review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, and complete documentation in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. The SECSC program should continue to monitor services to ensure duplicate/overlap services are prevented. The SECSC program is not required to submit a plan of improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business.

The Harris Center for Mental Health and IDD

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: March 1, 2023, through May 31, 2023.

Presenter: Demetria Luckett, Interim Compliance Director

Explanation of Reviews:
The following types of reviews were conducted by Compliance during the 3rd 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.

Six (6) Focus Reviews were conducted during the reporting period to ensure regulatory compliance in the following areas: Overlap of Time for Server Reviews, Plan of Care/Case Plan, Plan of Care Progress Note Review, and Operational Reviews.

Two (2) Overlap of Time for Server Reviews were conducted in accordance with The Compliance Department's Audit Schedule.

- Mental Health (MH) Southeast Community Service Center (SECSC)
- MH Co-Locations Children Mental Health (CMH)

One (1) Plan of Care/Case Plan Review was conducted in accordance with The Compliance Department's Audit Schedule.

- Forensics: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Jr. Plan of Care/Case Plan

One (1) Plan of Care/Progress Note Review was conducted in accordance with The Compliance Department's Audit Schedule.

- MH Community Unit Probation Services (CUPS) Plan of Care/Progress Note Review

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

- Intellectual Developmental Disability (IDD) Provider Services
- Comprehensive Psychiatric Emergency Program (CPEP) Provider Services

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.

Four (4) Routine Reviews were conducted to ensure the programs are compliant with Texas Administrative Codes, Agency Policy and Procedure, and programmatic guidelines.

- CPEP: Crisis Intervention Respnse Team (CIRT) Routine Review
- IDD: In-Home Respite Routine Review
- MH: Adult Mental Health (AMH) Northwest Community Service Center (NWCSC) Routine Review
- MH: AMH Southwest Community Service Center (SWCSC) Routine Review

Other Compliance Activities:

Training/Meeting:

- March 10, 2023: Compliance Staff Meeting
- April 11, 2023: Enterprise Risk Management (ERM) Meeting.
- April 20, 2023: Compliance Department Forensic Leadership Team Huddle Meeting
- May 3, 2023: Compliance Department IDD Leadership Team Huddle Meeting

Other Responsibilities:

- Epic Deficiency Tracking (Ongoing)
- Maintenance of The Harris Center's policy and procedure process and platform (Ongoing)
- Weekly Tracking for Audits, Deficiency Tracking, and RL Safe Care (Ongoing)

Q3 Audit Report Summary:

The chart below identifies the reviews conducted by Compliance for Q3 of FY 2023:

Review Type	Begin Date of the Review	Program Reviewed
Focus Review: Overlap in Time for a Server	3/7/2023	SECSC
Routine Review	3/9/2023	CIRT
Routine Review	3/15/2023	IDD Network Mgmt.
Focus Review	3/21/2023	TCOOMMI Jr
Focus Review: Overlap in Time for a Server	4/5/2023	CMH Co-locations
Focus Review	4/11/2023	CUPS
Routine Review	4/17/2023	NWCSC
Focus Review: Operational Review	4/28/2023	IDD Provider Services
Routine Review	5/11/2023	SWCSC
Focus Review: Operational Review	5/17/2023	CPEP

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Key Takeaways

1. Focus Review: Southeast Community Service Center and Children Mental Health Co-locations Duplicate Overlap Service Review: In efforts to continue mitigating the identified risk of not having systems in place to identify duplicate services, Compliance has continued to monitor documentation. Documentation strengths and areas of improvement were communicated to the Practice Manager and the identified duplicate services were provided for review and resolution.

   Compliance discovered, a request was submitted by Quality Assurance and Revenue management's leadership to add a solution in Epic to identify services with overlapping times at time of entry, however; Epic reported this was not possible and recommended that the Harris Center have a reporting team develop a report to be used for "after the fact" auditing of documentation.

   Action Plan: Compliance will continue to follow-up with the programs to ensure the execution of the Plan of Improvement (POI) within the next one hundred eighty (180) days concerning documentation findings. Compliance will follow- up with The Electronic Health Record Director on the development of the report to capture overlaps.

2. Focus Review: Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) Jr. Plan of Care/Case Plan Focus Review: Results are pending outcome of Review.

3. Focus Review: Community Unit Probation Services Plan of Care/Progress Notes Focus Review: During the review, Compliance observed multiple notes were not completed within 24 to 48 hours. As a result, forty-eight (48) progress notes reviewed were not completed within 24 to 48 hours due to the needing a co-signer. Compliance discovered during the review service delivery documentation erroneously appeared to need a co-Signer to finalize notes to the presence of a radio button in Epic that must be unchecked when a co-signer is not needed. The Electronic Health Record Director was not able to provide a timeline for resolution; however has an optimization request with Harris Health to have the cosigner checkbox default to unchecked instead of checked.

   Action Plan: Compliance recommended CUPS complete a Plan of Improvement (POI) to address the issues identified during the review. Compliance will follow up with the program to ensure the fulfillment of its Plan of Improvement (POI) obligations..

4. Focus Review: Intellectual and Developmental Disabilities Provider and Comprehensive Psychiatric Emergency Program Provider Operational Review: Identified deficiencies were corrected within 24hrs.

   Action Plan: Compliance will review the facilities annually to ensure they comply with state and federal regulations.

5. Routine Review: Crisis Intervention Response Team (CIRT): Overall, no deficiencies were discovered during the review; however, Compliance was made aware of a crisis mental health emergency call from The Harris Center, where the individual was told by HCSO or HPD dispatcher that no one was available to respond to the call due to not having enough available

staff. In further review, the CIRT program has seventeen (17) staff who provide crisis community-based services, and at any given time, The Program Director communicated there may be one (1) to four (4) Harris Center staff members working to assist Harris County Sheriff's Office (HCSO) and Houston Police Department (HPD) to address emergency crisis mental health calls during each work shift.

Action Plan: This information has been brought to the attention of the Harris Center's COO and the Division's VP who are in communication with HPD and HCSO to address the staffing issues.

6. Routine Review: ID Network Management In-home Respite Routine Review: Overall there were no deficiencies found with the Contracted Service Provider. The Contractor provided evidence to support contractual obligations. However, Compliance noted the ID Network Management did not provide evidence of monitoring the Contracted Service Provider's performance. The Program has begun corrective actions to ensure monitoring takes place quarterly.

   Action Plan: Compliance will follow up with the program in one hundred and eighty (180) days to ensure the ID Network Management has executed it's plans to track and monitor the contractor's Performance.

7. Routine Review: Northwest Community Service Center (NWCSC) and Southwest Community Service Center (SWCSC): During the review it was noted encounters coded as Routine Case Management did meet TAC case management documentation standards; however, did not align with Operational guidelines. The programmatic guidelines were more rigorous than TAC. The Adult Mental Health Director is in the process of updating its guidelines to adhere to TAC requirements.

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

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. Texas Health And Human Services Commission: Substance Use Disorder Compliance Group Routine Inspection Facility License 4554: Site 4708 03/07/2023
2. Texas Health And Human Services Commission: Substance Use Disorder Compliance Group Routine Inspection Facility License 4554: Site 4555 03/09/2023
3. Health and Human Services Commission (HHSC) QM Annual Yes Waiver 03/23/2023
4. HHSC BHS Quality Management Desk Review 4/13/2023
5. U.S. Department of Housing and Urban Development (HUD): Community-wide COVID Housing Program (CCHP)- The Harris Center Dennis St. (Covid -19), Project No. 2020-0048 4/24/2023

6. Harris County American Rescue Plan: Final Report Monitoring Summary and Quality Improvement Plan 04/25/2023.
7. Be Well Texas Quality Monitoring 5/ 2023

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Southeast Community Service Center (SECSC)
Duplicate/Overlap Services Focus Review

Compliance Auditor(s): Christopher Webb and Coneka Caleb

Compliance Review: March 7- 19, 2023

Purpose

The purpose of this review was to assess the SECSC program for overlapping service documentation. Additionally, 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, §306.263 MH Case Management Services Standards,* 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 SECSC staff during the 3rd Qtr. of FY 2023 (March 7- 19, 2023). Detailed data for the services reviewed are presented in the findings section below.

Findings

Compliance discovered two hundred and eighty-three (283) clear overlaps of time for services. There were also subsequent issues found with the progress notes in the following areas:

- Forty-three (43) Plans of Care (POC) were not written to authorize routine care services. *§301.353 (e)* and *ACC3B, Review of Plan of Care*
- Three (3) POCs were not developed within ten (10) business days after delivery of services. *§301.353 (e) and ACC3B, Review of Plan of Care*
- Two (2) POCs were not signed by credentialed staff members. *§301.353 (e)(1)*
- Six (6) 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)*
- Twenty (20) progress notes were not completed within two (2) business days after contact occurred. *§301.361 (b)*
- Two (2) progress notes did not identify the steps necessary to accomplish the goals required to meet the individual's identified needs by using a referral. *§306.263 (b)(7)*

HARRIS CENTER
Mental Health and IDD

Observations

In preparing for the review, Compliance discovered that there is no current system in place to run a report to prevent and identify overlapping services in the Epic system.

History

There are no previous reviews for duplicate/overlap services.

Recommendations

The SECSC program should review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, and complete documentation in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. The SECSC program should continue to monitor services to ensure duplicate/overlap services are prevented. The SECSC program is not required to submit a plan of improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business May 2, 2023.

Management Response:

	Freq.	%
Medical Providers	141	50%
Clinical Staff	103	36%
Nursing	37	13%
	281	99%

1. Findings by job duty indicate that 50% of the overlaps were by Medical Providers.
2. The overlap trend for Medical Providers was to stop services with one person, then start with another person at the same time (i.e., stop at 9am and the start at 9am) which is a different trend than previous audits with the overlapping of multiple minutes into another service. Systematic findings suggest a possible change in directive by Medical Leadership versus human error.
3. Findings indicate that staff with double digit overlaps represent 52% of the overlaps and done by only 6 staff (i.e., 5 Medical Providers, 1 Clinical Staff, and 1 Nursing staff).
4. PM will follow-up with Medical Leadership about possible changes in directives related to service documentation.
5. PM will request all staff listed in this audit to address both overlaps and additional findings.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

X

Brent Lawless
Program Director/Manager

X

Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Duplicate/Overlap Service Review:
Colocations Children Mental Health (CMH)
Mental Health (MH) Division
Review Dates: April 5- 14, 2023

I. **Audit Type:**
Duplicate/Overlap Service Focus Review

II. **Purpose:**
The purpose of this review was to assess the Colocations Children Mental Health (CMH) programs 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.*

III. **Audit 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 Colocations CMH programs during the 3rd Qtr. of FY 2023 (April 5- 14, 2023). Detailed data for the services reviewed are presented in the findings section below.

IV. **Audit Findings and History:**
Of the records reviewed for Alief, Airline, Magnolia, Pasadena, and Spring Branch Colocations CMH programs there were three hundred fifty-three (353) clear overlaps of time for services. There were also subsequent issues found with the progress notes. For Airline Colocation CMH, twenty-seven (27) progress notes were not completed within two (2) business days after contact occurred, four (4) progress notes identified the wrong name, three (3) progress notes did not identify the treatment plan objective, one (1) progress note did not identify the progress or lack of progress in achieving treatment plan goals, one (1) progress note documented the incorrect procedure code, and two (2) Plans of Care (POCs) were not developed within ten (10) business days. For Magnolia CMH, seven (7) progress notes were not completed within two (2) business days after contact occurred. For Pasadena CMH, three (3) progress notes did not identify the treatment plan objective, one (1) progress note was not completed within two (2) business days after contact occurred, one (1) progress note documented the incorrect location where the service was provided, and one (1) POC was not written to authorize routine care services. For Spring Branch CMH, six (6) progress notes documented different locations where the service was provided, one (1) progress note documented the incorrect procedure code, nine (9) progress notes were not completed within two (2) business days after contact occurred, and four (4) POCs were not completed and signed within ten (10) business days.

There are no previous reviews for duplicate/ overlap services.

V. **Recommendations:**
The Colocations Children Mental Health CMH programs should review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, and complete documentation in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. The CMH programs should continue to monitor services to ensure duplicate/overlap services are prevented. The CMH programs are not required to submit a plan of improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report, must be returned to Compliance within seven (7) business days, by close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division
Colocations Children Mental Health (CMH)
Duplicate/Overlap Services Focus Review

Compliance Auditor(s): Coneka Caleb

Compliance Review: April 5th - 14th, 2023

Purpose

The purpose of this review was to assess the Colocation Children Mental Health (CMH) programs for overlapping service documentation. Progress notes were also reviewed to determine adherence to 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 instances of overlaps in services or duplicate services by the Colocations CMH programs during the 3rd Qtr. of FY 2023 (April 5- 14, 2023). Detailed data for the services reviewed are presented in the findings section below.

Findings

The following programs for the CMH Colocations: Alief, Airline, Magnolia, Pasadena, and Spring Branch identified three hundred fifty-three (353) clear overlaps of time for services. There were also subsequent issues found with the progress notes in the following area:

Airline:

- Twenty-seven (27) progress notes were not completed within two (2) business days after contact occurred. *§301.361 (b)*
- Four (4) progress notes identified the wrong clients' name. *§301.361 (a)(1)*
- Three (3) progress notes did not identify the treatment plan objective. *§301.361 (a)(11)*
- One (1) progress note did not identify the progress or lack of progress in achieving treatment plan goals. *§301.361 (a)(12)*
- One (1) progress note documented the incorrect procedure code.
- Two (2) Plans of Care (POCs) were not developed within ten (10) business days. *§301.353 (e); ACC3B Plan of Care*

Magnolia:

- Seven (7) progress notes were not completed within two (2) business days after contact occurred. *§301.361 (b)*

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Pasadena:

- Three (3) progress notes did not identify the treatment plan objective. *§301.361 (a)(11)*
- One (1) progress note was not completed within two (2) business days after contact occurred. *§301.361 (b)*
- One (1) progress note documented the incorrect location where the service was provided. *§301.361(a)(5)*
- One (1) POC was not written to authorize routine care services. *§301.353 (e); ACC3B Plan of Care*

Spring Branch:

- Six (6) progress notes documented that services were provided in the community but coded the location as the individual's home. *301.361(a)(5)*
- One (1) progress note documented the incorrect procedure code.
- Nine (9) progress notes were not completed within two (2) business days after contact occurred. *§301.361 (b)*
- Two (2) POCs were not completed and signed within ten (10) business days. *§301.353 (e); ACC3B Plan of Care*

Observations

In preparing for the review, Compliance discovered that there is no current system in place to run a report to prevent and identify overlapping services in the EPIC system.

History

There are no previous reviews for duplicate/ overlap services.

Recommendations

The Colocation programs should review the findings and collaborate with the business office to clarify the correct service dates and times for the reported services, and complete documentation in accordance with TAC, Agency Policy and Procedures, and programmatic guidelines. The Colocation programs should continue to monitor services to ensure duplicate/overlap services are prevented. The Colocation programs are not required to submit a plan of improvement (POI). A management response signed by the Vice President of the MH Division and Program Director/Manager acknowledging receipt of this report, must be returned to Compliance within seven (7) business days, by close of business May 11, 2023.

Management Response:

Colocation PM has reviewed findings with staff and has met with All staff including physicians and has discussed with staff the importance of not overlapping services, importance of timeliness of data entry and accuracy in documenting all services including using appropriate modifiers to indicate location and place of service. PM and LPHA compliance monitor will continue to audit chart monthly and to meet with any staff who continue with improper documentation with notes and recovery plans.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

X

Program Director/Manager

X

Compliance Manager

The Harris Center for Mental Health and IDD:
Compliance Department (Compliance)
Executive Summary Cover Sheet for the
Plans of Care/Progress Note Focus Review
Mental Health (MH) Division Child and Adolescent Services (CAS)
Community Unit Probation Services (CUPS)
Review Date: April 11th2023- May 12th, 2023

I. Audit Type:
Focus Review

II. Purpose:
The purpose of this review is to ensure the program is in compliance with completing Plans of Care (POCs) and Progress Notes in accordance with Texas Administrative Code's (TAC) Provider Responsibility for Treatment Planning and Service Authorization 301.353, General Principles 415.5(e), agency policy and procedures ACC3A and ACC3B, and Health and Human Services (HHS) Information Item C VII.B.

III. Audit Method:
Active records were submitted from the CUPS Management staff for persons served during the 2nd Qtr. of FY (Fiscal Year) 2023 (December 1, 2022 – February 28th, 2023). Compliance conducted a desk review, sampling fourteen (14) service entries using the *MH Plan of Care/Progress Note Review Tool.* Detailed data from this review is presented in the findings section below.

IV. Audit Findings:
Assessments were routinely completed. the program consistently created POCs in collaboration with the individual and/or Legally Authorized Representative (LAR; if applicable) *)(C),* goals and objectives for the POCs address the person-served needs, preferences, experiences, co-occurring substance use, or physical health disorder; or reflect the individual's self-direction, autonomy, and desired outcomes., *t*he provider regularly determined if the plan adequately addressed the needs of the individual. the provider routinely documents progress on all goals and objectives, recommendations for continuing services, changes from current services, or discharges from services, the prescribing professionals routinely assess and document current historical psychiatric and medical information before initiating psychoactive medication to persons served. Areas of Improvement were identified as; the POCs were not consistently signed within ten (10) business days after the date of receipt of notification from the department or its designee that the person served is eligible and has been authorized for routine care services*,* the provider did not review the Recovery Plan prior to authorizing continued services*,* the Progress note was not made within two business days after each contact occurred*,* eligibility was not documented with applicable guidelines (i.e., the individual was not eligible for the service)*,* and *e*ligibility was not documented with applicable guidelines (i.e., initial POCs not authorized for services).

V. Recommendations:
The CUPS program should review the findings and continue to assess its processes with TAC rules, Agency Policy and Procedures, and HHS Information Item C. The program is required to submit a Plan of Improvement (POI) addressing the areas identified. A management response, POI, and signatures from the Vice President of the MH Division and Program Director/Manager of the CUPS department are required. The signed report with management response and POI should be returned to Compliance within seven (7) business days by the close of business.

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Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Mental Health (MH) Division Child and Adolescent Services (CAS)
Community Unit Probation Services (CUPS)
Plans of Care/Progress Note Focus Review

Compliance Auditor(s): Carla Reynolds

Review Dates: April 11th, 2023- May 12th, 2023

Purpose

The purpose of this review is to ensure the program is in compliance with completing Plans of Care (POCs) and Progress Notes in accordance with Texas Administrative Code's (TAC) Provider Responsibility for Treatment Planning and Service Authorization 301.353, General Principles 415.5(e), agency policy and procedures ACC3A and ACC3B, and Health and Human Services (HHS) Information Item C VII.B.

Method

Active records were submitted from the CUPS Management staff for persons served during the 2nd Qtr. of FY 2023 (December 1, 2022 – February 28th, 2023). Compliance conducted a desk review, sampling fourteen (14) service entries using the *MH Plan of Care/Progress Note Review Tool.* Detailed data from this review is presented in the findings section below.

Findings

The strengths and areas of improvement are identified as follows:

Strengths:

- Assessments were routinely completed. *Information Item C VII.B.2*
- The program consistently created POCs in collaboration with the individual and/or Legally Authorized Representative (LAR; if applicable) *TAC §301.353(d)(1)(C)*
- Goals and objectives for the POCs address the person-served needs, preferences, experiences, co-occurring substance use, or physical health disorder; or reflect the individual's self-direction, autonomy, and desired outcomes. *TAC §301.353 (e)(2) (A-E)*
- The provider regularly determined if the plan adequately addressed the needs of the individual. *TAC §301.353(f)(1)(C)*
- The provider routinely documents progress on all goals and objectives, recommendations for continuing services, changes from current services, or discharges from services. *TAC §301.353(f)(1)(D)*
- The prescribing professionals routinely assess and document current historical psychiatric and medical information before initiating psychoactive medication to persons served. *TAC §415.5(e)*

The HARRIS CENTER for Mental Health and IDD

Areas of Improvement:

- The POCs were not consistently signed within ten (10) business days after the date of receipt of notification from the department or its designee that the person served is eligible and has been authorized for routine care services. *TAC §301.353(e)(1) (A, B, D)*
- The provider did not review the Recovery Plan prior to authorizing continued services. *TAC §301.353(f)(1)(A)*
- The Progress note was not made within two business days after each contact occurred *TAC §301.361(b)*
- Eligibility was not documented with applicable guidelines (i.e., the individual was not eligible for the service). *TAC §301.353*
- Eligibility was not documented with applicable guidelines (i.e., initial POCs not authorized for services). *TAC §301.353*

History

No audits of this type have been previously conducted.

Observations

Upon reviewing the CUPS program, Compliance was made aware that by staying in the practice of client-driven services, our clients were able to receive CUPS services at the clinic of their choice. This resulted in multiple individuals in EPIC under different units identified by their clinic of choice.

Recommendations

The CUPS program should review the findings and continue to assess its processes with TAC rules, Agency Policy and Procedures, and HHS Information Item C. The program is required to submit a Plan of Improvement (POI) addressing the areas identified. A management response, POI, and signatures from the Vice President of the MH Division and Program Director/Manager of the CUPS department are required. The signed report with management response and POI should be returned to Compliance within seven (7) business days by the close of business on May 23rd, 2023.

Management Response:

A process has been implemented that consists of weekly tracking, monitoring and follow-up on all POC's across all teams. Findings have been reviewed with all CTL's to ensure and understanding of the requirement. An update is provided to the PM weekly as it pertains to POC's. Ongoing tracking and monitoring will continue.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of Mental Health

X 5/24/23

Program Director/Manager

X

Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Provider Operational Review
Intellectual and Developmental Disabilities (IDD) Division
Intellectual Disabilities (ID) Provider Facilities
Review Date: April 28, 2023-May 12, 2023

I. Audit Type:
Operational Review

II. Purpose:
This review assessed The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory facility operational guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace.

III. Audit Method:
The Compliance Department (Compliance) conducted the annual onsite Operational Review of the Intellectual and Developmental Disabilities (IDD) Division Provider facilities in the 3rd quarter (Qtr.) of Fiscal Year (FY) 2023. One (1) operational review was conducted to cover eight (8) IDD Provider facilities located at Hillcroft Empowerment Center, Donsky House, Westbury House, Pasadena Cottages A and B, Pasadena Enrichment Center, Humble Service Center, and Apple White. Each facility reviewed was provided an entrance email, a copy of the operational review tool, and notified of the date and time of the review and the name and contact information of the compliance auditor conducting the review. The facilities were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, and Required Postings and Documentation. Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

IV. Audit Findings/History:
All (8) facilities met all the criteria within seven (7) days of the review. During the review, Compliance observed that the Rights Handbook given to the consumers needed to be updated. Operational reviews were conducted in the 2nd Qtr. FY2019 by the Compliance Department.

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V. Recommendations:
The program managers or designees should be informed of their specific facility's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the IDD Division is required to sign this report and return it to the Compliance Department within, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disabilities (IDD)
Provider Operational Review

Compliance Auditor(s): Emmanuel Golakai, Coneka Caleb, and Chris Beard

Review Date: April 28, 2023, to May 12, 2023

Purpose

This review assessed The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory facility operational guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite Operational Review of the Intellectual and Developmental Disabilities (IDD) Division Provider facilities in the 3rd quarter (Qtr.) of Fiscal Year (FY) 2023. One (1) operational review was conducted to cover eight (8) IDD Provider facilities located at Hillcroft Empowerment Center, Donsky House, Westbury House, Pasadena Cottages A and B, Pasadena Enrichment Center, Humble Service Center, and Apple White. Each facility reviewed was provided an entrance email, a copy of the operational review tool, and notified of the date and time of the review and the name and contact information of the compliance auditor conducting the review. The facilities were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation

Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

The HARRIS CENTER for Mental Health and IDD

Findings

All (8) facilities met all the criteria within seven (7) days of the review.

Observations

During the review, Compliance observed that the Rights Handbook given to the consumers needed to be updated.

History

Operational reviews were conducted in the 2nd Qtr. FY2019 by the Compliance Department.

Recommendations

The program managers or designees should be informed of their specific facility's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the IDD Division is required to sign this report and return it to the Compliance Department by June 20, 2023, acknowledging receipt and review of the information presented in this report.

Management Response:
[Insert Response Here]

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Evanthe Collins

Vice President of IDD Division

X Lily Pan

Program Director/Manager

X

Interim Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Provider Operational Review
Comprehensive Psychiatric Emergency Program (CPEP) Division
CPEP Provider Facilities
Review Date: May 17, 2023-May 31, 2023

I. Audit Type:
Operational Review

II. Purpose:
This review assessed The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory facility operational guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace. Compliance conducted the annual onsite Operational Review of the Comprehensive Psychiatric Emergency Program (CPEP) Division Provider facilities in the 3rd quarter (Qtr.) of Fiscal Year (FY) 2023

III. Audit Method:
The operational reviews were conducted to cover nineteen (19) CPEP Provider facilities: Hospital to Home/Expansion, Step Down State Hospital Transition, Outpatient Competency Restoration (OCR), Jail Re-entry, Substance Use Recovery, Jail Diversion, Crisis Stabilization Unit (CSU), Psychiatric Emergency Services (PES), Behavioral Health Response Team (BHRT), Mobile Crisis Outreach Team (MCOT) Rapid Response, Mobile Crisis Outreach Team (MCOT), 811 Property at Kipp Way, Enrichment Center Villas at Eastwood, 811 Property at Acre Home, Projects for Assistance in Transition from Homelessness (PATH), Substance Use Disorder Outreach Program (SUDOP), Crisis Residential Unit (CRU)-Southmore, Crisis Residential Unit (CRU)-Caroline, and P.E.E.R.S. (person-centered, engaging, empowering, recovery-oriented support) for Hope House. Each facility reviewed was provided an entrance email, a copy of the operational review tool, and notified of the date and time of the review and the compliance auditor's name and contact information. The facilities were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed were Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, and Required Postings and Documentation. Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

IV. Audit Findings/History:
Eighteen (18) facilities met all the criteria. One facility, P.E.E.R.S for Hope House, did not meet all the requirements (see below):

- There was no evidence of maintenance performed on vehicles for FY 2023. ***25 TAC 448§448.510(b)(2); EM24B***
- The Facility did not make provisions for Patients/Consumers that are visual/hearing.

Operational reviews were conducted in the 2nd Qtr. FY2019 by the Compliance Department.

V. Recommendations:
The program managers or designees should be informed of their specific facility's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division is required to sign this report and return it to the Compliance Department within, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Operational Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP)
Provider Operational Review

Compliance Auditor(s): Emmanuel Golakai and Chris Beard

Review Date: May 17, 2023, to May 31, 2023

Purpose

This review assessed The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory facility operational guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace. Compliance conducted the annual onsite Operational Review of the Comprehensive Psychiatric Emergency Program (CPEP) Division Provider facilities in the 3rd quarter (Qtr.) of Fiscal Year (FY) 2023.

Method

The operational reviews were conducted to cover nineteen (19) CPEP Provider facilities: Hospital to Home/Expansion, Step Down State Hospital Transition, Outpatient Competency Restoration (OCR), Jail Re-entry, Substance Use Recovery, Jail Diversion, Crisis Stabilization Unit (CSU), Psychiatric Emergency Services (PES), Behavioral Health Response Team (BHRT), Mobile Crisis Outreach Team (MCOT) Rapid Response, Mobile Crisis Outreach Team (MCOT), 811 Property at Kipp Way, Enrichment Center Villas at Eastwood, 811 Property at Acre Home, Projects for Assistance in Transition from Homelessness (PATH), Substance Use Disorder Outreach Program (SUDOP), Crisis Residential Unit (CRU)-Southmore, Crisis Residential Unit (CRU)-Caroline, and P.E.E.R.S. (person-centered, engaging, empowering, recovery-oriented support) for Hope House. Each facility reviewed was provided an entrance email, a copy of the operational review tool, and notified of the date and time of the review and the compliance auditor's name and contact information. The facilities were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are identified below:

- Accessibility
- Appearance
- Safety and Infectious Waste
- Patient/Consumer/Consumer Service
- Confidentiality
- Required Postings and Documentation

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Detailed information for the Operational Reviews was presented to the unit managers post-review and posted in the appropriate program subfolders of the Compliance Shared Folder (SharePoint).

Findings

Eighteen (18) facilities met all the criteria. One facility, P.E.E.R.S for Hope House, did not meet all the requirements (see below):

- There was no evidence of maintenance performed on vehicles for FY 2023. ***25 TAC 448§448.510(b)(2); EM24B***

- The Facility did not make provisions for Patients/Consumers that are visually/hearing impaired.

History

Operational reviews were conducted in the 2nd Qtr. FY2019 by the Compliance Department.

Recommendations

The program managers or designees should be informed of their specific facility's operational requirements and continue to comply with all regulatory guidelines. The Vice President of the CPEP Division is required to sign this report and return it to the Compliance Department by June 14, 2023, acknowledging receipt and review of the information presented in this report.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X

Vice President of CPEP Division

X

Interim Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Comprehensive Psychiatric Emergency Program Division (CPEP)
Crisis Intervention Response Team (CIRT)
Routine
Review Date: March 9, 2023 to March 14, 2023

I. Audit Type:
Routine.

II. Purpose:
The purpose of this review was to assess CIRT's documentation to ensure services are being provided in accordance with Texas Administrative Code (TAC) *§301.351* and *The Harris Center CIRT Policy No. 1 Standard Operating Procedure/Guidelines and Policy No. 4 Daily Documentation Standards.*

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 2nd Qtr. of FY 2023 (December 1, 2022 – February 28, 2023). Compliance conducted a desk review, sampling twenty (20) records using a CIRT Encounter Review Tool. Detailed data for this review is presented in the findings section below:

IV. Audit Findings and History:
During the review it was evident the crisis intervention assessment was consistently completed. Documentation regularly reflected the persons served had a disposition to ensure access to treatment. The one-click registration was routinely completed.

No areas of improvement were noted for this review.

No audits of this type have been previously conducted.

V. Recommendations:
The CIRT program should continue to assess its processes for completing crisis documentation and ensure adherence to TAC, The Harris Center CIRT Policy and Procedures and any other official agreement. The CIRT program is not required to submit a Plan of Improvement (POI). The Vice President (VP) of the CPEP Division and the Program Manager/Director CIRT should return the signed report with a management response to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP)
Crisis Intervention Response Team (CIRT)
Routine Review

Compliance Auditor(s): Marvin Williams

Review Date: March 9, 2023, to March 14, 2023

Purpose

The purpose of this review was to assess CIRT's documentation to ensure services are being provided in accordance with Texas Administrative Code (TAC) *§301.351* and *The Harris Center CIRT Policy No. 1 Standard Operating Procedure/Guidelines* and *Policy No. 4 Daily Documentation Standards.*

Method

Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 2nd Qtr. of FY 2023 (December 1, 2022 – February 28, 2023). Compliance conducted a desk review, sampling twenty (20) records using a CIRT 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 *Crisis Intervention Assessment* was consistently completed. *The Harris Center: CIRT Policy No. 1 Standard Operating Procedure/Guidelines and Policy. TAC §301.351*
- Persons served had a disposition to ensure access to treatment. *The Harris Center: CIRT Policy No. 1 Standard Operating Procedure/Guidelines and Policy*
- The one-click registration was routinely completed. *The Harris Center: CIRT Policy No. 4 Daily Documentation Standards*

Areas of Improvement:

- No areas of improvement were noted for this review.

The HARRIS CENTER for Mental Health and IDD

History

No audits of this type have been previously conducted.

Recommendations

The CIRT program should continue to assess its processes for completing crisis documentation and ensure adherence to TAC, The Harris Center CIRT Policy and Procedures and any other official agreement. The CIRT program is not required to submit a Plan of Improvement (POI). The Vice President (VP) of the CPEP Division and the Program Manager/Director CIRT should return the signed report with a management response to Compliance within seven (7) business days, by close of business on May 2, 2023.

Management Response:

[CIRT management will continue to monitor the progress notes to ensure entering the of last four of the SSN is in the note or listed as unknown or not provided/refuse to provide in note]

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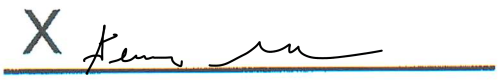
Signature Page

X 

Vice President of CPEP Division

X 

Program Director/Manager

X 

Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
In-Home Respite Service Routine Review
Intellectual and Developmental Disabilities (IDD) Division
Intellectual Disabilities (ID) Network Management
Review Date: March 15-22, 2023

I. Audit Type:
Routine

II. Purpose:
The purpose of this review was to assess the ID Network Management's In-Home Respite service to ensure that respite services are provided in accordance with the FY 2023 Standard In-Home Respite Contract and the IDD Service Definition Manual.

III. Audit Method:
Active records were randomly selected from the *Affiliated* (*AFF) Harris County (HC)Encounter Data Outpatient (OP) Service Details report* in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2023 (December 1, 2022 – February 28, 2023). The Compliance Department conducted a desk review, sampling twenty-eight (28) records, using an In-Home Respite Review tool developed by Compliance. Detailed data from this review is presented in the findings section below.

IV. Audit Findings/History:
The contractor provided mandated agency training to caregivers who provided supervision to persons served. Background checks were completed for caregivers who provided care and supervision of persons served. The contractor submitted a signed and fully completed Respite Voucher. Persons served met the eligibility criteria of being diagnosed with IDD, Autism, or a Pervasive Developmental Disorder (PDD) that dates before the age of 18. Ten (10) individuals who received In-Home respite exceeded the maximum of ten (10) hours of daily respite per encounter.

No reviews of this type were previously conducted.

V. Recommendations:
ID Network Management should continue to monitor the service documentation to ensure compliance with the FY2023 contract and Service Definition Manual. The ID Network Management is not required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of IDD and Program Director, including a management response addressing the present findings, and returned to the Compliance Department within seven (7) business days.

Compliance Department (Compliance) Review Report
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disabilities (IDD) Division
Intellectual Disabilities (ID) Network Management
In-Home Respite Routine Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: March 15**,** 2023, to March 22, 2023

Purpose

The purpose of this review was to assess the ID Network Management's In-Home Respite service to ensure that respite services are provided in accordance with the FY 2023 Standard In-Home Respite Contract and the IDD Service Definition Manual.

Method

Active records were randomly selected from the *Affiliated* (*AFF) Harris County (HC)Encounter Data Outpatient (OP) Service Details report* in the Electronic Health Record (EHR) for persons served during the 2nd Qtr. of FY 2023 (December 1, 2022 – February 28, 2023). The Compliance Department conducted a desk review, sampling twenty-eight (28) records, using an In-Home Respite 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:

- The contractor provided mandated agency training to caregivers who provided supervision to persons served. *FY 2023 Standard In-Home Respite Contract Exhibit A*
- Background checks were completed for caregivers who provided care and supervision of persons served. *FY 2023 Standard In-Home Respite Contract Exhibit A*
- The contractor submitted a signed and fully completed Respite Voucher. *FY2023 Standard Contract FY 2023 Standard In-Home Respite Contract Exhibit A*
- Persons served met the eligibility criteria of being diagnosed with IDD, Autism, or a Pervasive Developmental Disorder (PDD) that dates before the age of 18. *FY 2023 Standard In-Home Respite Contract Exhibit B*

Areas of Improvement:

- Ten (10) persons who received In-Home respite exceeded the maximum of ten (10) hours of daily respite per encounter. *IDD Service Definition Manual Community Services*

Observations

Compliance discovered that ID Network Management is using outdated guidelines. Presently, ID Network Management is using the contract as its guidelines. The Program Director stated that they are in the process of updating their guidelines.

History

No reviews of this type were previously conducted.

Recommendations

ID Network Management should continue to monitor the service documentation to ensure compliance with the FY2023 contract and Service Definition Manual. The ID Network Management is not required to submit a Plan of Improvement (POI). The report must be signed by the Vice President of IDD and Program Director, including a management response addressing the present findings, and returned to the Compliance Department within seven (7) business days, May 2, 2023.

Management Response:
April 25, 2023

The purpose of this document is to address the findings listed under the following sections of the Compliance Department Review Report, 3rd Quarter, Fiscal Year 2023 for the IDD Network Development and Management Department, conducted by Compliance Auditor, Emmanuel Golakai. We have reviewed the compliance report and provided management responses for Areas of Improvement and Observations.

Areas of Improvement:

The compliance auditor documented that "*Ten (10) persons who received In-Home respite exceeded the maximum of ten (10) hours of daily respite per encounter. IDD Service Definition Manual Community Services."*

The Service Definition Manual (updated March 2018) of the Health and Human Services Commission, Medical and Social Services Division, and Contract Accountability and Oversight for IDD Services specifies that the respite community service includes:

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- In-Home Respite – Respite based at the home of the individual. This includes Hourly Respite, grid code 3123, which has a maximum duration of 10 hours per encounter, and
- Daily Respite, grid code 3133. Daily Respite is reported if the planned duration is either overnight or greater than 10 hours. Client_Time reported for Daily Respite may be less than 10 hours per day. All Daily Respite encounters are converted to 24 hours upon processing of the final encounter data file.

Therefore, the duration of service hours is permissible and delivered according to the guidelines of the service definition manual.

Observations:

The Compliance Auditor documented that "*Compliance discovered that ID Network Management is using outdated guidelines. Presently, ID Network Management is using the contract as its guidelines. The Program Director stated that they are in the process of updating their guidelines.*"

In reference to the Compliance Auditor's statement, the Director was transparent and disclosed that the Operational Service Manual was not applicable to the current operations of the unit and is being amended. In addition, the unit follows the regulatory guidelines of the LIDDA's Performance Contractual Measures, the HHSC Service Definition Manual and the Professional Services Contract.

X Evanthe Collins

Vice President of IDD Division

X Margo Childs

Margo Childs
Program Director/Manager

X

Compliance Director/Compliance Manager

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH)
Northwest Community Service Center (NWCSC)
Routine
Review Date: April 17, 2023 to April 20, 2023

I. Audit Type:
Routine.

II. Purpose:
The purpose of this review was to assess NWCSC Plans of Cares (POC) and progress note documentation for compliance with the Texas Administrative Code (TAC) *§301.353, 301.361, 306.263, 306.315* and *415.5*.

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 3rd Qtr. of FY 2023 (March 1 – 31, 2023). Compliance conducted a desk review, sampling twenty (20) records using the POC and Progress Note Review Tool. Detailed data for this review is presented in the findings section below:

IV. Audit Findings and History:
During the review it was evident the POCs consistently reflected a description of each person served presenting problem. The POCs routinely listed each service the person served will receive to assist in their recovery. The POCs were consistently updated and final approved within ten (10) business days. The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment. Progress note documentation routinely reflected the credentials of the staff member who provided the service. Progress note documentation consistently demonstrated that each person served was eligible to receive services.

The areas of improvement indicated case management documentation did not evidence the person served strengths. Progress notes did not reflect the persons served issues as stated on the POC and inconsistent with the purpose and intent of the service. Case management documentation did not evidence a timeline for obtaining and reevaluating the person's served needs. The POCs did not regularly address the persons served co-occurring substance use.

During the review there were inconsistencies observed with the service encounter codes on the *Affiliated Harris Center Data OP Service Details Auditing* report: the codes did not reflect the services staff provided. In response to the observation, NWCSC Leadership reported staff are scheduling for a specific service encounter type but provided services and billing for a different encounter type.

No audits of this type have been previously conducted.

V. Recommendations:
The NWCSC program should review the findings and continue to assess its processes for completing plan of cares and progress note documentation to ensure adherence to TAC code standards. The NWCSC 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 MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days.

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Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Adult Mental Health (AMH)
Northwest Community Service Center (NWCSC)
Routine Review

Compliance Auditor(s): Marvin Williams

Review Date: April 17, 2023, to April 20, 2023

Purpose

The purpose of this review was to assess NWCSC Plans of Care (POC) and progress note documentation for compliance with the Texas Administrative Code (TAC) *§301.353, 301.361, 306.263, 306.315* and *415.5*.

Method

Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 3rd Qtr. of FY 2023 (March 1 – 31, 2023). Compliance conducted a desk review, sampling twenty (20) records using the POC and Progress Note 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 POCs consistently reflected a description of each person served presenting problem. *TAC §301.353 (e) (1) (A)*
- The POCs routinely listed each service the person served will receive to assist in their recovery. *TAC §301.353 (e) (1) (F)*
- The POCs were consistently updated and final approved within ten (10) business days. *TAC §301.353 (e)*
- The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment. *TAC §415.5 (e)*
- Progress note documentation routinely reflected the credentials of the staff member who provided the service. *TAC §301.361 (a) (14)*
- Progress note documentation consistently demonstrated that each person served was eligible to receive services. *TAC §301.353*

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Areas of Improvement:

- Case Management documentation did not evidence the person served strengths. *TAC §306.263 (b) (3)*
- Progress notes did not reflect the persons served issues as stated on the POC and inconsistency with the purpose and intent of the service. *TAC §301.361 (a) (14)*
- Case Management documentation did not evidence a timeline for obtaining and reevaluating the person's served needs. *TAC §306.263 (b) (6) (13)*
- The POCs did not regularly address the persons served co-occurring substance use. *TAC §301.353 (e) (2) (B)*

Observation

There were inconsistencies observed with the service encounter codes on the *Affiliated Harris Center Data OP Service Details Auditing* report: the codes did not reflect the services staff provided. In response to the observation, NWCSC Leadership reported staff are scheduling for a specific service encounter type but provided services and billing for a different encounter type.

History

No audits of this type have been previously conducted.

Recommendations

The NWCSC program should review the findings and continue to assess its processes for completing plan of cares and progress note documentation to ensure adherence to TAC code standards. The NWCSC 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 MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days, by close of business on May 11, 2023.

Management Response:

Findings	Total Notes	%-w/findings	%-w/no findings	Trend
4	49	8%	92%	CM documentation did not evidence the person served strengths.
11	49	22%	78%	Progress notes did not reflect the persons served issues as stated on the POC and inconsistency with the purpose and intent of the service.
5	49	10%	90%	CM documentation did not evidence a timeline for obtaining and reevaluating the person's served needs.
1	49	2%	98%	The POCs did not regularly address the persons served co-occurring substance use.

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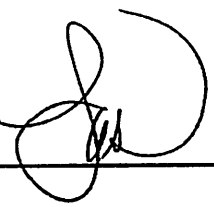
Practice Manager will provide the findings to CTL for ongoing follow-up for the teams and correction of plan of cares and progress notes.

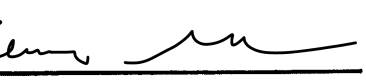
X 

Vice President of MH Division

5/8/2023

X Stephanie Johnson

Program Director/Manager
Signed by: Stephanie Johnson

X 

Compliance Manager / Interim Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH)
Southwest Community Service Center (SWCSC)
Routine
Review Date: May 11, 2023 to May 16, 2023

I. Audit Type:
Routine.

II. Purpose:
The purpose of this review was to assess NWCSC Plans of Cares (POC) and progress note documentation for compliance with the Texas Administrative Code (TAC) *§301.353, 301.361, 306.263, 306.275, 306.315* and *415.5*.

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 3rd Qtr. of FY 2023 (April 1 – 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the POC and Progress Note Review Tool. Detailed data for this review is presented in the findings section below:

IV. Audit Findings and History:
During the review it was evident progress notes routinely reflected the credentials of the staff member who provided the service. Progress notes consistently demonstrated that each person served was eligible to receive services. The POCs routinely listed each service the person served will receive to assist in their recovery. Each person served had an updated POC in the EHR. The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment.

The areas of improvement indicated progress notes did not reflect the persons served objectives as stated in the POC and were inconsistent with the focus of service. Progress notes did identify the persons served strengths, services needs, and the assistance required to address those needs. POCs did not regularly document a description of the persons served presenting problem.

It was observed that staff were coding progress notes as Routine Case Management (RCM); however, the notes did not consist of the elements (i.e., referral, linkage, advocacy, and monitoring) that are necessary to assist the persons served in gaining access to community resources. *TAC 306.263 (b) (7)*

No audits of this type have been previously conducted.

V. Recommendations:
The SWCSC program should review the findings and continue to assess its processes for completing plans of care and progress note documentation to ensure adherence to TAC standards. The SWCSC 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 MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
3rd Quarter (Qtr.) of Fiscal Year (FY) 2023
Adult Mental Health (AMH)
Southwest Community Service Center (SWCSC)
Routine Review

Compliance Auditor(s): Marvin Williams

Review Date: May 11, 2023, to May 16, 2023

Purpose

The purpose of this review was to assess SWCSC Plans of Care (POC) and progress note documentation for compliance with the Texas Administrative Code (TAC) *§301.353, 301.361, 306.263, 306.275, 306.315* and *415.5*.

Method

Active records were randomly selected from the *Affiliated Harris Center Data OP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during 3rd Qtr. of FY 2023 (April 1 – 30, 2023). Compliance conducted a desk review, sampling twenty (20) records using the POC and Progress Note 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:

- Progress notes routinely reflected the credentials of the staff member who provided the service. *TAC §301.361 (a) (14)*
- Progress notes consistently demonstrated that each person served was eligible to receive services. *TAC §301.353*
- The POCs routinely listed each service the person served will receive to assist in their recovery. *TAC §301.353 (e) (1) (F)*
- Each person served had an updated POC in the EHR. *TAC §301.353 (e)*
- The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment. *TAC §415.5 (e)*

Areas of Improvement:

- Progress notes did not reflect the persons served objectives as stated in the POC and were inconsistent with the focus of the service. *TAC §301.361 (a) (11)*

The HARRIS CENTER for Mental Health and IDD

- Progress notes did not identify the persons served strengths, service needs, and the assistance required to address those needs. *TAC §306.263 (b) (3) (7)*
- The POCs did not regularly document a description of the persons served presenting problem. *TAC §301.353 (e) (1) (A)*

Observation

It was observed that staff were coding progress notes as Routine Case Management (RCM); however, the notes did not consist of the elements (i.e., referral, linkage, advocacy, and monitoring) that are necessary to assist the persons served in gaining access to community resources. *TAC 306.263 (b) (7)*

History

No audits of this type have been previously conducted.

Recommendations

The SWCSC program should review the findings and continue to assess its processes for completing plans of care and progress note documentation to ensure adherence to TAC standards. The SWCSC 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 MH Division and the Program Manager/Director should return the signed report with a management response and POI to Compliance within seven (7) business days, by close of business on June 5, 2023.

Management Response:

Set	Findings	Total Notes	%-w/findings	%-w/no findings	Trend
A	2	50	4%	96%	No clear evidence on how the consumer demonstrated progress or the lack of progress towards POC goals. Consumer response to services and progress towards recovery goals are identical
B	1	50	2%	98%	Progress note documentation does not consist of the elements to be considered Medication Training and Support (MTS). The POC did not show clear evidence of the consumer presenting problem.
C	13	50	26%	74%	Service provided is not supported by documentation progress note does not show clear evidence identifying strengths.

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D	9	50	18%	82%	The note does not reflect the issues as stated in the POC and be consistent with the purpose and intent of the service.

Sets A, B, C and D: Compliance Monitor will provide informational training to all clinicians regarding these expectations and education on completing progress notes according to TAC and agency requirements. Plan of Improvement include:

1. Starting June 1st, SW AMH CTLs will begin co-signing <u>all</u> progress notes completed by clinicians to ensure TAC and agency requirements.

2. Compliance Monitor and Unit Trainer will conduct a 2hr training collaborative on progress note writing, TAC and agency requirements on Tuesday, June 6th in clinic (training will be mandatory).

X Lance Britt

Vice President of MH Division

The HARRIS CENTER for Mental Health and IDD

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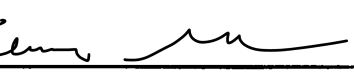
Program Director/Manager

X 

Compliance Manager / Interim Director

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

May 31, 2023

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

Mr. Young,

Thank you for your corrective action response to the Notice of Findings regarding the March 8, 2023, inspection of your licensed facility in Houston (# 4708). The deficiencies noted from the Notice of Findings have been sufficiently corrected and no further documentation regarding this inspection is required. This will serve as notification the inspection is closed.

Please note that the items cited in this inspection may be reviewed by other HHSC units, and during subsequent inspections to ensure the plan of correction has been adequately implemented.

Should the facility discontinue services or make changes to the existing services, please notify the Facility Licensing Department in writing prior to implementing the change.

I want to thank you for your assistance during the inspection process. Please contact me at 512/542-9989, or charles.reubens@hhs.texas.gov if you have any questions regarding facility inspections.

Sincerely,
Charles A. Reubens

Charles Reubens, Inspector VI
Substance Use Disorder and Professional Licensing Compliance

cc: Evelyn Urdiales Locklin - Director, Emergency Services and Residential Programs

TEXAS Health and Human Services

TEXAS HEALTH AND HUMAN SERVICES COMMISION
Substance Use Disorder Compliance Group
Notice of Findings Report

Name of Facility: The Harris Center for Mental Health and IDD		**Facility License Number:4554**
Address of Facility: 6160 South Loop East Frwy, Houston, TX 77087		**Site(s):4708**
Inspector Name(s): Charles Reubens	**Type of Inspection:** ☒ Routine ☐ Change-in-Status ☐ New ☐ Special ☐ Other: Pre-licensure	**Date(s) of Inspection** Start: March 7, 2023 End: March 8, 2023

IN RESPONSE TO AN INSPECTION OF THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, FACILITY LOCATED AT 6160 SOUTH LOOP EAST FRWY, HOUSTON, TX YOUR ATTENTION IS DIRECTED TO THE FINDINGS OF NON-COMPLIANCE WITH 25 TEXAS ADMINISTRATIVE CODE, CHAPTER 448, STANDARD OF CARE RULES, AS NOTED BELOW:

At the time of the inspection, the facility census reported two (2) detox clients receiving services at the facility. The inspector reviewed four (4) client files, four (4) employee files, the facility's policies and procedures, and completed a physical site inspection to determine compliance status.

Citation	Statement	Finding	Provide the Corrective Action	Commission Response (for Commission use ONLY)
§448.218 Standards of Conduct	(d) The facility shall have written policies on staff conduct that complies with this section.	The facility's policy does not include how they will comply with 448.218(b), including current Commission contact information.	Agency Policy "RR3B Assurance of Individual Rights" updated on 05/04/23 (pending full board approval 6/27/23) to reflect compliance with 448.218(b), including current Commission contact information. (see Attachment A)	
§448.403 (h) New Licensure Application.	(h) The facility shall display its licensure certificate prominently at each outpatient location and each approved residential site.	The facility posted the licensure certificate in the side hallway entrance for the clients and did not post the licensure certificate in a prominent public location.	Bulletin case purchased and required posting displayed in the main entrance of the building on 04/13/23 (see pictures 1, 2, and 3) to be compliant with 448.403(h)	

§448.505 (g) General Environment.	(g) The facility shall prohibit smoking inside facility buildings and vehicles and during structured program activities. If smoking areas are permitted, they shall be clearly marked as designated smoking areas and shall not be less than 15 feet from any entrance to any building(s) and comply with local codes and ordinances. Staff shall not provide or facilitate client access to tobacco products.	The facility did not have the smoking area clearly marked as a designated smoking area.	Smoking Area sign purchased and posted along perimeter wall near smoking benches 05/09/23 (see pictures 4, 5, and 6) to be in compliance with 448.505(g)	
§448.505 (h) General Environment.	(h) The facility shall prohibit firearms and other weapons, alcohol, illegal drugs, illegal activities, and violence on the program site or at or during the course of any program activity.	The facility did not prohibit firearms and other weapons, alcohol, illegal drugs illegal activities, and violence at the facility or during program activities.	In accordance with 448.505(h), Community Guidelines amended and 05/08/23 to reflect the prohibition of firearms and other weapons, alcohol, illegal drugs illegal activities, and violence at the facility or during program activities. (See Attachment B)	

§448.506 (a) Required Postings.	(a) The facility shall post a legible copy of the following documents in a prominent public location that is readily available to clients, visitors, and staff: (1) the Client Bill of Rights; (2) the Commission's current poster on reporting complaints and violations; and (3) the client grievance procedure.	The Client Bill of Rights, the Commission's current poster on reporting complaints and violations; and the client grievance procedure were posted on a side hallway entrance and not in a prominent public location that is readily available to clients, visitors, and staff.	In accordance with 448.506(a), Bulletin case purchased and required posting displayed in the main entrance of the building on 04/13/23 (see pictures 1, 2, and 3)	
§448.506 (b) Required Postings.	(b) These documents shall be displayed in English and in a second language(s) appropriate to the population(s) served at every location where services are provided.	The facility did not post the required documents in a second language in a prominent public location.	In accordance with 448.506(a), Bulletin case purchased and required posting displayed in the main entrance of the building on 04/13/23 (see pictures 1, 2, and 3)	

§448.510 (a) Client Transportation.	(a) The facility shall have a written policy on the use of facility vehicles and/or staff to transport clients. (b) If the facility allows the use of facility vehicles and/or staff to transport clients, it shall adopt transportation procedures which include the following. (8) Every vehicle used for client transportation shall have a fully stocked first aid kit and an A:B:C fire extinguisher that are easily accessible.	The facility provides client transportation, and the transportation policy did not include requirement (8) Every vehicle used for client transportation shall have a fully stocked first aid kit and an A:B:C fire extinguisher that are easily accessible as required by rules.	In accordance with 448.510(a), Agency Policy "EM17B Emergency Incidents While Transporting Consumers" verbiage updated 05/03/23 (pending full board approval on 06/27/23) to include every vehicle used for client transportation shall have a fully stocked first aid kit and an A:B:C fire extinguisher that are easily accessible as required by rules. (See Attachment C) All agency vehicles are equipped with an A:B:C fire extinguisher and fully stocked First Aid kit that are easily accessible to staff.	

§448.601. (d) Hiring Practices.	(d) The facility shall obtain and assess the results of a criminal background check from the Department of Public Safety on all staff within four weeks of the hiring date. Individuals hired may not have any client contact until the results of the criminal background check are assessed. The facility shall use the criteria listed in TEX. OCC. CODE ANN. §53.022, §53.023 (Vernon 2004) to evaluate criminal history reports and make related employment decisions.	The DPS background checks were completed late for the following employees: • Staff– date of hire: 9/27/21; (completed on 2/28/22) • Staff– date of hire: 2/13/22; (completed on 1/26/23)	In effort to support and maintain compliance with 448.601(d) and Harris Center Hiring policies and procedures, the timeline for onboarding was revised 09/01/22 to ensure all pre-employment tasks are complete prior to New Employee Orientation. (See Attachments D and E)	
§448.601. (e) Hiring Practices.	(e) The facility shall not hire an individual who has not passed a pre-employment drug test that meets criteria established by the Commission. This requirement does not restrict facilities from implementing random drug testing of its staff as permitted by law.	The pre-employment drug tests were completed late for the following employees: • Staff– date of hire: 2/13/22; (completed on 9/19/23) • Staff– date of hire: 2/13/22; (completed on 1/17/23)	In effort to support and maintain compliance with 448.601(d) and Harris Center Hiring policies and procedures, the timeline for onboarding was revised 09/01/22 to ensure all pre-employment tasks are complete prior to New Employee Orientation. (See Attachments D and E)	

§448.603. Training. (b) (1)	(b) The facility shall maintain documentation of all required training. (1) Documentation of external training shall include: (A) date; (B) number of hours; (C) topic; (D) instructor's name; and (E) signature of the instructor (or equivalent verification).	In the file reviewed for employee ATG – date of hire – 9/27/21, the documentation for HIV, Hepatitis B and C, Tuberculosis, and Sexually Transmitted Diseases was not documented correctly. Documentation for external training must include A-E as required by rules.	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T)	
§448.603 (b) (2) Hiring Practices.	(2) The facility shall maintain documentation of all internal training. For each topic, the file shall include: (A) an outline of the contents; (B) the name, credentials, relevant qualifications of the person providing the training, and (C) the method of delivery.	In the file reviewed for employee ATG – date of hire – 9/27/21, the documentation for NVCI Training - Handle with Care II was not documented correctly. Documentation for internal training must include A-C as required by rules.	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T)	

§448.603. (c) Training.	(c) Prior to performing their duties and responsibilities, the facility shall provide orientation to staff, volunteers, and students. This orientation shall include information addressing: (1) TCADA rules; (2) facility policies and procedures; (4) client grievance procedures; (7) emergency and evacuation procedures.	In the following staff files reviewed, the facility did not provide orientation training requirements (1), (2), (4) and (7) to the following employees prior to performing their duties and responsibilities: • Staff– date of hire: 2/13/23 • Staff– date of hire: 9/27/21 • Staff– date of hire: 10/25/21 • Staff– date of hire: 2/13/23	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T) *Staff RA resigned prior to Detox NOF Response.*	

§448.603. Training. (d) (1)	(d) The following initial training(s) must be received within the first 90 days of employment and must be completed before the employee can perform a function to which the specific training is applicable. Subsequent training must be completed as specified. (1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.	In the following files reviewed the employees did not receive the initial eight hours of face-to-face ANE training: • Staff– date of hire: 2/13/23 • Staff– date of hire: 2/13/23	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T) *Staff RA resigned prior to Detox NOF Response.*	

§448.603. Training. (d) (2) (A)	(2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases. (A) The initial training shall be three hours in length.	In the following files reviewed the employees did not receive the initial three hours of HEP B and C, and TB training: • Staff– date of hire: 2/13/23 • Staff– date of hire: 9/27/21 • Staff– date of hire: 10/25/21 • Staff– date of hire: 2/13/23	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T) *Staff RA resigned prior to Detox NOF Response.*	
§448.603. Training. (d) (2) (B)	(B) Staff shall receive annual updated information about these diseases.	There was no evidence provided the following employees, received annual updated information about HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases for 2022: • Staff– date of hire: 9/27/21 • Staff– date of hire: 10/25/21	In accordance with 448.603 (d)(2)(B), SUD Detox Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts.	

§448.603. (3) Training.	(3) Cardio Pulmonary Resuscitation (CPR). (A) All direct care staff in a residential program shall maintain current CPR and First Aid certification. (B) Licensed health professionals and personnel in licensed medical facilities are exempt if emergency resuscitation equipment and trained response teams are available 24 hours a day.	In the staff file reviewed for Staff– date of hire: 10/25/21, the employee did not have CPR and First Aid certification.	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T)	

§448.603. (d) (4) (A) Training.	(4) Nonviolent Crisis Intervention. All direct care staff in residential programs and outpatient programs shall receive this training. The face-to-face training shall teach staff how to use verbal and other non-physical methods for prevention, early intervention, and crisis management. The instructor shall have documented successful completion of a course for crisis intervention instructors or have equivalent documented training and experience. (A) The initial training shall be four hours in length.	In the staff file Staff– date of hire: 9/27/21, the NVCI training was completed late on 10/18/22.	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T)	
§448.603. (d) (4) (B) Training.	(B) Staff shall complete two hours of annual training thereafter.	In the staff file reviewed for Staff– date of hire: 10/25/21, the employee did not complete the annual NVCI training for the year 2022.	In accordance with 448.603 (d)(4)(B), SUD Detox Program Assistant to track and maintain training completion records to ensure compliance with annual updated trainings and information via electronic learning system (SABA) manager alerts.	

§448.603. Training. (d) (6) (A)	(6) Intake, Screening and Admission Authorization. All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses. (A) The initial training shall be eight hours in length.	In the following files reviewed, the following employees did not receive eight (8) hours of Intake, Screening and Admission Authorization training including the program's screening and admission procedures and two hours of DSM diagnostic criteria prior to screening and authorizing admissions: • Staff– date of hire: 10/25/21 • Staff– date of hire: 2/13/23	Detox Staff Orientation Checklist created on 5/9/23 to ensure compliance with 448.603(b). Organizational Development revised Certificates of Completion to reflect required elements required in 448.603(b)(1) as of 05/05/23. (See Attachment F; All training certificates are in Attachment T)	
§448.603. (d) (6) (B) Training.	(B) Staff shall complete eight hours of annual training thereafter.	In the following files reviewed, the following employees did not complete the annual eight (8) hours of training for Intake, Screening, and Admission Authorization and two hours of DSM diagnostic criteria for the year 2022: • Staff– date of hire: 10/25/21	In accordance with 448.603 (d)(6)(B), SUD Detox Program Assistant to track and maintain training completion records to ensure compliance with annual updated trainings and information via electronic learning system (SABA) manager alerts.	

§448.702 (d) Client Grievances.	(d) The procedure shall also inform clients that they can submit a complaint directly to the Commission at any time and include the current mailing address and toll-free telephone number of the Commission's investigations division.	The facility's client grievance procedure should update the current mailing address and toll-free telephone number of the Commission's investigations division.	Grievance procedure and client Grievance handout updated on 04/28/23 with the current mailing address and toll-free telephone number of the Commission's investigations division to comply with 448.702(d). (See attachment G and attachment H)	

§448.703. (a)(1) Abuse, Neglect, and Exploitation.	(a) Any person who receives an allegation or has reason to suspect that a client or participant has been, is, or will be abused, neglected, or exploited by any person shall immediately inform the Commission's investigations division and the provider's chief executive officer or designee. If the allegation involves the chief executive officer, it shall be reported directly to the provider's governing body. (1) The person shall also report allegations of child abuse or neglect to the Texas Department of Protective and Regulatory Services as required by TEX. FAM. CODE ANN. § 261.101 (Vernon 2002 & Supp. 2004).	The facility's ANE procedures should update the Texas Department of Family and Protective Services (DFPS) hotline phone number, website for online reporting, and the timeframes for reporting allegations of child abuse and neglect to DFPS.	In accordance with 448.703(a)(1), Procedure RR1B Reporting Allegations of Abuse, Neglect, and Exploitation of Elderly Persons and persons with Disabilities updated on 05/04/23 (pending full board approval 06/27/23) to include Texas Department of Family and Protective Services (DFPS) hotline phone number, website for online reporting, and the timeframes for reporting allegations of child abuse and neglect to DFPS. (See Attachment I)	

§448.703. (a)(2) Abuse, Neglect, and Exploitation.	(2) The person shall also report allegations of abuse or neglect of an elderly or disabled individual to the Texas Department of Protective and Regulatory Services as required by TEX. HUM. RES. CODE ANN. § 48.051 (Vernon 2001 & Supp. 2004).	The facility's ANE procedures should update the DFPS hotline phone number, website for online reporting, and the timeframes for reporting allegations of abuse and neglect of an elderly or disabled individual to DFPS.	In accordance with 448.703 (a)(2), Procedure RR1B Reporting Allegations of Abuse, Neglect, and Exploitation of Elderly Persons and persons with Disabilities updated on 05/04/23 (pending full board approval 06/27/23) to include Texas Department of Family and Protective Services (DFPS) hotline phone number, website for online reporting, and the timeframes for reporting allegations of child abuse and neglect to DFPS. (See Attachment I)	

§448.708. (f) Searches.	(f) Routine searches of possessions performed when a client returns to a facility may be documented in a central log. All other client searches shall be documented in the client record, including the reason for the search, the result of the search, and the signatures of the individual conducting the search and the witness.	The facility conducts routine searches and does not have a policy on routine searches.	Please see Policy ACC14A Personal Property (attachment J) Persons Served Searches Procedure updated on 05/08/23 to reflect addition of a central log and compliance with 448.708(f). (See Attachment K and Attachment L)	

§448.801. (e) Screening.	(e) For admission to a detoxification program, the screening will be conducted by a physician, physician assistant, nurse practitioner, registered nurse, or licensed vocational nurse (LVN). An LVN may conduct a screening under the following conditions: (1) the LVN has completed detoxification training and demonstrated competency in the detoxification process; (2) the training and competency verification is documented in the LVN's personnel file; (3) the LVN shall convey the medical data obtained during the screening process to a physician in person or via telephone. The physician shall determine the appropriateness of the admission and authorize the admission or give instructions for an alternative course of action; and (4) the physician shall examine the client in person and sign the admission order within 24 hours of authorizing admission.	In the following client files reviewed the Detox screening was conducted by a LCDC and not conducted by a physician, physician assistant, nurse practitioner, registered nurse, or licensed vocational nurse (LVN): • client– screening dated – 3/5/23 • client– screening dated – 3/4/23 • client– screening dated – 7/8/22 • client– screening dated – 7/3/22	Amended the Recovery Services (Detox) Standard Operating Procedure on 05/08/23 to include both the QCC and RN in the screening process and ensured that process change was implemented by staff to meet the requirements of 448.801(e). (See Attachment M)	

§448.802 (b) (1–16) Admission Authorization and Consent to Treatment.	(b) The facility shall obtain written authorization from the consenter before providing any treatment or medication. The consent form shall be dated and signed by the client, the consenter, and the staff person providing the information, and shall document that the client and consenter have received and understood the following information: (1) the specific condition to be treated; (2) the recommended course of treatment; (3) the expected benefits of treatment; (4) the probable health and mental health consequences of not consenting; (5) the side effects and risks associated with the treatment; (6) any generally accepted alternatives and whether an alternative might be appropriate; (7) the qualifications of the staff that will provide the treatment; (8) the name of the primary counselor; (9) the client grievance procedure; (10) the Client Bill of Rights as specified in §148.701 of this title;	In the files reviewed for the following clients, there was no consent to treatment: • client– date of admission – 3/5/23 • client–date of admission – 3/4/23 • client–date of admission – 7/8/22 • client–date of admission – 7/3/22	Consents aligned with 448.802 (b) (1-16) were created and translated into Spanish on 04/25/23. They are in use now (See attachment N and O)	

	(11) the program rules, including rules about visits, telephone calls, mail, and gifts, as applicable; (12) violations that can lead to disciplinary action or discharge; (13) any consequences or searches used to enforce program rules; (14) the estimated daily charges, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources and insurance benefits; (15) the facility's services and treatment process; and (16) opportunities for family to be involved in treatment.			
§448.802 (d) Admission Authorization and Consent to Treatment.	(d) The client record shall include a copy of the Client Bill of Rights dated and signed by the client and consenter.	In the files reviewed for the following clients there was no Client Bill of Rights dated and signed by the client: • client–date of admission – 3/5/23 • client–date of admission – 3/4/23 • client–date of admission – 7/8/22 • client– date of admission – 7/3/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P)	

§448.803 (e) Assessment.	(e) The assessment shall be signed by a QCC and filed in the client record within three individual service days of admission.	In the files reviewed for the following clients the assessment was not signed by the QCC: • client–assessment dated – 7/12/22 • client–assessment dated – 7/3/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P)	
§448.804. (a) Treatment Planning, Implementation and Review.	(a) The counselor and client shall work together to develop and implement an individualized, written treatment plan that identifies services and support needed to address problems and needs identified in the assessment. When appropriate, family shall also be involved. (1) When the client needs services not offered by the facility, appropriate referrals shall be made and documented in the client record. When feasible, other QCCs or mental health professionals serving the client from a referral agency should participate in the treatment planning process. (2) The client record shall contain justification when identified needs are temporarily deferred or not addressed during treatment.	A treatment plan was not developed for the following detox clients: • client–date of admission – 3/5/23 • client–date of admission – 3/4/23 • client–date of admission – 7/8/22 • client–date of admission – 7/3/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P)	

§448.805. (a) Discharge.	(a) The counselor and client/consenter shall develop and implement an individualized discharge plan.	A discharge plan was not developed for the following detox clients: • client–date of admission – 3/5/23 • client–date of admission – 3/4/23 • client–date of admission – 7/8/22 • client–date of admission – 7/3/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P)	
§448.805 (j) Discharge.	(j) The facility shall contact each client no sooner than 60 days and no later than 90 days after discharge from the facility and document the individual's current status or the reason the contact was unsuccessful.	The facility did not provide documentation indicating the following clients were contacted no sooner than 60 days and no later than 90 days after discharge from the facility: • client–date of admission – 7/8/22 –discharge date not provided • client–date of admission – 7/3/22 – discharge date 7/12/22	Will utilize CMBHS Discharge Follow Up Reminder List to alert need for contact during the designated time frames after discharge from the facility. Updated SUD Recovery Services Discharge and Follow Up Procedure on 05/08/23 to reflect Program Director's responsibility for the task and compliance with 448.805(j). (See Attachment Q)	

§448.901. Requirements Applicable to All Treatment Services. (d)	(d) The program shall provide education about Tuberculosis (TB), HIV, Hepatitis B and C, and sexually transmitted diseases (STDs) based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.	The facility did not provide education on HIV, Tuberculosis, Hepatitis B and C, and sexually transmitted diseases as required, for the following clients: • client–date of admission – 3/5/23– projected discharge date not provided • client–date of admission – 3/4/23– projected discharge date not provided • client– date of admission – 7/8/22 – discharge date not provided • client– date of admission – 7/3/22 – discharge date 7/12/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P) Amended unit schedule on 05/01/23 to designate time for this offering. (See Attachment R)	
§448.901. Requirements Applicable to All Treatment Services. (e)	(e) The program shall provide education about the health risks of tobacco products and nicotine addiction.	The facility did not provide education about the health risks of tobacco products and nicotine addiction as required, for the following clients: • client–date of admission – 3/5/23– projected discharge date not provided • client–date of admission – 3/4/23– projected discharge date not provided • client–date of admission – 7/8/22 – discharge date not provided • client–date of admission – 7/3/22– discharge date 7/12/22	Created and implemented use of SUD Detox Client Checklist on 05/09/23 for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment P) Amended unit schedule on 05/01/23 to designate time for this offering. (See Attachment R)	

§448.902. (d) (4) Requirements Applicable to Detoxification Services.	(d) The medical director or his/her designee (physician assistant, or nurse practitioner) shall approve all medical policies, procedures, guidelines, tools, and the medical content of all forms, which shall include: (3) procedures to deal with medical emergencies;	The detox medical policies did not include procedures to deal with medical emergencies.	Created Medical Emergencies Procedure on 5/1/2023 in accordance with 448.902(d)(4). (See attachment S)	

§448.902. (f) Requirements Applicable to Detoxification Services.	(f) Providers shall develop and implement a mechanism to ensure that all direct care staff in detoxification programs have the knowledge, skills, abilities to provide detoxification services, as they relate to the individual's job duties. Providers must be able to demonstrate through documented training, credentials and/or experience that all direct care staff are proficient in areas pertaining to detoxification, including but not limited to areas regarding: (1) signs of withdrawal; (2) observation and monitoring procedures; (3) pregnancy-related complications (if the program admits women); (4) complications requiring transfer; (5) appropriate interventions; and (6) frequently used medications including purpose, precautions, and side effects.	In the following files reviewed, the facility did not have documentation that the employees were proficient in areas pertaining to detoxification as required by rules 1-6: • client– date of hire: 2/13/23 • client–date of hire: 9/27/21 • client–date of hire: 10/25/21 • client– date of hire: 2/13/23	Nurse Educator created knowledge, skills, and abilities for Detox and began training on 03/24/23 with supporting documentation that the employees were proficient in areas pertaining to detoxification as required by 448.902(f) rules 1-6. Training will occur upon hire and as needed. (See attachment T)	

§448.1003. (a) Medication Inventory and Disposal.	(a) The program shall use an effective system to track and account for all prescription medication.	During the inspection process, the Nursing Supervisor CV, stated the facility does not use a system to track and account for all prescription medication.	MED21B Medication Control Procedure updated 5/09/23 to reflect compliance with 448.1003(a). (See Attachment U)	
§448.1003. (d) Medication Inventory and Disposal.	(d) Staff shall separate unused and outdated medication immediately and dispose of it within 30 days.	The facility empties all medication into one disposal container for unused and outdated medication. Staff could not provide information on the last time the container was emptied. There were medications pending disposal in the container, and staff were unable to verify if the medications were over 30 days old.	MED21B Medication Control Procedure updated 05/09/23 to reflect compliance with 448.1003(d). (See Attachment U) Rx Destroyer Log created on 05/09/23 to track/verify all medications are disposed of within 30 days. (See Attachment V)	

§448.1203 (1) Emergency Evacuation.	Every residential program shall: (1) have emergency evacuation procedures that include provisions for individuals with disabilities;	The facility's emergency evacuation procedures do not have emergency evacuation procedures that include provisions for individuals with disabilities.	In compliance with 448.1203(1) EM21B Facility Alert-Fire Evacuation Plan updated on 05/03/23 (pending full board approval 06/27/23) to include verbiage that include provisions for individuals with disabilities (See Attachment W) Building Disaster and Emergency Response Plan updated 05/09/23 to include provisions for individuals with disabilities (See Attachment X)	

§448.1203 (2) Emergency Evacuation.	(2) hold fire drills on each shift at least quarterly and correct identified problems promptly;	The facility did not conduct quarterly fire alarm drills in 2022.	Fire Drill conducted 03/08/23. Created schedule for quarterly fire drills on each shift to be completed and reports maintained by the building's Safety Officer to comply with 448.1203(2). (See Attachment Y)	
§448.1206 (c) Fire Systems.	(c) Quarterly fire alarm system tests shall be conducted and documented by facility staff.	The facility did not conduct quarterly fire alarm system tests in 2022.	Will occur in conjunction with quarterly fire drills by the building's Safety Officer to comply with 448.1206(c). (See Attachment Y)	
§448.1206 (e) Fire Systems.	(e) Fire extinguishers shall be mounted throughout the facility as required by code and approved by the fire marshal. (1) Each laundry and walk-in mechanical room shall have at least one portable A:B:C extinguisher.	The facility did not have a portable A:B:C fire extinguisher in the laundry room as required.	Portable A:B:C fire extinguisher installed in the laundry room on 03/14/23 to comply with 448.1206 (see picture 7)	

Technical Assistance **§448.502. (b) Operational Plan, Policies and Procedures.**	(b) The facility shall adopt and implement written policies and procedures as deemed necessary by the facility and as required herein. The policies and procedures shall contain sufficient detail to ensure compliance with all applicable Commission rules.	The facility's policies and procedures should be updated from DSHS to HHSC.	Noted	

You are required to submit a written response within twenty (20) business days from the receipt of this report **(by COB: 5/17/2023)** addressing each finding and detailing the corrective action you have taken to achieve compliance with 25 Texas Administrative Code Chapter 448. In your Plan of Correction (POC), cite the rule number and corrective action taken. Compile all pertinent documentation, the signed Notice of Finding, and submit with your POC. Forward all responsive documents by email to: inspector's email address, or by mail to the following address:

Charles Reubens, Inspector
Substance Use Disorder and Professional Licensing Compliance
Texas Health and Human Services Commission
701 W. 51st Location code: 1001; Mail code: 1979
Austin, TX. 78751

Charles A. Reubens — April 18, 2023

Substance Use Disorder Compliance Inspector — Date

Evelyn U. Locklin — May 16, 2023

Facility Representative — Date

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

April 18, 2023

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

Mr. Young,

This is in response to the routine inspection completed March 9, 2023, regarding your licensed facility in Houston, TX (license no. 4555). Your attention is directed to the findings of non-compliance to 25 TAC, Chapter §448, Standard of Care rules, as noted in the attached Notice of Findings.

You are required to submit a written response within twenty (20) business days from the receipt of this report (by COB **5/17/2023**), detailing the corrective action you have taken to achieve compliance with the notice of findings.

In your response provide the corrective action taken (under the appropriate column) for each finding and indicate how you will ensure compliance going forward. Compile all pertinent documents and submit with your response. Forward your response to charles.reubens@hhs.texas.gov or:

Health and Human Services Commission
Charles Reubens, Inspector
Substance Use Disorder and Professional Licensing Compliance
701 W. 51st Location code: 1001; Mail code: 1979
Austin, TX. 78751

If you have any questions, please contact me at charles.reubens@hhs.texas.gov or (512) 541-9989.

Sincerely,
Charles A. Reubens

Inspector VI
Substance Use Disorder and Professional Licensing Compliance
Texas Health and Human Services Commission

The HARRIS CENTER for Mental Health and IDD

Transforming Lives

9401 Southwest Freeway
Houston, TX 77074
713-970-7000

May 17, 2023

Charles Reubens, Inspector
Texas Health and Human Services Commission
Substance Use Disorder Compliance Unit
701 W. 51st Location Code: 1001; Mail Code: 1979
Austin, TX 78751

Inspector Reubens,

This cover letter is in response to the routine inspection of The Harris Center's licensed facility (license no. 4555) conducted on March 9, 2023. Our staff has worked diligently to address the issues identified in your review. As instructed, please find attached the corrective action plan to each of the findings in reference to 25 TAC, Chapter 448, Standard of Care rules.

It is our goal to continuously improve service delivery and quality of care. We appreciate the opportunity to progress towards that goal. Please let us know if you have any questions about the information contained in this response.

For Outpatient TRA/TRF services, please feel free to contact the Director of Mental Health Projects, Sandra Brock, at 713-970-3307 or via email at Sandra.Brock@theharriscenter.org or the Program Manager, Byanca Hernandez at 713-970-4432 or via email at Byanca.Hernandez@theharriscenter.org.

For Detox services, please feel free to contact the Director of Emergency Services and Residential Programs, Evelyn Locklin, at 713-970-4729 or via email at Evelyn.Locklin@theharriscenter.org or the Program Director, Shalanda Williams, at 713-970-3419 or via email at Shalanda.Williams@theharriscenter.org

Respectfully,

,

DocuSigned by:
Wayne Young
5CDF2A7E52A04EA...

Wayne Young, MBA, LPC, FACHE
Chief Executive Officer
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074
(713) 970-7160 I wayne.young@theharriscenter.org

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

June 28, 2023

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

Mr. Young,

Thank you for your corrective action response to the Notice of Findings regarding the March 9, 2023, inspection of your licensed facility in Houston (# 4555). The deficiencies noted from the Notice of Findings have been sufficiently corrected and no further documentation regarding this inspection is required. This will serve as notification the inspection is closed.

Please note that the items cited in this inspection may be reviewed by other HHSC units, and during subsequent inspections to ensure the plan of correction has been adequately implemented.

Should the facility discontinue services or make changes to the existing services, please notify the Facility Licensing Department in writing prior to implementing the change.

I want to thank you for your assistance during the inspection process. Please contact me at 512/542-9989, or charles.reubens@hhs.texas.gov if you have any questions regarding facility inspections.

Sincerely,
Charles A. Reubens

Charles Reubens, Inspector VI
Substance Use Disorder and Professional Licensing Compliance

cc: Byanca Hernandez - Clinical Team Leader

TEXAS Health and Human Services

TEXAS HEALTH AND HUMAN SERVICES COMMISION
Substance Use Disorder Compliance Group
Notice of Findings Report

Name of Facility: The Harris Center for Mental Health and IDD		**Facility License Number:4554**
Address of Facility: 9401 Southwest Freeway Suite 127, Houston, TX 77087		**Site(s):4555**
Inspector Name(s): Charles Reubens	**Type of Inspection:** ☒ Routine ☐ Change-in-Status ☐ New ☐ Special ☐ Other: Pre-licensure	**Date(s) of Inspection** Start: March 9, 2023 End: March 9, 2023

IN RESPONSE TO AN INSPECTION OF THE HARRIS CENTER FOR MENTAL HEALTH AND IDD, FACILITY LOCATED AT 9401 SOUTHWEST FREEWAY SUITE 127, HOUSTON, TX YOUR ATTENTION IS DIRECTED TO THE FINDINGS OF NON-COMPLIANCE WITH 25 TEXAS ADMINISTRATIVE CODE, CHAPTER 448, STANDARD OF CARE RULES, AS NOTED BELOW:

At the time of the inspection, the facility census reported sixty-three (63) outpatient clients receiving services at the facility. The inspector reviewed six (6) client files, four (4) employee files, the facility's policies and procedures, and completed a physical site inspection to determine compliance status.

Citation	Statement	Finding	Provide the Corrective Action	Commission Response (for Commission use ONLY)
§448.218 Standards of Conduct	(d) The facility shall have written policies on staff conduct that complies with this section.	The facility's policy does not include how they will comply with 448.218(b), including current Commission contact information.	**Original Response:** Agency Policy "RR3B Assurance of Individual Rights" updated on 5/4/23 (pending full board approval set for 6/27/23) to reflect compliance with 448.218(d), including current Commission contact information. (See Attachment A(1) and A(2)) **Updated Response:** Standards of Conduct (Attachments A(1) updated and A(2) updated) have been updated to include the full contact information for the Commission's Investigations division.	**HHSC response 5/31/2023: Not accepted** The facility updated the contact information for HHSC and not the current toll-free telephone number of the Commission's investigations division. Texas Health and Human Services Commission Regulatory Services Complaint and Incident Intake, Mail Code E-249 P.O. Box 149030 Austin, TX 78714-9030; 1-800-458-9858, Option 6 **Provide the updated standards of conduct which should include the current toll-free telephone number of the Commission's investigations division by COB 6/14/23.**

§448.401. (b) (c) License Required.	(b) The facility shall have a license for each physical location at which it provides residential services or outpatient services. (c) A license is not transferable to a separate legal entity or to a different physical address.	During the inspection process the Senior Director DW, stated the facility has 63 clients assigned to this facility but allowed clients to go to any outpatient facilities associated with the HQ license. All of clients for the three HQ #4554 satellite locations located at 7200 North Loop East Freeway, Houston, TX; 5901 Long Dr, Houston, TX 77087 and 3737 Dacoma, Houston, TX are assigned to License #4554-4555 – 6160 South Loop East Frwy Suite 127, Houston, TX 77087. The clients should receive services at the licensed facility they are enrolled at.	**Original Response:** The facility has met with Contract Management to obtain necessary Clinic Request forms for each satellite site to have their own location in CMBHS. Pending response. (See Attachments B(1)-B(6) **Updated Response:** The facility has submitted the Clinic Request forms for each satellite site to have its own location in CMBHS per contract. Additionally, the instruction to assign and provide services to clients only at the location they are enrolled in has been added to the program's operational guidelines. (See Attachment B(7), page 9 under Description of SURS Services &	**HHSC response 5/31/2023: Not Accepted** The facility did not provide a plan to ensure clients would only receive services for the licensed facility they are enrolled at. **Provide a plan to ensure clients are only receiving services at the licensed facility they are enrolled at by COB 6/14/2023**

			Practices). This plan will ensure that clients only receive services at the location they are enrolled at. Once each CMBHS location is established, clients will be transitioned to the assigned location they are receiving services. From there, all future clients will be admitted to the location they are to receive services.	
§448.603. (b) (1) Training.	(b) The facility shall maintain documentation of all required training. (1) Documentation of external training shall include: (A) date; (B) number of hours; (C) topic; (D) instructor's name; and (E) signature of the instructor (or equivalent verification).	In the file reviewed for employee ATG – date of hire – 9/27/21, the documentation for SUD – HIV, Hepatitis B and C, Tuberculosis, and Sexually Transmitted Diseases was not documented correctly. Documentation for external training must include A-E as required by rules.	[Detox employee] Finding addressed under SURS Detox Corrective Action Plan	**HHSC response 5/31/2023: Accepted**

§448.603 (b) (2) Hiring Practices.	(2) The facility shall maintain documentation of all internal training. For each topic, the file shall include: (A) an outline of the contents; (B) the name, credentials, relevant qualifications of the person p roviding the training, and (C) the method of delivery.	In the file reviewed for employee ATG – date of hire – 9/27/21, the documentation for Handle with Care II is not documented correctly. Documentation for internal training must include A-C as required by rules.	[Detox employee] Finding addressed under SURS Detox Corrective Action Plan	**HHSC response 5/31/2023: Accepted**
§448.603. (c) Training.	(c) Prior to performing their duties and responsibilities, the facility shall provide orientation to staff, volunteers, and students. This orientation shall include information addressing: (1) TCADA rules; (2) facility policies and procedures; (4) client grievance procedures; (6) standards of conduct; and (7) emergency and evacuation procedures.	In the file reviewed for employee SS – date of hire: 3/28/22, the facility did not provide orientation training on required topics (1), (2), (4) (6) and (7).	SURS Staff Orientation Checklist has been updated to ensure compliance with 448.603(c). (See Attachment C)	**HHSC response 5/31/2023: Accepted**

§448.603. Training. (d) (1)	(d) The following initial training(s) must be received within the first 90 days of employment and must be completed before the employee can perform a function to which the specific training is applicable. Subsequent training must be completed as specified. (1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.	In the file reviewed for employee SS, date of hire – 3/28/22, there was no evidence provided the employee completed ANE training.	**Original Response:** In accordance with 448.603 (d)(1), SURS Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts and Internal training tracking tool (See Attachment D) **Additional Response:** See SS ANE Training Attachment	**HHSC response 5/31/2023: Partially accepted** The facility provided a plan ensure compliance with the rules going forward but did not provide the documentation for the training for the cited employee. **Provide the documentation for the training for the cited employee by COB 6/14/23.**

§448.603. Training. (d) (2) (A)	(2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases. (A) The initial training shall be three hours in length.	In the file reviewed for employee SS, date of hire – 3/28/22 the employee did not receive 3 hours of HIV, HEP B and C, TB, and STD training.	In accordance with 448.603 (d)(2)(A), SURS Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts and Internal training tracking tool (See Attachment D) **Additional Response:** See Certificate Attachment SS 448.603d2A***	**HHSC response 5/31/2023: Partially accepted** The facility provided a plan ensure compliance with the rules going forward but did not provide the documentation for the training for the cited employee. **Provide the documentation for the training for the cited employee by COB 6/14/23**

§448.603. Training. (d) (2) (B)	(B) Staff shall receive annual updated information about these diseases.	There was no evidence provided the following employees, received annual updated information about HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases for 2022: • Staff – date of hire: 10/13/17 • Staff – date of hire: 1/5/18 • Staff – date of hire: 2/14/20	In accordance with 448.603 (d)(2)(B), SURS Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts and Internal training tracking tool (See Attachment D) **Additional Response:** See Certificate Attachments BS 448.603d2B, DW 448.603d2B, and SW 448.603d2B***	**HHSC response 5/31/2023: Partially accepted** The facility provided a plan ensure compliance with the rules going forward but did not provide the documentation for the training for the cited employees. **Provide the documentation for the training for the cited employees by COB 6/14/23**

§448.603. Training. (d) (6) (A)	(6) Intake, Screening and Admission Authorization. All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses. (A) The initial training shall be eight hours in length.	In the file reviewed for employee SS, date of hire – 3/28/22, the employee did not complete eight (8) hours of Intake, Screening and Admission Authorization training including the program's screening and admission procedures and two hours of DSM diagnostic criteria prior to screening and authorizing admissions.	In accordance with 448.603 (d)(6)(A), SURS Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts. Staff have completed training as of 5/11/23. **Additional Response:** See Attachment E updated for Certificate***	**HHSC response 5/31/2023: Partially accepted** The facility provided a plan ensure compliance with the rules going forward but did not provide the documentation for the training for the cited employee. **Provide the documentation for the training for the cited employee by COB 6/14/23**

§448.603. (d) (6) (B) Training.	(B) Staff shall complete eight hours of annual training thereafter.	In the following files reviewed, the following employees did not complete the annual eight (8) hours of training for Intake, Screening, and Admission Authorization and two hours of DSM diagnostic criteria for the year 2022: • Staff – date of hire: 10/13/17 • Staff – date of hire: 1/5/18 • Staff – date of hire: 2/14/20	In accordance with 448.603 (d)(6)(B), SURS Program Assistant to track and maintain training completion records to ensure compliance with annual trainings and updated information via electronic learning system (SABA) manager alerts. Staff have completed required training as of 5/15/23. **Additional Response:** See Attachments F updated, G updated, and H updated for certificates	**HHSC response 5/31/2023: Partially accepted** The facility provided a plan ensure compliance with the rules going forward but did not provide the documentation for the training for the cited employees. **Provide the documentation for the training for the cited employees by COB 6/14/23**
§448.702 (d) Client Grievances.	(d) The procedure shall also inform clients that they can submit a complaint directly to the Commission at any time and include the current mailing address and toll-free telephone number of the Commission's investigations division.	The facility's client grievance procedure did not include the current mailing address and toll-free telephone number of the Commission's investigations division.	Grievance procedure updated with the current mailing address and toll-free telephone number of the Commission's investigations division to comply with 448.702(d). (See attachment I)	**HHSC response 5/31/2023: Accepted**

§448.802 (b) (1–16) Admission Authorization and Consent to Treatment.	(b) The facility shall obtain written authorization from the consenter before providing any treatment or medication. The consent form shall be dated and signed by the client, the consenter, and the staff person providing the information, and shall document that the client and consenter have received and understood the following information: (1) the specific condition to be treated; (2) the recommended course of treatment; (3) the expected benefits of treatment; (4) the probable health and mental health consequences of not consenting; (5) the side effects and risks associated with the treatment; (6) any generally accepted alternatives and whether an alternative might be appropriate; (7) the qualifications of the staff that will provide the treatment; (8) the name of the primary counselor; (9) the client grievance procedure; (10) the Client Bill of Rights as specified in §148.701 of this title;	In the files reviewed for the following clients, there was no consent to treatment: • Client– date of admission – 11/2/22 • Client– date of admission – 11/18/22 • Client– date of admission – 12/19/22	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.802(b)(1-16). (See Attachment J)	**HHSC response 5/31/2023: Accepted**

	(11) the program rules, including rules about visits, telephone calls, mail, and gifts, as applicable; (12) violations that can lead to disciplinary action or discharge; (13) any consequences or searches used to enforce program rules; (14) the estimated daily charges, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources and insurance benefits; (15) the facility's services and treatment process; and (16) opportunities for family to be involved in treatment.			
§448.802 (d) Admission Authorization and Consent to Treatment.	(d) The client record shall include a copy of the Client Bill of Rights dated and signed by the client and consenter.	In the files reviewed for the following clients there was no copy of the Client Bill of Rights dated and signed by the client: • Client– date of admission – 11/2/22 • Client– date of admission – 11/18/22 • Client– date of admission – 7/2/22 • Client– date of admission – 12/19/22 • Client– date of admission – 3/4/22 In the files reviewed for client KM the Client Bill of Rights dated 12/21/22 was not signed by the client:	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.802(d). (See Attachment J)	**HHSC response 5/31/2023: Accepted**

§448.803 (e) Assessment.	(e) The assessment shall be signed by a QCC and filed in the client record within three individual service days of admission.	In the files reviewed for the following clients the assessment was not signed by the QCC: • Client– date of admission – 11/2/22 • Client– date of admission – 12/19/22 • Client– date of admission – 3/4/22	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.803(e). (See Attachment J)	**HHSC response 5/31/2023: Accepted**
§448.804. (e) Treatment Planning, Implementation and Review.	(e) The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan.	In the following files reviewed, the treatment plan was not signed by the client, and the counselor: • Client– treatment plan dated – 12/15/22 • Client– treatment plan dated – 2/6/23 • Client– treatment plan dated – 12/28/22	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.804 (e). (See Attachment J)	**HHSC response 5/31/2023: Accepted**
§448.805. (g) Discharge.	(g) The completed discharge plan shall be dated and signed by the counselor, the client, and the consenter (if applicable).	In the files reviewed for the following clients, the discharge plan was not dated and signed by the counselor or client: • Client– discharge plan dated – 12/13/22 • Client– discharge plan dated – 2/6/23 • Client– discharge plan dated – 12/28/22	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.805(g). (See Attachment J)	**HHSC response 5/31/2023: Accepted**

§448.901. Requirements Applicable to All Treatment Services. (d)	(d) The program shall provide education about Tuberculosis (TB), HIV, Hepatitis B and C, and sexually transmitted diseases (STDs) based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.	The facility did not provide education on HIV, Tuberculosis, Hepatitis B and C, and sexually transmitted diseases as required, for the following clients: • Client– date of admission – 11/2/22 – projected discharge date – 01/29/23 (HIV only) • Client– date of admission – 11/18/22 –projected discharge date – 2/20/23 • Client– date of admission – 7/2/22 – projected discharge date – 10/29/22 (HIV only) • Client– date of admission – 12/21/22 –projected discharge date – 06/6/23 • Client– date of admission – 12/19/22 –projected discharge date – 03/28/23 • Client– date of admission – 3/4/22 – discharge date – 03/24/22 (HIV only)	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.901. (See Attachment J)	**HHSC response 5/31/2023: Accepted**
§448.901. Requirements Applicable to All Treatment Services. (e)	(e) The program shall provide education about the health risks of tobacco products and nicotine addiction.	The facility did not provide education about the health risks of tobacco products and nicotine addiction as required, for the following clients: • Client– date of admission – 11/2/22 – projected discharge date – 01/29/23 • Client– date of admission – 11/18/22 –projected discharge date – 2/20/23 • Client– date of admission – 7/2/22 – projected discharge date – 10/29/22 • Client– date of admission – 12/21/22 –projected discharge date – 06/6/23 • Client– date of admission – 12/19/22 –projected discharge date – 03/28/23 • Client– date of admission – 3/4/22 – discharge date – 03/24/22	Program has created and implemented use of Client Checklist for staff to ensure this is complete for every client in accordance with 448.901. (See Attachment J)	**HHSC response 5/31/2023: Accepted**

You are required to submit a written response within ten (10) business days from the receipt of this report **(by COB: 6/14/2023)** addressing each finding and detailing the corrective action you have taken to achieve

compliance with 25 Texas Administrative Code Chapter 448. In your Plan of Correction (POC), cite the rule number and corrective action taken. Compile all pertinent documentation, the signed Notice of Finding, and submit with your POC. Forward all responsive documents by email to: inspector's email address, or by mail to the following address:

Charles Reubens, Inspector
Substance Use Disorder and Professional Licensing Compliance
Texas Health and Human Services Commission
701 W. 51st Location code: 1001; Mail code: 1979
Austin, TX. 78751

Charles A. Reubens	May 31, 2023
Substance Use Disorder Compliance Inspector	Date
Byanca Hernandez	*June 12, 2023*
Facility Representative	Date

TEXAS Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

April 5, 2023

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

Dear Wayne Young,

In compliance with the Centers for Medicare and Medicaid Services, the Health and Human Services Commission (HHSC) completed the annual review of the Youth Empowerment Services (YES) program The Harris Center for Mental Health and IDD on March 23, 2023.

HHSC staff reviewed clinical and administrative records and provided technical assistance regarding the YES program. The attached Site Review Report summarizes the results of the review. For all review items below 90% compliance, a Corrective Action Plan must be submitted by close of business on May 5, 2023, to YESWaiver@hhs.texas.gov.

While this report identified areas needing remediation, we would like to acknowledge that your YES team demonstrates a strong commitment to the service of YES Waiver participants, including your YES Waiver program staff's ongoing commitment to participation in Wraparound Coaching from the National Wraparound Implementation Center.

Sincerely,

Linda Gonzalez, YES Waiver, Quality Management Specialist
Medical and Social Services, Behavioral Health Services

Cc: Stella Olise, Practice 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

1915c YES Waiver Site Review
Harris Center
March 23, 2023

The Health and Human Services Commission, Youth Empowerment Services (YES) program staff completed the annual on-site review to ensure all planned waiver services were available and delivered in accordance with requirements. The following Performance Measures are based on the participant chart reviews in accordance with waiver requirements. YES program staff reviewed a sample of 10 participants during the time period of December 20, 2022-March 20, 2023. For all review items below 90% compliance and areas needing improvement, please address within the Plan of Correction. A sample of personnel records were also reviewed for compliance.

Positives:

- Individual/LAR received a return call from the LMHA within 24 hours or 1 business day from registration on the Inquiry List.
- Waiver participants are afforded choice between the home and community-based waiver services and institutional care, choice of waiver home and community-based waiver services, choice among home and community-based providers and are informed orally and in writing of the process for reporting Abuse, Neglect and/or Exploitation and filing complaints.
- Annual Renewal Clinical Eligibility Assessment was completed within 365 days.
- Crisis and safety plan is developed during the Wraparound facilitator's first face to face meeting with the child and LAR.
- The crisis/safety plan addresses health and safety needs identified in the reason for referral, CANS scoring and/or Clinical Eligibility. The crisis/safety plan(s) identifies triggers or behaviors that precipitated the referral and includes specific actions, interventions and contact information for persons and resources identified.
- Wraparound Plans includes at least one needs statement for the youth.
- Wraparound Plans includes at least one needs statement for the youth and one for a family member.
- Wraparound plans reflect reason for referral.
- Wraparound Plan includes outcome statements, strategies and/or tasks addressing the actionable items (score of 2 or 3) identified on the CANS/Clinical Eligibility.
- Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Child and Family Team Meeting to reflect progress or lack or progress in all areas.
- Wraparound plans are updated at least every 90 days as the youth and

family's needs change (including critical incidents or change in family, school, environmental dynamics, etc.). DART will assess providers on the continued requirement to update the wraparound plans every 30 days.

- Incidents noted during the review period have a corresponding Critical Incident Report.
- Facilitator submitted the Critical Incident Report to HHSC within 72 hours (or 3 business days) after being informed of the incident.
- The Facilitator has a face-to-face meeting with the youth and family within 72 hours, but no later than 7 business days, after learning of a critical incident. If the youth is hospitalized, in detention or otherwise unavailable, face to face meeting takes place within 72 hours of discharge.
- Response to critical incidents are appropriate to ensure the health and safety of the participant.
- All incidents involving restraint applications, seclusion or other restrictive interventions meet the requirements (see Review Tips).
- A Termination Clinical Eligibility document is entered for all youth discharging from YES Waiver services.
- There is a discharge/transition plan for youth who successfully graduate the YES program or request termination of services. If the youth is turning 19 there is a discharge/transition plan that includes a summary of community mental health services, current status, and plans to coordinate ongoing services.
- Wraparound facilitators do not exceed 1:10 caseload ratios without expressed authorization from HHSC.
- Wraparound facilitators do not provide or bill for any service other than Intensive Case Management without expressed authorization from HHSC.
- All provider qualifications and trainings were completed by center staff and subcontractors.

Concerns and Areas for Improvement:

- Individual did not always receive a face-to-face intake assessment/Clinical Eligibility within 7 business days of the initial demographic eligibility determination contact. Applicants on the YES waiver inquiry list are offered an assessment for eligibility on a first-come first-served basis by LMHAs or LBHAs.
- Waiver participant and LAR did not always have a face-to-face meeting with Facilitator within 7 business days of CE approval.
- Wraparound plans do not sufficiently describe service type, amount, frequency, duration, and location.

Performance Measure	Compliance Score
Individual/LAR received a return call from the LMHA within 24 hours or 1 business day from registration on the Inquiry List.	**100%**
Individual received a **face-to-face intake assessment/Clinical Eligibility within 7 business days** of the initial demographic eligibility determination contact.	**88%**
Waiver participants are afforded choice between the home and community-based waiver services and institutional care, choice of waiver home and community-based waiver services, choice among home and community-based providers and are informed orally and in writing of the process for reporting Abuse, Neglect and/or Exploitation and filing complaints.	**100%**
Waiver participant and LAR has a face-to-face **meeting with Facilitator within 7 business days of CE approval**.	**89%**
Annual Renewal Clinical Eligibility Assessment was completed within 365 days.	**100%**
Crisis and safety plan is developed during the Wraparound facilitator's first face to face meeting with the child and LAR.	**100%**
The **crisis/safety plan addresses health and safety needs** identified in the reason for referral, CANS scoring and/or Clinical Eligibility. The crisis/safety plan(s) identifies triggers or behaviors that precipitated the referral and includes specific actions, interventions and contact information for persons and resources identified.	**100%**
Wraparound Plans includes at least **one needs statement for the youth**	**100%**
Wraparound Plans includes at least **one needs statement for the youth and one for a family member**.	**90%**
Wraparound plans reflect the reason for referral.	**100%**
Wraparound Plan includes **outcome statements, strategies and/or tasks addressing the actionable items** (score of 2 or 3) identified on the CANS/Clinical Eligibility.	**90%**

Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Child and Family Team Meeting to reflect progress or lack or progress in all areas.	**90%**
Waiver participant receives services according to the **type, scope, and amount specified in their Wraparound Plans.**	**70%**
Waiver participants whose services are delivered according to the **frequency specified in their Wraparound Plans.**	**70%**
Waiver participants whose services are delivered according to the **duration specified in their Wraparound Plans.**	**30%**
Waiver participants whose services are delivered according to the **location specified in their Wraparound Plans.**	**60%**
Wraparound plans are updated at least every 90 days as the youth and family's needs change (including critical incidents or change in family, school, environmental dynamics, etc.). DART will assess providers on the continued requirement to update the wraparound plans every 30 days.	**100%**
Incidents noted during the review period have a corresponding **Critical Incident Report**.	**100%**
Facilitator submitted the **Critical Incident Report to HHSC within 72 hours** (or 3 business days) after being informed of the incident.	**100%**
The Facilitator has a **face to face meeting with the youth and family within 72 hours**, but no later than 7 business days, after learning of a critical incident. If the youth is hospitalized, in detention or otherwise unavailable, face to face meeting takes place within 72 hours of discharge.	**100%**
Response to critical incidents are appropriate to ensure the health and safety of the participant.	**100%**
All incidents involving **restraint applications, seclusion or other restrictive interventions** meet the requirements (see Review Tips).	**N/A**
A Termination Clinical Eligibility document is entered for all youth discharging from YES Waiver services	**100%**

There is a **discharge/transition plan** for youth who successfully graduate the YES program or request termination of services. If the youth is turning 19 there is a discharge/transition plan that includes a summary of community mental health services, current status, and plans to coordinate ongoing services.	**100%**
Wraparound facilitators do not exceed 1:10 caseload ratios without expressed authorization from HHSC	**100%**
Wraparound facilitators do not provide or bill for any service other than Intensive Case Management without expressed authorization from HHSC	**100%**
Did the contractor document the appropriate information in the free text field as required by EVV policy? Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system. Free text is also required whenever the following reason codes are used:*Reason Code 131 - Emergency: The program provider must describe the nature of the emergency and document any missing actual clock in or clock out time.*Reason Code 600 - Other: The program provider must document the reason why "other" was selected and document any missing actual clock in or clock out time.	N/A
Did the Provider/Contractor use EVV system as required by HHSC EVV Policy?	**100%**

Provider Qualifications and Trainings Performance Measure	Compliance Score
Current Criminal Background Check (TDPS) - Include date of check (Prior to employment and annually thereafter)	**100%**
Employee Misconduct Registry (DADS) - Include date of check (Prior to employment and annually thereafter)	**100%**
State license or certification, with documented training and experience relative to the specific service provided.	**100%**
Waiver Provider Agencies that have a process to complete annual criminal history and employee misconduct checks. Provider submits documentation of process to complete annual criminal history and employee misconduct checks.	**100%**
Waiver Provider agency has a process that ensures direct service providers meet state requirements for provider training. Provider submits documentation of the procedure for provider training.	**100%**
Identifying and reporting of abuse, neglect, and exploitation (Annually)	**100%**
HIPAA Training (Annually)	**100%**
Critical incident reporting (Annually)	**100%**
"National wraparound initiative (Intro to Systems of Care): 1. What's This Thing Called Wraparound? 2. Team Roles in Wraparound; and 3. YES 101 Training	**100%**

Service Documentation requirements (One Time)	**100%**
Crisis and Safety planning (Once)	**100%**
Restraint and Restrictive Interventions. (Annually)	**100%**
CPR and First Aid (Must be Current)	**100%**
DFPS Trauma Informed Care (Must be completed every two years)	**100%**
Did the Provider/Contractor select an EVV system prior to delivering EVV services?(Once)	**100%**
Did the Provider/Contractor complete all required EVV training initial and annually. Required training includes training with EVV vendor or Proprietary System, EVV portal training with TMHP and EVV Policy training with HHSC or MCO. Must keep update to date record of training and all users of the EVV system (Annually)	**100%**

YES Waiver Corrective Action Plan

[The Harris Center for Mental Health & IDD] **[4/28/2023]**

Performance Measure/Area of Concern	Compliance Score (if applicable)	Actions to Correct Finding	Responsible Party	Anticipated Date of Completion	Actions to Evaluate/Monitor Effectiveness	Actions to Monitor Compliance/Identify Deficiencies
Individual received a face-to-face intake assessment/Clinical Eligibility within 7 business days of the initial demographic eligibility determination contact.	88%	1. Within the next 30 days, Administrative Staff will continue to send out e-mails to the leadership team providing the number of intakes available within the next 7-business days. 2.Practice Manager will review and monitor the daily Inquiry Call e-mail, with the assistance of the Clinical Team Leader over intakes, and keep track of the available intakes within the next 7-business days. 3. Practice Manager, Clinical Team Leader and Administrative staff will review the intake slots and ensure appointment are available. In the event that intakes slots are decreasing, Clinical Team Leaders will assist with completing intakes. 4. Any intakes scheduled outside of 7-business days, due to LAR's choice, must have an explanation noted on the Inquiry Line spreadsheet and documented in Epic.	1. Administrative Staff 2. Practice Manager 3. Clinical Team Leaders	5/31/2023	Action steps will be monitored on a daily basis utilizing e-mail communication and daily tracking of available intakes.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.
Waiver participant and LAR has a face-to-face meeting with Facilitator within 7 business days of CE approval.	89%	1. Within the next 30 days, a daily tracking will be in place to monitor intake status in CMBHS. An e-mail will be sent out by an Administrative Staff to the Clinical Team Leaders when client has been approved for YES Waiver services. 2. The Clinical Team Leader will assign the case to a Wraparound Facilitator and send an e-mail to the staff member. The e-mail will include the enrollement date and the date the Facilitator must schedule a face-to-face meeting with the family. 3. The Wraparound Facilitator will document their introductory meeting with the family as appropriate.	1. Administrative staff 2. Clinical Team Leaders 3. Wraparound Facilitator	5/31/2023	Action steps will be monitored on a daily basis via e-mail and monthly utilizing chart reviews.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.
Waiver participant receives services according to the type, scope, and amount specified in their Wraparound Plans.	70%	1. Within the next 30 days, in-person refresher training will be provided to all Wraparound Facilitators reviewing "type, scope and amount" of all tasks and strategies documented in the wraparound plan. 2. The Wraparound Facilitator will note "Reviewed" or "Revised" on the plan after each update and team meeting held. 3. Additionally, the Clinical Team Leader will review the Wraparound Plan and request the Wraparound Facilitator to make corrections as needed, prior to approving the plan. They will ensure "type, scope and amount" is accurately documented and address any areas of concern as needed. 4. YES Waiver Compliance Monitor will complete a monthly chart review and use the YES Waiver QM tool as a guide. Any areas of concern will be addressed by the Clinical Team Leader with additional coaching and training when needed.	1. Wraparound Facilitator 2. Clinical Team Leaders 3. YES Waiver Compliance Monitor	5/31/2023	Action steps will be monitored on a monthly basis through the review of wraparound plans and chart reviews.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.

YES Waiver Corrective Action Plan

[The Harris Center for Mental Health & IDD] **[4/28/2023]**

Performance Measure/Area of Concern	Compliance Score (if applicable)	Actions to Correct Finding	Responsible Party	Anticipated Date of Completion	Actions to Evaluate/Monitor Effectiveness	Actions to Monitor Compliance/Identify Deficiencies
Waiver participants whose services are delivered according to the frequency specified in their Wraparound Plans.	70%	1. Within the next 30 days, in-person refresher training will be provided to all Wraparound Facilitators reviewing "frequency" of all tasks and strategies documented in the wraparound plan. 2. The Wraparound Facilitator will note "Reviewed" or "Revised" on the plan after each update and team meeting held. 3. Additionally, the Clinical Team Leader will review the Wraparound Plan and request the Wraparound Facilitator to make corrections as needed, prior to approving the plan. They will ensure "frequency" is accurately documented and address any areas of concern as needed. 4. YES Waiver Compliance Monitor will complete a monthly chart review and use the YES Waiver QM tool as a guide. Any areas of concern will be addressed by the Clinical Team Leader with additional coaching and training when needed.	1. Wraparound Facilitator 2. Clinical Team Leaders 3. YES Waiver Compliance Monitor	5/1/2023	Action steps will be monitored on a monthly basis through the review of wraparound plans and chart reviews.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.
Waiver participants whose services are delivered according to the duration specified in their Wraparound Plans.	30%	1. Within the next 30 days, in-person refresher training will be provided to all Wraparound Facilitators reviewing "duration" of all tasks and strategies documented in the wraparound plan. 2. The Wraparound Facilitator will note "Reviewed" or "Revised" on the plan after each update and team meeting held. 3. Additionally, the Clinical Team Leader will review the Wraparound Plan and request the Wraparound Facilitator to make corrections as needed, prior to approving the plan. They will ensure "duration" is accurately documented and address any areas of concern as needed. 4. YES Waiver Compliance Monitor will complete a monthly chart review and use the YES Waiver QM tool as a guide. Any areas of concern will be addressed by the Clinical Team Leader with additional coaching and training when needed.	1. Wraparound Facilitator 2. Clinical Team Leaders 3. YES Waiver Compliance Monitor	5/31/2023	Action steps will be monitored on a monthly basis through the review of wraparound plans and chart reviews.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.
Waiver participants whose services are delivered according to the location specified in their Wraparound Plans.	60%	1. Within the next 30 days, in-person refresher training will be provided to all Wraparound Facilitators reviewing "location" of all tasks and strategies documented in the wraparound plan. 2. The Wraparound Facilitator will note "Reviewed" or "Revised" on the plan after each update and team meeting held. 3. Additionally, the Clinical Team Leader will review the Wraparound Plan and request the Wraparound Facilitator to make corrections as needed, prior to approving the plan. They will ensure "location" is accurately documented and address any areas of concern as needed. 4. YES Waiver Compliance Monitor will complete a monthly chart review and use the YES Waiver QM tool as a guide. Any areas of concern will be addressed by the Clinical Team Leader with additional coaching and training when needed.	1. Wraparound Facilitator 2. Clinical Team Leaders 3. YES Waiver Compliance Monitor	5/31/2023	Action steps will be monitored on a monthly basis through the review of wraparound plans and chart reviews.	Daily updates will be provided to Practice Manager. Any areas of concern/deficiencies will be addressed by updating or modifying the current flow. This will be reviewed as needed.

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Review Period		
4/13/2023	Thru	5/5/2023

Reviewer Contact Information		Contactor Information		Corrective Action Plan		Review #	23SU13
Name/Title:	Michael Guerrero / QM Specialist	Contractor Name:	The Harris Center for MHIDD	Submitted By:	Byanca Hernandez	CAP Due Date:	6/20/2023
Monitoring Entity:	BHS Quality Management, Contract Services	Location:	Houston, TX (region 6)	Approved/Issued By:		Submission Date:	6/20/2023
Phone/Email:	(512) 206-4515 / michael.guerrero@hhs.texas.gov	Monitoring Period:	FY 2022, 4th Quarter	Returned for Correction By:		Approved Date:	
						Returned Date:	

Citation	Statement	Score	Row Comments	Person Responsible			Actions to correct the finding	Actions for monitoring compliance	Actions to evaluate and monitor ongoing effectiveness	Time Frame	HHSC Response
				Title	First Name	Surname					
Policy and Procedure											
Wait Lists											
TCO Record Review											
TCO Program Review											
TCO Personnel											
TRA Record Review											
TRA SOW III Service Requirements Treatment Planning, Implementation and Review D.1	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC for SUD programs as stated in the in the TAC regarding Treatment Planning, Implementation and Review, as referenced in Service Delivery of the SUD Program Guide? 448.804 Treatment Planning, Implementation and Review Individualized written plan that identifies services and support to problems and address needs identified on the assessment to include: the length of stay, appropriate referrals for services not offered, and when feasible other QCC's or mental health professionals serving the client from referral should participate in the treatment planning process, justification when identified needs are temporarily deferred or not addressed during treatment. Treatment plan shall include: goals (based on clients problems/needs, strengths and preferences), objectives (individualized, realistic, measurable, time specific, appropriate for level of care and in behavioral terms), and strategies (types and frequencies of specific services, and interventions needed to help the client achieve the identified goal and appropriate for the level of intensity of the service type and level. Plans shall be evaluated on a regular basis and revised as needed (evaluation of client's progress toward each goal and objectives, revision of goals, objectives, and justification for continued length of stay). The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan. Treatment plan shall be completed and filed in the client record within five (5) service days of admission.	0%	Treatment plans did not appear to meet TAC requirements. Specifically, objectives did not appear realistic, measurable, or time specific.	Clinical Team Leader (CTL)	Byanca	Hernandez	1. CTL will enlist assistance from HHSC Technical Assistance for additional training on developing treatment plans to meet TAC requirements 2. CTL will review SOW and TAC 448.804 with staff 3. Review CMBHS refersher course and TAC rule as recommended by Technical Assistance	Update internal audit tool to reflect 448.804 Treatment Plan requirements. At least one treatment plan will be reviewed for each staff on a quarterly basis	Conduct internal audit quarterly to monitor; At least one treatment plan will be reviewed for each staff on a quarterly basis. 80% will be considered acceptable.	First round of audits will be completed by July 20th	
TRA SOW III Service Requirements Treatment Planning, Implementation and Review D.3 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services	If there was a need for a referral, did the Contractor document referral and referral follow-up in CMBHS to the appropriate community resources based on the individual need of the client? If the client was an HIV Intensive Residential client did the Contractor provide and document a referral in CMBHS for psychiatric evaluations as needed and indicated?	0%	CMBHS client records do not appear to reflect the use of CMBHS referral and referral follow-up functionality to document referrals for identified needs.	Clinical Team Leader (CTL)	Byanca	Hernandez	CTL will retrain team on the use of CMBHS referral, referral follow-up functionality, and referral documentation.	Update internal audit tool to include Referral and Referral Follow up as action items. The assessment and client chart will be reviewed to determine if appropriate referrals were made, documented, and followed up with.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	

TRA SOW III Service Requirements Discharge D.1-2 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.3	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC regarding Discharge, as referenced in Service Delivery of the SUD Program Guide? 448.805 Discharge Did the contractor develop and implement an individualized discharge plan with the client to assist in sustaining recovery? Plans shall be updated as the client progresses through treatment and shall address appropriateness of the current treatment level, and plan shall address continuity of services to the client. When a client is referred or transferred to another chemical dependency or mental health service provider for continuing care, the facility shall contact the receiving program before the client is discharged to make arrangements for the transfer. Coordination of services and activities as well as proper consent with copies of relevant parts of the client's record. Discharge plan shall be developed to address ongoing client needs, including: individual goals or activities to sustain recovery, referrals, and recovery maintenance services, if applicable. If the client was an HIV Intensive Residential client did the Contractor conduct discharge planning and emphasize referrals to community resources for continued medical care and other support services?	0%	**Discharge plan did not appear to change from initial draft plan or address plan to sustain recovery.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. CTL will enlist assistance from HHSC Technical Assistance to ensure a clear understanding of SOW Discharge requirements.2. CTL will review SOW Service Requirements with staff 3. Program to seek peer to peer support/feedback as recommended by Technical Assistance	Update internal audit tool to include Disharge/Aftercare plan as action items. The treatment plan will be reviewed to ensure the information reflected on the discharge plan is accurate. The aftercare plan will be reviewed to ensure appropriate (and different) objectives are developed to assist in sustaining recovery.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRA SOW III Service Requirements Additional Service Requirements F.4 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services	Did the CMBHS client record reflect the Contractor provided evidenced-based education at minimum on the following topics: (i) Tuberculosis; (ii) HIV; Hepatitis B and C; (iii) Sexually Transmitted Infections/Diseases; and (iv) health risks of tobacco and nicotine product use? If the client was an HIV Intensive Residential client, did the CMBHS record reflect the Contractor facilitated two hours per month of HIV and Hepatitis C co-infection group counseling	0%	**CMBHS client records did not appear to reflect education was provided on these required topics.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. Update the monthly program schedule to include HIV, Hep B&C, STIs, and health risks of tobacco and nicotine product use. 2. CTL to review SOW with staff to ensure an understanding of required educations and need for documentation.	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRA SOW III Service Requirements Additional Service Requirements F.6 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.2	Did the CMBHS client record reflect the Contractor ensure client access to the full continuum of treatment services and provided sufficient treatment intensity to achieve treatment plan goals? If the client was an Intensive HIV Residential client did the CMBHS reflect the Contractor provided and documented medical monitoring and treatment of HIV and ensure the provision of expedited timely co-occurring needs and treatment for related conditions? Please note: Addressing issues associated with antiviral drug resistance and adherence, symptoms associated with drug-induced side effects and prescribed prophylaxis for opportunistic infection(s).	0%	**CMBHS client records did not reflect clients consistently received the services as required by the SOW.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. CTL will review SOW with staff. 2. Training will be provided to review quality standards including ensuring client has access to treatment services. 3. Internal Audit tool will be updated to include a review of opportunities where access to services and sufficient treatment intensity would be identified (ie Screening, Assessment, Progress Notes, Treatment Plan, etc)	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRA SOW III Service Requirements Additional Service Requirements F.9	Did the CMBHS record reflect the Contractor provided overdose prevention and reversal education to all clients?	0%	**CMBHS client records did not reflect evidence of overdose prevention and reversal education.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. Update the monthly program schedule to include overdose prevention and reversal education. 2. CTL to review SOW with staff to ensure an understanding of required educations and need for documentation.	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRA Program Review											
TRA Personnel											
TAC 448.603(d) Substance Use Program Guide 9 Personnel Requirements and Documentation 1 and 5	Ensure staff completed the following trainings within the first 90 days in accordance with SOW i. Motivational interviewing techniques or Motivational Enhancement Therapy; ii. Trauma-informed care; iii. Cultural competency; iv. Harm reduction trainings; v. HIPAA and 42 CFR Part 2 training; and vi. State of Texas co-occurring psychiatric and substance use disorder (COPSD) training located at the following website: www.centralizedtraining.com. The following initial training(s) must be received within first 90 days of employment and must be completed before the employee can perform a function to which to which the specific training is applicable. (1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training. (2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases. (A) The initial training shall be three hours in length	0%	**Staff record did not indicate staff received Trauma-informed care or Cultural Competency training.**	Clinical Team Leader (CTL)	Byanca	Hernandez	All staff will receive Trauma-Informed Care provided by the facility.	Staff Training Tracker will be developed and utilized to log trainings required by contract. New Employee Orientation Checklist will be updated to include Trauma Informed Care.	Trainings will be assigned and reviewed within 90 days of hire. Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	

TAC 448.603(d)(6) Substance Use Program Guide 9 Personnel Requirements and Documentation 1	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses. (A) The initial training shall be eight hours in length. (B) Staff shall complete eight hours of annual training thereafter. (C) The training shall be completed before staff screen or authorize applicants for admission.	0%	**Staff record did not indicate staff received Intake, screening, and admission training.**	Clinical Team Leader (CTL)	Byanca	Hernandez	All staff will receive Intake, Screening, and Admission training. CTL to review training if provided online.	Staff Training Tracker will be developed and utilized to log trainings required by contract. New Employee Orientation Checklist will be updated to include Intake Screening and Admission training.	Trainings will be assigned and reviewed within 90 days of hire. Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	
TRF Record Review											
TRF SOW III Service Requirements Treatment Planning, Implementation and Review D.1	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC for SUD programs as stated in the in the TAC regarding Treatment Planning, Implementation and Review, as referenced in Service Delivery of the SUD Program Guide? 448.804 Treatment Planning, Implementation and Review Individualized written plan that identifies services and support to problems and address needs identified on the assessment to include: the length of stay, appropriate referrals for services not offered, and when feasible other QCC's or mental health professionals serving the client from referral should participate in the treatment planning process, justification when identified needs are temporarily deferred or not addressed during treatment. Treatment plan shall include: goals (based on clients problems/needs, strengths and preferences), objectives (individualized, realistic, measurable, time specific, appropriate for level of care and in behavioral terms), and strategies (types and frequencies of specific services, and interventions needed to help the client achieve the identified goal and appropriate for the level of intensity of the service type and level. Plans shall be evaluated on a regular basis and revised as needed (evaluation of client's progress toward each goal and objectives, revision of goals, objectives, and justification for continued length of stay). The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan. Treatment plan shall be completed and filed in the client record within five (5) service days of admission.	0%	**Treatment plans did not appear to meet TAC requirements. Specifically, objectives did not appear realistic, measurable, or time specific.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. CTL will enlist assistance from HHSC Technical Assistance for additional training on developing treatment plans to meet TAC requirements 2. CTL will review SOW and TAC 448.804 with staff 3. Review CMBHS refersher course and TAC rule as recommended by Technical Assistance	Update internal audit tool to reflect 448.804 Treatment Plan requirements. At least one treatment plan will be reviewed for each staff on a quarterly basis	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW III Service Requirements Treatment Planning, Implementation and Review D.3	If there was a need for a referral, did the Contractor document referral and referral follow-up in CMBHS to the appropriate community resources based on the individual need of the client?	0%	**CMBHS client records do not appear to reflect the use of CMBHS referral and referral follow-up functionality to document referrals for identified needs.**	Clinical Team Leader (CTL)	Byanca	Hernandez	CTL will retrain team on the use of CMBHS referral, referral follow-up functionality, and referral documentation.	Update internal audit tool to include Referral and Referral Follow up as action items. The assessment and client chart will be reviewed to determine appropriate referrals were made, documented, and followed up with.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW III Service Requirements Discharge E.1	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC regarding Discharge, as referenced in Service Delivery of the SUD Program Guide? 448.805 Discharge Individualized plan to sustain recovery and address continuity of care services for the client Updated as the client progresses through treatment, Family involvement, when appropriate Referrals Recovery maintenance If the client was referred or transferred to another chemical dependency or mental health service provider for continuing care was there evidence that the facility contacted the receiving program before the client was discharged to make arrangements for the transfer? (Coordination of services and activities as well as proper consent with copies of relevant parts of the client's record.	0%	**Discharge plan did not appear to change from initial draft plan or address plan to sustain recovery.**	Clinical Team Leader (CTL)	Byanca	Hernandez	1. CTL will enlist assistance from HHSC Technical Assistance to ensure a clear understanding of SOW Discharge requirements.2. CTL will review SOW Service Requirements with staff 3. Program to seek peer to peer support/feedback as recommended by Technical Assistance	Update internal audit tool to include Disharge/Aftercare plan as action items. The treatment plan will be reviewed to ensure the information reflected on the discharge plan is accurate. The aftercare plan will be reviewed to ensure appropriate (and different) objectives are developed to assist in sustaining recovery.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW III Service Requirements Discharge E.3	Did the contractor document in CMBHS the client-specific information that supports the reason for discharge listed on the discharge report? A QCC must sign the discharge summary. Appropriate referrals shall be made and documented in the client record. A client's treatment is considered successfully completed, if the following criteria are met: i. Client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS. ii. All problems on the treatment plan have been addressed iii. CMBHS record reflect the Contractor utilized the treatment plan component of CMBHS to create a final and completed treatment plan version.	33%	**CMBHS client records reflected discharge summaries were not consistently completed.**	Clinical Team Leader (CTL)	Byanca	Hernandez	Discharge process will be reviewed with all staff in accordance with SOW and TAC requirements	Update internal audit tool to include Discharge Summary as action items. The discharge summary will be reviewed to ensure client-specific information supporting reason for discharge is listed.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	

TRF SOW III Service Requirements Discharge E.4	Did the Contractor document the client-specific information that supports the reason for discharge listed on the discharge report? A client's treatment is considered successfully completed, if both of the following criteria are met: i. Client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS. ii. All problems on the treatment plan have been addressed. Grantee shall use the Treatment Plan component of CMBHS to create a final and completed treatment plan version. (1) Problems designated as "treat" or "case manage" status shall have all objectives resolved prior to successful discharge. (2) Problems that have been "referred" shall have associated documented referrals in CMBHS. (3) Problems with "deferred" status shall be re-assessed. Upon successful discharge, all deferred problems shall be resolved, either through referral, withdrawal, treatment, or case management with clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components. (4) "Withdrawn" problems shall have clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components	50%	Final treatment plan appeared to have been closed completed instead of closed incomplete due to client not completing treatment.	Clinical Team Leader (CTL)	Byanca	Hernandez	Discharge criteria will be reviewed with staff to ensure understanding of appropriate CMBHS Closed status in relation to their discharge status.	Update internal audit tool to include an action item reviewing the status of final treatment plan to ensure they are closed in the appropriate status (ie Successful discharge with closed complete vs discharging for not completing treatment with closed incomplete status)	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW III Service Requirements Additional Service Requirements F.9	Did the CMBHS record reflect the Contractor provided overdose prevention and reversal education to all clients?	0%	CMBHS client records did not reflect evidence of overdose prevention and reversal education.	Clinical Team Leader (CTL)	Byanca	Hernandez	1. Update the monthly program schedule to include overdose prevention and reversal education. 2. CTL to review SOW with staff to ensure an understanding of required educations and need for documentation.	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW III Service Requirements Additional Service Requirements F.13	Did the CMBHS record reflect the Contractor provided and documented research-based education on the effects of Alcohol, Tobacco, and Other Drugs (ATOD) on the fetus?	0%	CMBHS client records did not reflect evidence of education on the effects of ATOD on the fetus.	Clinical Team Leader (CTL)	Byanca	Hernandez	1. Update the monthly TRF program schedule to include ATOD on the fetus. 2. CTL to review SOW with staff to ensure an understanding of required educations and need for documentation	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.3	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	50%	CMBHS client records did not consistently reflect that a discharge follow-up was conducted.	Clinical Team Leader (CTL)	Byanca	Hernandez	1. Review discharge follow up process and retrain appropriate staff on SOW requirements.	Discharge Follow Up report in CMBHS will be ran monthly. Discharge Follow Ups eligible for contact will be contacted by a QCC at least 3 times between 60 - 90 days of discharge. Contact attempts will be documented in EHR.	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.5	Did the CMBHS record reflect the Contractor provided and documented: i. A minimum of one (1) hour per week (or one (1) hour per month for Clients who have been transferred to outpatient after successfully completing a residential level of care) of evidence-based parenting education and document these services; and ii. A minimum of six (6) hours (or two (2) hours for Clients who have been transferred to outpatient after successfully completing a residential level of care) of reproductive health education prior to discharge and document these services.	0%	CMBHS client records did not reflect evidence of reproductive health education.	Clinical Team Leader (CTL)	Byanca	Hernandez	CTL to review SOW with staff to ensure an understanding of required educations and need for documentation.	Update internal audit tool to reflect Additional Service Requirements as required by the SOW	Conduct internal audit quarterly to monitor; Findings will be addressed. Additional training and further review will be provided as needed. 80% passing will be considered acceptable.	First round of audits will be completed by July 20th	
TRF Program Review											
TRF Personnel											
TAC 448.603(d) Substance Use Program Guide 9 Personnel Requirements and Documentation 1 and 5	Did the contractor ensure staff completed the following trainings within the first 90 days in accordance with SOW i. Motivational interviewing techniques or Motivational Enhancement Therapy; ii. Trauma-informed care; iii. Cultural competency; iv. Harm reduction trainings; v. HIPAA and 42 CFR Part 2 training; vi. Alcohol, Tobacco and Other Drugs on the Developing Fetus; vii. Child welfare education viii. State of Texas co-occurring psychiatric and substance use disorder (COPSD) training located at the following website: www.centralizedtraining.com. The following initial training(s) must be received within first 90 days of employment and must be completed before the employee can perform a function to which to which the specific training is applicable. (1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training. (2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases. (A) The initial training shall be three hours in length.	33%	Training records indicated that not all staff received COPSD, ATOD effects on the fetus, and child welfare education training.	Clinical Team Leader (CTL)	Byanca	Hernandez	All staff will be trained in COPSD, ATOD on the fetus, and Child Welfare Education.	Staff Training Tracker will be developed and utilized to log trainings required by contract. New Employee Orientation Checklist will be updated to include COPSD, ATOD, and child welfare education trainings.	Trainings will be assigned and reviewed within 90 days of hire. Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	

TAC 448.603.6 Substance Use Program Guide 9 Personnel Requirements and Documentation 1	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses. (A) The initial training shall be eight hours in length. (B) Staff shall complete eight hours of annual training thereafter. (C) The training shall be completed before staff screen or authorize applicants for admission.	0%	Training records indicated staff did not receive intake, screening, and admission authorization training.	Clinical Team Leader (CTL)	Byanca	Hernandez	All staff will receive Intake, Screening, and Admission training. CTL to review training if provided online.	Staff Training Tracker will be developed and utilized to log trainings required by contract. New Employee Orientation Checklist will be updated to include Intake Screening and Admission training.	Trainings will be assigned and reviewed within 90 days of hire. Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	
TRF SOW IV Staff Competencies and Requirements 2-3	Did the Contractor ensure that direct care staff received a copy of the statement of work and SUD requirements as well as reviewed all policies and procedures related to the Program or organization on an annual basis?	33%	Training records indicated that not all staff received a copy of the Statement of Work.	Clinical Team Leader (CTL)	Byanca	Hernandez	Provide SOW to all staff and obtain signature of receipt.	Update New Hire checklist to reflect receipt of SOW and signature line at the time of hire. Signed acknowledgement form will be retained in existing Staff's file.	Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	
TRF SOW IV Staff Competencies and Requirements 6-7	Did the contractor: 6. Ensure all direct care staff complete annual education on HIPAA and 42 CFR Part 2 training. 7. Ensure all direct care staff complete a minimum of ten (10) hours of training each State Fiscal Year in any of the following areas: i. Motivational Interviewing Techniques; ii. Cultural competencies; iii. Reproductive health education; iv. Risk and harm reduction strategies; v. Trauma Informed Care; vi. Substance exposed pregnancy (such as Fetal Alcohol Spectrum Disorder or DocuSign Envelope ID: 60EB3AB2-D4C9-4130-8E87-9164BFD5A4B8 HHSC Contract No. HHS000663700239 Page 10 of 20 Amendment No. 1 vii. Neonatal Abstinence Syndrome); viii. Child welfare education; or ix. Suicide prevention and intervention.	0%	Training records indicated that not all staff completed 10hrs of annual training.	Clinical Team Leader (CTL)	Byanca	Hernandez	Staff have obtained 8 hours of MI training to date. CTL will review the ability to designate Hire Date as the start date of the program (FY 2022 - 9/1/2021) versus the employee's start date with the agency. CTL will collaborate with Organizational Development for assitance with training reminders and registration of annual trainings.	Staff Training Tracker will be developed and utilized to log trainings required by contract.	Staff Training Tracker will be updated when annual trainings are completed.	July 20th	
TRF SOW IV Staff Competencies and Requirements 15	Did the Contractor staff demonstrate through documented training, credentials and/or experience that all direct care staff are proficient in areas pertaining to the needs of and provision of services to women and children?	33%	Training records do not indicate staff received specialized training.	Clinical Team Leader (CTL)	Byanca	Hernandez	All TRF staff will receive specialized training pertaining to the needs of and provision of services to women and children.	Staff Training Tracker will be developed and utilized to log trainings required by contract. New Employee Orientation Checklist will be updated to include	Trainings will be assigned and reviewed within 90 days of hire. Prior to service provision, checklist will be reviewed with staff, signatures obtained, and stored in staff's file.	July 20th	
TRY Record Review											
TRY Program Review											
TRY Personnel											
MAT Record Review											
MAT Program Review											
MAT Personnel											
TYF Record Review											
OSAR Record Review											
OSAR Program Requirements											
OSAR Personnel											
CCC Record Review											
CCC Program Review											
CCC Personnel											
SUD CHW											
PADRE Record Review											
PADRE Program Review											
PADRE Personnel											
PPI Record Review											
PPI Program Review											
PPI Personnel											
RBI Record Review											
RBI Program Review											
RBI Personnel											
RSS Record Review											
RSS Program Review											
RSS Personnel Review											
NAS Requirements											

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Review Period			Program Type(s)	TRA/TRF	Total Reviewed	Total Findings
4/13/2023	Thru	5/5/2023	Location	Houston, TX (reg 6)	1	0
Review Number :		23SU13	Reviewer's Initials			

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
Operational Plans, Policies and Procedures										
	TAC §392.511	Did the Contractor ensure to maintain an up-to-date manual that includes all policies and procedures required by DSHS's funding policy manual. (1) Policies shall be approved by the board, reviewed periodically, and revised as needed. (2) Procedures shall be approved by the chief executive officer, reviewed periodically, and revised as needed. (3) The policy and procedures manual shall be current, consistent with current Commission rules, individualized to the program, well organized, and easily accessible to all staff at all times. (4) Contractors shall require each employee to read the policies and procedures applicable to the position and maintain documentation signed by the employee that the policies and procedures have been read and understood.	1	1	1	1	1	100%	0	
	TAC §448.502	Did the Contractor ensure (a) The facility operated according to an operational plan. The operational plan shall reflect: (1) program purpose or mission statement; (2) services and how they are provided; (3) description of the population to be served; and (4) goals and objectives of the program. (b) The facility shall adopt and implement written policies and procedures as deemed necessary by the facility and as required herein. The policies and procedures shall contain sufficient detail to ensure compliance with all applicable Commission rules. (c) The policy and procedure manual shall be current, consistent with program practices, individualized to the program, and easily accessible to all staff at all times.	1	1	1	1	1	100%	0	Contractor has a separate SU operational plan from agency operational plan.
	TAC §448.504	Did the Contractor develop procedures and implement a quality management process. The procedures shall address at a minimum: (1) goals and objectives that relate to the program purpose or mission statement; (2) methods to review the progress toward the goals and a documented process to implement corrections or changes; (3) a mechanism to review and analyze incident reports, monitor compliance with rules and other requirements, identify areas where quality is not optimal and procedures to analyze identified issues, implement corrections, and evaluate and monitor their ongoing effectiveness; (4) methods of utilization review to ensure appropriate client placement, adequacy of services provided and length of stay; and (5) documentation of the activities of the quality management process.	1	1	1	1	1	100%	0	
	TAC §448.507	Did the Contractor ensure the following: (a) The facility shall keep complete, current documentation. (b) All documents shall be factual and accurate. (c) All documents and entries shall be dated and authenticated by the person responsible for the content. (1) Authentication of paper records shall be an original signature that includes at least the first initial, last name, and credentials. Initials may be used if the client record includes a document that identifies all individuals initialing entries, including the full printed name, signature, credentials, and initials. (2) Authentication of electronic records shall be by a digital authentication key. (d) Documentation shall be permanent and legible. (e) When it is necessary to correct a client record, incident report, or other document, the error shall be marked through with a single line, dated, and initialed by the writer. (f) Records shall contain only those abbreviations included on the facility's list of approved abbreviations.	1	1	1	1	1	100%	0	
	TAC §448.508	Did the Contractor ensure the following: (a) The facility shall establish and maintain a single record for every client beginning at the time of admission. The content of client records shall be complete, current, and well organized. (b) The facility shall protect all client records and other client-identifying information from destruction, loss, tampering, and unauthorized access, use or disclosure. (1) All active client records shall be stored at the facility. Inactive records, if stored off-site, shall be fully protected. All original client records shall be maintained in the State of Texas. (2) Information that identifies those seeking services shall be protected to the same degree as information that identifies clients. (3) Electronic client information shall be protected to the same degree as paper records and shall have a reliable backup system. (c) Only personnel whose job duties require access to client records shall have such access. (d) Personnel shall keep records locked at all times unless authorized staff is continuously present in the immediate area. (e) The facility shall ensure that all client records can be located and retrieved upon request at all times.	1	1	1	1	1	100%	0	
	TAC §448.509 (a-b)	a) The facility shall report to the Commission's investigations division, all allegations of client abuse, neglect, and exploitation. Acts constituting client abuse, neglect and exploitation are specifically described in §148.703 of this title (relating to Abuse, Neglect, and Exploitation). (b) The facility shall complete an internal incident report for all client incidents, including: (1) a violation of a client rights, including but not limited to, allegations of abuse, neglect and exploitation; (2) accidents and injuries; (3) medical emergencies; (4) psychiatric emergencies; (5) medication errors; (6) illegal or violent behavior; (7) loss of a client record; (8) personal or mechanical restraint or seclusion; (9) release of confidential information without client consent; (10) fire; (11) death of an active outpatient or residential client (on or off the program site); (12) clients absent without permission from a residential program; (13) suicide attempt by an active client (on or off the program site); (14) medical and psychiatric emergencies that result in admission to an inpatient unit of a medical or psychiatric facility; and (15) any other significant disruptions.	1	1	1	1	1	100%	0	
	TAC §448.509 (c-f)	Did the Contractor ensure the incident report was completed within 24 hours of the occurrence of an incident on-site, or within 24 hours of when the facility became aware of, or reasonably should have known of an incident that occurred off-site. The incident report shall provide a detailed description of the event, including the date, time, location, individuals involved, and action taken. (d) The individual writing the report shall sign it and record the date and time it was completed. (e) All incident reports shall be stored in a single, separate file. (f) The facility shall have a designated individual responsible for reviewing incident reports and all incidents should be evaluated through the quality management process to determine opportunities to improve or address program and staff performance.	1	1	1	1	1	100%	0	

	TAC §448.510	If the Contractor provides transportation through the use of facility vehicles or staff transporting clients, does the approved manual include the following: Insurance coverage, as well a current safety inspection sticker and license Vehicles are in safe driving condition Drivers have valid driver's license Mandatory seatbelts at all times while the vehicle is in operation as required by law Vehicle shall not transport more passengers than allowed by the manufacturer Drivers cannot use cell phones while driving Use of tobacco products are not allowed in the vehicle; and Every vehicle must have a fully stocked first aid kit and an A:B:C fire extinguisher that are easily accessible	1	NA	0	NA	0	N/A	0	
	TAC §448.701 (a)	Did the Contractor have a policy and procedure to support that the facility would respect, protect, implement and enforce each client's rights required to be contained in the facility's Client Bill of Rights? Please see TAC rule for requirements.	1	1	1	1	1	100%	0	
	TAC §448.702(a-b)	Did the Contractor develop a policy and procedure manual that met TAC requirements; (a) The facility shall have a written client grievance procedure. (b) Staff shall give each client and consenter a copy of the grievance procedure within 24 hours of admission and explain it in clear, simple terms that the client understands.	1	1	1	1	1	100%	0	
	TAC §448.703	Did the Contractor have a written policy that clearly prohibits the abuse, neglect, and exploitation of clients and/or participants that met HHS requirements?	1	1	1	1	1	100%	0	
	TAC §448.704	Did the Contractor establish therapeutically sound written program rules addressing client behavior designed to protect their health, safety, and welfare?	1	1	1	1	1	100%	0	
	TAC §448.707	Did the Contractor have written procedures for responding to medical and psychiatric emergencies. (b) The facility shall have written procedures for responding to medical and psychiatric emergencies. (c) Emergency numbers shall be posted by all telephones. (d) The facility shall have fully stocked first aid supplies that are visible, labeled and easy to access.	1	1	1	1	1	100%	0	
	TAC §448.905(a)(8)	If the Contractor provided youth services; did the approved manual include notifying parents or guardians when an adolescent leaves Contractor's facility without authorization?	1	NA	0	NA	0	N/A	0	
	Substance Use Program Guide 14 Quality Management Quality Management Policies and Procedures	Did the Contractor develop and implement policies and procedures to ensure informed consent was received when admitting an individual with an opioid use disorder? i. For all individuals seeking treatment services who are determined to have a diagnosis of opioid use disorder, Provider will engage the individual in completing the Informed Consent for Individuals Seeking Treatment Form. ii. The appropriate, signed Informed Consent for Individuals Seeking Treatment Form will be uploaded with the individuals' signature to an administrative note in CMBHS. iii. The appropriate Informed Consent should be completed based on the individual's circumstance.	1	1	1	1	1	100%	0	
	Substance Use Program Guide 14 Quality Management Continuous Quality Improvement	Did the Contractor maintain documentation to support participation in continuous quality improvement (CQI) activities as defined and scheduled by HHSC including, but not limited to data verification, performing self-reviews; submitting self-review results and supporting documentation for the HHSC's desk reviews; and participating in the HHSC's onsite or desk reviews? 2. Submit plan of improvement or corrective action plan and supporting documentation as requested by HHSC. 3. Participate in and actively pursue CQI activities that support performance and outcomes improvement. 4. Respond to consultation recommendations by HHSC, which may include, but are not limited to the following: a. Staff training; b. Self-monitoring activities guided by HHSC, including use of quality management tools to self-identify compliance issues; and c. Monitoring of performance reports in HHSC electronic clinical management system	1	1	1	1	1	100%	0	
		Column Comments								
		Filtered Score	16		14	14		**100%**	**0**	
		Overall Score	16		14	14		**100%**	**0**	

End of worksheet

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Review Period			Program Type(s)	TRA/TRF	Total Reviewed
4/13/2023	Thru	5/5/2023	Location	Houston, TX (reg 6)	1
Review Number :		23SU13	Reviewer's Initials		

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
Priority Population and Waitlist										
	Substance Use Program Guide 8 **Federal** Priority Populations for Treatment Programs 1 and 3	Did the Contractor adhere to the Federal Priority Populations by and ensured the following three priority population were given preference: a. Pregnant injecting individuals will be admitted within 48 hours; b. Pregnant individuals will be admitted within 48 hours; and c. Injecting drug users will be admitted within 14 days. **Please note:** *The availability of such services and the fact that pregnant women receive much preference must be made publicly by street outreach, ongoing public service announcements, regular advertisements, posters in targeted areas as well as frequent notification on availability distributed to the network of community-based organizations, health care providers, and social service agencies.*	1	1	1	1	1	100%	0	
	Substance Use Program Guide 8 **State** Priority Populations for Treatment Programs 1	Did the Contractor establish screening procedures to identify individuals of federal and State priority populations?* A. Individuals identified as being at high risk for overdose will be admitted to requested services within 72 hours; B. Individuals referred by DFPS will be admitted to requested services within 72 hours; C. Individuals experiencing housing instability or homelessness will be admitted to requested services within 72 hours; and D. All other populations. *Texas has established priority populations for entering state-funded SUD services. State priority populations are **secondary** to the SAMHSA priority populations and include:	1	1	1	1	1	100%	0	
	Substance Use Program Guide 8 **State** Priority Populations for Treatment Programs 2-3	Did the Contractor ensure priority populations were served in accordance to the federal guidelines by: A. Establish screening procedures to identify individuals of federal and state priority populations; B. Ensure successful referral and admittance within the time frame to another HHSC-funded Provider, or HHSC Wait List and Capacity Coordinator, and begin interim services; C. Notify HHSC program staff if placement cannot be made to priority population; and D. Accept individuals from every region in the state and from the OSAR, when capacity is available, to accommodate federal and state priority populations. E. If two individuals are of equal priority status, preference may be given to the individual residing in Provider's service region. F. Include the federal and state priorities in all brochures and post a notice in all applicable lobbies. **Please note:** *If two individuals are of equal priority status, preference may be given to the individual residing in Provider's service region.*	1	1	1	1	1	100%	0	
	Substance Use Program Guide 8 Waitlist	Did the Contractor maintain a policy and procedure as well as subsequent documentation to support the following wait list requirements: Participation in Quarterly Wait List and Capacity Conference Calls Upon determining the appropriate level of care, Provider will make a wait list entry in CMBHS describing the service type the individual is waiting for and, if applicable, the priority population designation. Provider will complete all wait list entry fields and ensure the following is accomplished: a. Arrange for appropriate services in another treatment facility or provide access to interim services as indicated within 48 hours when efforts to refer to other appropriate services are exhausted; i. Have a written policy on Wait List management that defines why, when and how individuals are removed from the Wait List for any purpose other than admission to treatment; ii. Ensure eligible individuals who cannot be admitted within one week of requesting services be placed on the CMBHS wait list iii. Not hold empty beds or slots for anticipated clients for more than 48 hours; iv. Immediately upon admission, Provider will close the wait list entry by entering removal reason "client started into wait list service" in CMBHS indicating the date of admission as the Wait List end date; v. Ensure, either directly or through referral, that individuals waiting for admission receive interim services as required by SAMHSA Block Grant requirements; vi. Document a minimum weekly contact with all individuals on its Wait List; vii. If client is enrolled in interim services or utilizing another funding source while awaiting HHSC funded services weekly contact is still expected to occur; and viii. Notify Substance Use Disorder or HHSC Program Specialist for assistance to ensure immediate admission to other appropriate services and proper coordination when appropriate.	1	1	1	1	1	100%	0	Need to discuss
	Substance Use Program Guide 8 Waitlist Removal Reasons	Did the Contractor maintain a policy and procedure as well as subsequent documentation to support the following Wait List Removal Reasons are listed below: a. Client Started in Service b. Client Withdrew Request for Service c. Client Started in Alternate Service d. Client Referred to Another Provider e. Client Did Not Present for Service: Client does not present for admission appointment and the facility removes the client from the waitlist. Note: Each Provider should develop and implement Policies and Procedures when a client does not present for services. f. Client Could Not Be Contacted: Each Provider should develop and implement Policies and Procedures for waitlist removal when a client cannot be contacted. g. Client Deceased: The client has passed away; and h. Other: This reason is to capture scenarios that arise and are not otherwise categorized by any of the above reasons.	1	1	1	1	1	100%	0	
	Substance Use Program Guide 8 Interim Services	Did the Contractor maintain a policy and procedure as well as subsequent documentation to support the following Interim Services requirements: 1. Provider will directly provide Interim Services to individuals on the Wait List or refer the individual to another organization who can admit the individual to SUD treatment services. Interim Services will be documented in CMBHS. 2. When interim services are required the Provider will: a. Provide interim services to an individual on a Wait List until the individual is admitted, to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission communicable disease. Individuals placed on a Wait List must be offered interim services within 48 hours. b. Screen and maintain documentation of interim services indicated by the screening and provided in CMBHS. Interim services (see definitions section). c. Referrals should be documented in CMBHS for HIV and/or TB services (see definitions section) must be provided if necessary. d. For pregnant women, interim services must include counseling and education on the effects of substance use (including alcohol, tobacco, and other substances) on the fetus, as well as, referral documented in CMBHS for prenatal care, if not already engaged in prenatal care.	1	1	1	1	1	100%	0	
		Column Comments								
		Filtered Score	6		6	6		**100%**	**0**	
		Overall Score	6		6	6		**100%**	**0**	

End of worksheet

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		Review Period			Client ID Number							Total Reviewed						
		4/13/2023	Thru	5/5/2023	Program Type	TRA OP	TRA OP	TRA OP	TRA OP	TRA OP	TRA OP	6						
		Review Number :		23SU13	Begin Service Date	4.11.22	6.9.22	6.22.22	8.2.22	4.25.22	5.23.22							
					End Service Date	8.25.22	9.29.22	9.7.22	9.19.22	7.6.22	8.16.22							
					Discharge Date	8.25.22	9.29.22	9.7.22	9.19.22	7.6.22	8.16.22							
					Reviewer's Initials													

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Observed	Observed	Observed	Observed	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
TRA Screening, Admission and Assessment															
	TRA SOW III Service Requirements Screening and Assessment C.1	Did the CMBHS record reflect the Contractor followed applicable rules for Substance Use Disorder (SUD) programs in the TAC regarding Screening and Assessment, as referenced in Eligibility of the SUD Program Guide? **448.801 Screening, 448.802 Admission Authorization and Consent to Treatment** *Screen to determine the type of services to meet the individual's needs with TDI Criteria to guide referral and treatment recommendations as well documentation to support placement decisions* *Date, signature and credentials of the QCC supervising the screening process* *If admission to a detoxification program must be a physician, physician assistant, nurse practitioner, registered nurse or LVN. (The LVN must meet the following criteria - completed training and display competency in the detoxification process, LVN can convey to the physician in person or over the phone, the physician will determine the appropriateness or the physician will examine the client in person and sign the admission within 24 hours of admission.)* *QCC reviewed results of the screen before authorizing admission and the authorization must be documented in the client's file and contain sufficient documentation to support the diagnosis and the placement decision.* *Consent to Treat* *Individuals identified as having an Opioid use disorder informed consent Form 4008 (Youth 13 - 18) Form 4009 (Pregnant Women) and Form 4010 (Adults)*	1	1	1	0	1	1	1	6	5	6	83%	0	
	TRA SOW III Service Requirements Screening and Assessment C.2	Did the CMBHS record reflect the Contractor conducted and documented the screening through a confidential face-to-face interview unless there is a reasonable and documented justification for an interview by phone?	1	1	1	1	1	1	1	6	6	6	100%	0	
	TRA SOW III Service Requirements Screening and Assessment C.3 TRA SOW III Service Requirements Additional Service Requirements F.12	Did the Contractor document Financial Eligibility in CMBHS as referenced in Eligibility of the SUD Program Guide? Did the Contractor ensure HHSC was the payer of last resort if the client has other/outside funding available (i.e. wages insurance, etc.) *Please note* ***SUD Program Guide 2. Definitions*** *- Financial Eligibility: A screening conducted to determine if a client may receive financial assistance from the HHSC. CMBHS allows for documentation of a client's financial information obtained during the client screening and receive an automated response as to the client's financial eligibility status for services according to the provider type. CMBHS also allows the user to attach digital scans of paper documents to the client's electronic health record so they are easily available for*	1	1	1	1	1	1	1	6	6	6	100%	0	
	TRA SOW III Service Requirements Screening and Assessment C.4	Did the Contractor conduct and document a CMBHS SUD Initial Assessment with the client to determine the appropriate levels of care for SUD treatment? The CMBHS assessment will identify the impact of substances on the physical, mental health, and other identified issues including Tuberculosis, Hepatitis B and C, sexually transmitted infection (STI), and Human Immunodeficiency Virus (HIV). i. If client indicates risk for these communicable diseases, did the Contractor refer the client to the appropriate community resources for further testing and counseling? ii. If the client is at risk for HIV, did the Contractor refer the client to pre and post-test counseling on HIV? *Comprehensive psychosocial assessment* *Signed and dated by a QCC within three individual service days of admission* *If, residential did a licensed health professional conduct a health assessment of the client's physical health within 96 hours of admission. The Contractor may accept an outside source completed no more than 30 days before admission or received directly from a transferring facility.*	1	0	1	1	1	1	1	6	5	6	83%	0	
	TRA SOW III Service Requirements Screening and Assessment C.6 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.12	If a client is living with HIV, did the Contractor refer the client to the appropriate community resources to complete the necessary referrals and health related paperwork? **If the client was an HIV Intensive Residential client** did the Contractor document a referral and referral follow-up prior to discharge to HIV medical care and community resources for ongoing support?	1	NA	NA	NA	NA	NA	NA	0	NA	0	N/A	0	
	TRA SOW III Service Requirements Screening and Assessment C.7	Was the assessment signed by a Qualified Credential Counselor (QCC) and filed in the client record within three (3) service days of admission or if the program accepted an evaluation from an outside entity did it meet the criteria for admission and was it completed during the thirty (30) business days preceding admission.	1	NA	NA	NA	NA	NA	NA	0	NA	0	N/A	0	Duplicate question
Treatment Planning, Implementation and Review															
	TRA SOW III Service Requirements Treatment Planning, Implementation and Review D.1	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC for SUD programs as stated in the in the TAC regarding Treatment Planning, Implementation and Review, as referenced in Service Delivery of the SUD Program Guide? **448.804 Treatment Planning, Implementation and Review** *Individualized written plan that identifies services and support to problems and address needs identified on the assessment to include:* *the length of stay, appropriate referrals for services not offered, and when feasible other QCC's or mental health professionals serving the client from referral should participate in the treatment planning process, justification when identified needs are temporarily deferred or not addressed during treatment.* *Treatment plan shall include: goals (based on clients problems/needs, strengths and preferences), objectives (individualized, realistic, measurable, time specific, appropriate for level of care and in behavioral terms), and strategies (types and frequencies of specific services, and interventions needed to help the client achieve the identified goal and appropriate for the level of intensity of the service type and level.* *Plans shall be evaluated on a regular basis and revised as needed (evaluation of client's progress toward each goal and objectives, revision of goals, objectives, and justification for continued length of stay.).* *The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan.* *Treatment plan shall be completed and filed in the client record within five (5) service days of admission.*	1	0	0	0	0	0	NA	5	0	5	0%	1	Treatment plans did not appear to meet TAC requirements. Specifically, objectives did not appear realistic, measurable, or time specific.
	TRA SOW III Service Requirements Treatment Planning, Implementation and Review D.2 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.3	Was there documentation to support active collaboration with clients and family, when appropriate, to develop and implement an individualized, written treatment plan that identifies services and support needed to address problems and needs identified in the assessment? The treatment plan documents the expected length of stay and treatment intensity. Did the Contractor use clinical judgment to assign a projected length of stay for each individual client? **If the client was an HIV Intensive Residential client** did the Contractor provide directly or through referral, brief family intervention, support and educational groups, and associated family therapy designed to build support and resources for clients in treatment?	1	1	1	1	1	1	NA	5	5	5	100%	0	
	TRA SOW III Service Requirements Treatment Planning, Implementation and Review D.3 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.6	If there was a need for a referral, did the Contractor document referral and referral follow-up in CMBHS to the appropriate community resources based on the individual need of the client? **If the client was an HIV Intensive Residential client** did the Contractor provide and document a referral in CMBHS for psychiatric evaluations as needed and indicated?	1	0	0	0	NA	0	NA	4	0	4	0%	1	CMBHS client records do not appear to reflect the use of CMBHS referral and referral follow-up functionality to document referrals for identified needs.
Discharge															
	TRA SOW III Service Requirements Discharge D.1-2 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.3	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC regarding Discharge, as referenced in Service Delivery of the SUD Program Guide? **448.805 Discharge** *Did the contractor develop and implement an individualized discharge plan with the client to assist in sustaining recovery?* *Plans shall be updated as the client progresses through treatment and shall address appropriateness of the current treatment level, and plan shall address continuity of services to the client.* *When a client is referred or transferred to another chemical dependency or mental health service provider for continuing care, the facility shall contact the receiving program before the client is discharged to make arrangements for the transfer. Coordination of services and activities as well as proper consent with copies of relevant parts of the client's record.* *Discharge plan shall be developed to address ongoing client needs, including: individual goals or activities to sustain recovery, referrals, and recovery maintenance services, if applicable.* **If the client was an HIV Intensive Residential client** did the Contractor conduct discharge planning and emphasize referrals to community resources for continued medical care and other support services?	1	0	0	NA	0	NA	NA	3	0	3	0%	1	Discharge plan did not appear to change from initial draft plan or address plan to sustain recovery.
	TRA SOW III Service Requirements Discharge E.2 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.11	Did the Contractor develop and implement an individualized discharge plan with the client to assist in sustaining recovery? **If the client was an HIV Intensive Residential client** did the Contractor conduct discharge planning and emphasize referrals to community resources for continued medical care and other support services?	1	NA	NA	NA	NA	NA	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Discharge E.3	Did the contractor document in CMBHS the client-specific information that supports the reason for discharge listed on the discharge report? **A QCC must sign the discharge summary.** Appropriate referrals shall be made and documented in the client record. A client's treatment is considered successfully completed, if the following criteria are met: i. Client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS. ii. All problems on the treatment plan have been addressed iii. CMBHS record reflect the Contractor utilized the treatment plan component of CMBHS to create a final and completed treatment plan version.	1	1	1	1	1	1	1	6	6	6	100%	0	
	TRA SOW III Service Requirements Discharge E.4 and 5.	Did Grantee use the Treatment Plan component of CMBHS to create a final and completed treatment plan version? (1) Problems designated as "treat" or "case manage" status shall have all objectives resolved prior to successful discharge. (2) Problems that have been "referred" shall have associated documented referrals in CMBHS. (3) Problems with "deferred" status shall be re-assessed. Upon successful discharge, all deferred problems shall be resolved, either through referral, withdrawal, treatment, or case management with clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components. (4) "Withdrawn" problems shall have clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components	1	1	1	1	1	1	1	6	6	6	100%	0	
Additional Requirements															

	TRA SOW III Service Requirements Additional Service Requirements F.4 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.5	Did the CMBHS client record reflect the Contractor provided evidenced-based education at minimum on the following topics: (i) Tuberculosis; (ii) HIV; Hepatitis B and C; (iii) Sexually Transmitted Infections/Diseases; and (iv) health risks of tobacco and nicotine product use? **If the client was an HIV Intensive Residential client**, did the CMBHS record reflect the Contractor facilitated two hours per month of HIV and Hepatitis C co-infection group counseling	1	0	0	NA	0	NA	NA	3	0	3	0%	1	CMBHS client records did not appear to reflect education was provided on these required topics.

	TRA SOW III Service Requirements Additional Service Requirements F.5	Did the CMBHS client record reflect the Contractor provided Case Management as needed with documentation in CMBHS, as Case Management is essential to the ultimate success of the client? **If the client was an HIV Intensive Residential client** did the CMBHS record reflect the Contractor worked collaboratively with other community-based case management services to resolve admission barriers for clients seeking treatment for SUD or medical care?	1	1	1	1	1	1	1	6	6	6	100%	0	
	TRA SOW III Service Requirements Additional Service Requirements F.6 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.2	Did the CMBHS client record reflect the Contractor ensure client access to the full continuum of treatment services and provided sufficient treatment intensity to achieve treatment plan goals? **If the client was an Intensive HIV Residential client** did the CMBHS reflect the Contractor provided and documented medical monitoring and treatment of HIV and ensure the provision of expedited timely co-occurring needs and treatment for related conditions? **Please note:** *Addressing issues associated with antiviral drug resistance and adherence, symptoms associated with drug-induced side effects and prescribed prophylaxis for opportunistic infection(s).*	1	0	0	NA	0	NA	NA	3	0	3	0%	1	CMBHS client records did not reflect clients consistently received the services as required by the SOW.
	TRA SOW III Service Requirements Additional Service Requirements F.8	Did the CMBHS record reflect the Contractor provided trauma-informed services that address the multiple and complex issues related to violence, trauma, and substance use disorders?	1	1	1	NA	0	NA	1	4	3	4	75%	0	
	TRA SOW III Service Requirements Additional Service Requirements F.9	Did the CMBHS record reflect the Contractor provided overdose prevention and reversal education to all clients?	1	0	0	NA	0	NA	NA	3	0	3	0%	1	CMBHS client records did not reflect evidence of overdose prevention and reversal education.
	TRA SOW III Service Requirements Additional Service Requirements F.10	**If the client had an opioid use disorder or used drugs intravenously**, did the CMBHS record reflect specific overdose prevention activities? The Contractor will directly provide the services or refer the client to community support services for overdose prevention and reversal education to all identified at risk clients prior to discharge.	1	NA	NA	NA	NA	NA	NA	0	NA	0	N/A	0	
	TRA SOW III Service Requirements Additional Service Requirements F.11	Did the CMBHS record reflect the Contractor ensure access to adequate and appropriate medical and psychosocial tobacco cessation treatment as follows: i. Assess all clients for tobacco use and all clients seeking to cut back or quit. ii. If the client indicates wanting assistance with cutting back or quitting, the client will be referred to appropriate tobacco cessation treatment.	1	1	1	1	1	1	1	6	6	6	100%	0	
OUTPATIENT TREATMENT SERVICES ASAM Level 1 Outpatient Services															
	TRA SOW V Levels of Care Outpatient Treatment Services A.2	Did the CMBHS record reflect the Contractor provided and documented one hour of group or individual counseling services for every six hours of educational activities?	1	1	1	NA	0	NA	1	4	3	4	75%	0	
	TRA SOW V Levels of Care Outpatient Treatment Services A.3	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	1	1	1	1	0	1	1	6	5	6	83%	0	
SUPPORTIVE RESIDENTIAL TREATMENT SERVICES ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services															
	TRA SOW V Levels of Care Supportive Residential Treatment Services C.1	Did the CMBHS record reflect the Contractor complied with TAC requirements and as referenced in Information, Rules, and Regulations of the SUD Program Guide? **448.903(g)(1-2) Requirements Applicable to Residential Services** *Six hours of services each week to include at least 3 hours of chemical counseling (one hour per month shall be individual counseling); and* *Three hours of additional counseling, chemical dependency education, life skills training, and relapse prevention education.*	1							0	NA	0	N/A	0	
	TRA SOW V Levels of Care Supportive Residential Treatment Services C.2	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	1							0	NA	0	N/A	0	
INTENSIVE RESIDENTIAL TREATMENT SERVICES ASAM Level 3.5 Clinically Managed High-Intensity Residential Services															
	TRA SOW V Levels of Care Supportive Residential Treatment Services C.1 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.3	Did the CMBHS record reflect the Contractor complied with the SOW, TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.903(d)(1-3) Requirements Applicable to Residential Services** *30 hours of service each week comprised of at least:* *ten hours of chemical dependency (one hour of which is individual counseling);* *ten of hours of additional counseling, chemical dependency education, life skills training, relapse prevention education; and* *ten hours of planned, structured activities monitored by staff. Five hours of these services shall occur on the weekends and evenings.* **If the client was an HIV Intensive Residential client** did the CMBHS record reflect the Contractor provided and documented individual counseling and groups (including educational groups and other structured activities) and included goals for the client to achieve and involve discussion and active learning situations? Required topics include, but are not limited to: i. HIV disease management including medical adherence; ii. Nutrition; iii. Risk reduction, including the opportunity to address risk reduction in lifestyle specific settings; iv. Mental health; v. Relapse prevention; vi. 12-step support; and vii. Life skills.	1							0	NA	0	N/A	0	
	TRA SOW V Levels of Care Supportive Residential Treatment Services SUP C.2	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the residential treatment services?	1							0	NA	0	N/A	0	
RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES ASAM Level 3.7 Medically Monitored Withdrawal Management															
	TRA SOW V Levels of Care Residential Withdrawal Management Services E.1	Did the CMBHS record reflect the Contractor complied to as referenced in Service Delivery of the SUD Program Guide? **448.902(e, g-h) Requirements Applicable to Detoxification Services** *Was there documentation to support the medical director or his/her designee (physician assistant, nurse practitioner) authorized all admissions, conducted a face-to-face examination, to include both a history and physical examination of each applicant for services to establish the Axis I diagnosis, assess level of intoxication or withdrawal potential, and determine the need for treatment and the type of treatment to be provided to reach a placement decision?* *If the physician determined an admission was not appropriate, was the client transferred to an appropriate service provider?* *If an examination was completed during the 24 hours preceding admission, was it is approved by the program's medical director or designee that met HHS requirements? The program may not require a client to obtain a history and physical as a condition of admission.* *If it was a residential facility, was monitoring conducted, at a minimum every four hours for the first 72 hour and as ordered by the medical director or designee thereafter, dependent upon the client's signs and symptoms?* *Did all detoxification service levels CMBHS monitoring documentation include: changes in mental state, vital signs and response of the client's symptoms?*	1							0	NA	0	N/A	0	
	TRA SOW V Levels of Care Residential Withdrawal Management Services E.2 i-iv	Did the CMBHS record reflect the Contractor complied with the following additional service delivery requirements: i. Document in CMBHS a Withdrawal Management Intake Form. ii. Document in CMBHS a discharge plan prior to discharge or transfer. iii. Document in CMBHS a discharge follow-up no more than ten (10) calendar days after discharge from withdrawal management services.	1							0	NA	0	N/A	0	
AMBULATORY WITHDRAWAL MANAGEMENT ASAM Level 2 Withdrawal Management															
	TRA SOW V Levels of Care Ambulatory Withdrawal Management Services F.1	Did the CMBHS record reflect the Contractor complied with the TAC requirements and SUD Program Guide for detoxification/withdrawal management services. **448.902(e, g-i) Requirements Applicable to Detoxification** Services *Was there documentation to support the medical director or his/her designee (physician assistant, nurse practitioner) authorized all admissions, conducted a face-to-face examination, to include both a history and physical examination of each applicant for services to establish the Axis I diagnosis, assess level of intoxication or withdrawal potential, and determine the need for treatment and the type of treatment to be provided to reach a placement decision?* *If the physician determined an admission was not appropriate, was the client transferred to an appropriate service provider?* *If an examination was completed during the 24 hours preceding admission, was it is approved by the program's medical director or designee that met HHS requirements? The program may not require a client to obtain a history and physical as a condition of admission.* *Did all detoxification service levels CMBHS monitoring documentation include: changes in mental state, vital signs and response of the client's symptoms?*	1							0	NA	0	N/A	0	
	TRA SOW V Levels of Care Ambulatory Withdrawal Management Services F.2	Did the CMBHS record reflect the Contractor complied with the following additional service delivery requirements: i. Document in CMBHS a Withdrawal Management Intake Form. ii. Document in CMBHS a discharge plan prior to discharge or transfer. iii. Document in CMBHS a discharge follow-up no more than ten (10) calendar days after discharge from withdrawal management services	1							0	NA	0	N/A	0	
	TAC §448.902.g	Did the CMBHS record reflect the Contractor complied with the TAC applicable ambulatory services requirements; ambulatory detoxification is not a stand-alone service the client is simultaneously admitted to a substance use disorder treatment service while admitted to ambulatory detoxification services.	1							0	NA	0	N/A	0	
		Filtered Score	31							80	63		**71%**	**6**	
		Overall Score	31							80	63		**71%**	**6**	

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	The Harris Center for MHIDD	Del Active			
	Review Period		Program Type(s)	TRA/TRF	Total Reviewed
	4/13/2023 Thru 5/5/2023		Location	Houston, TX (reg 6)	1
	Review Number : 23SU13		Reviewer's Initials		

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
CMBHS TRA Program Requirements (All Programs)										
	TRA SOW III Service Requirements Administrative Requirements A.1, 3-4	Did the Contractor adhere to the most current SUD Program Guide, Level of Care/Service Type licensure requirements and comply with all applicable Texas Administrative Code (TAC) rules adopted by System Agency related to SUD treatment? **Please note:** If the Contractor scored 70% or less on the overall score on the TRA Record Review Tab, it is considered a finding.	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.2 TRA SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.7 and D.10	Did the Contractor provide age-appropriate medical and psychological therapeutic services designed to treat an individual's SUD while promoting recovery? **If the Contractor was an HIV Intensive Residential** did the services include: Nursing care 24 hours a day, 7 days a week Access to recreational facilities and scheduled daily exercise / activity for all clients capable of participation	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.5	Did the Contractor document all specified required activities and services in the Clinical Management of Behavioral Health Services (CMBHS) system? Were the documents that required client or staff signature maintained according to TAC requirements and made available to System Agency for review upon request?	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.6	Did the Contractor develop and implement organizational policies and procedures for the following: i. A marketing plan to engage local referral sources and provide information to these sources regarding the availability of SUD treatment and the Client Eligibility criteria for admissions; ii. All marketing materials published shall include Priority Populations for Treatment Programs admissions; iii. Client Retention in services, including protocols for addressing clients absent from treatment and policies defining treatment non-compliance; and iv. All policies and procedures must be provided to System Agency upon request	1	1	1	1	1	100%	0	
	TRA SOW IV Staff Competencies and Requirements 12	Did the Contractor develop a policy to ensure that information gathered from Clients was conducted in a respectful, non-threatening, and culturally competent manner?	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.7	Did the Contractor ensure that program directors participated in their specific program and service type conference calls as scheduled by System Agency? Program Directors must participate unless otherwise agreed to by System Agency in writing. Grantee executive management may participate in the conference calls.	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.8	Did the Contactor actively attend and share representative knowledge about their system and services at the Outreach, Screening, Assessment, and Referrals (OSAR) quarterly regional collaborative meetings? **Please note**: *Participation includes discussion demonstrated via meeting minutes, call and/or sign in sheets.*	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.9	Did the Contractor ensure compliance with Client Eligibility requirements to include: Texas eligibility, financial eligibility and clinical eligibility as required in SUD UM Guidelines? **Please note:** *If the Contractor has significant issues related to edibility requirements listed above it is identified as a finding.*	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.10	Did the Contractor develop a local agreement with Texas Department of Family and Protective Services (DFPS) local offices to address referral process, coordination of services, and sharing of information as allowed per the consent and agreement form? **Please note:** *The Contractor may not have this MOU due to local issues/rules.*	1	1	1	1	1	100%	0	
	TRA SOW III Service Requirements Administrative Requirements A.11	Did the Contractor maintain Memorandum of Understanding requirements as stated in SUD Program Guide? *All MOU and Local Agreements must be renewed annually* *Within six months of initial contract execution - (Regional OSAR - Outreach, Screening, Assessment and Referral, LMHA - Local Mental Health Authority, and Local Community Health organizations)* ***OSAR** - daily capacity, referral, confidentiality, interim services, waitlist list/waitlist removal, quarterly updates of staff who handles client placement, implementation/expiration dates and signatures of both parties)* ***LMHA** - Objectives, roles and responsibilities of each party, scope of services, confidentiality, priority population admission requirements, CMBHS referral/referral follow-up, non-duplication of services, emergency transportation, coordination of services, implementation/expiration dates, and signatures of both parties* ***TRA/TRF** - Must have an MOU with Recovery Support Services providers in their region: Referrals, coordination (enrollment/engagement/coordination of non-duplication of services, collaboration for improved participant outcomes, implementation/expiration dates, and signature of both parties.* ***TRY** - Must have a MOU with YRC in their region, if no YRC then an RSS to include: Referrals, follow-up contact (enrollment/engagement/coordination of non-duplication of services, collaboration for improved participant outcomes, implementation/expiration dates, and signature of both parties.*	1	1	1	1	1	100%	0	
		Column Comments								
		Filtered Score	10		8	8		**100%**	**0**	
		Overall Score	10		8	8		**100%**	**0**	

End of worksheet

Transfer Data | Transfer | Spell | Add Column | Del Active

Review Period			Staff Name		Total Reviewed
4/13/2023	Thru	5/5/2023	Position	Counselor	1
	Review Number :	23SU13	Program Type	TRA OP	
			Date of Hire	11.9.21	
			License Type	LCDC	
			License Expiration	1.31.25	

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
TRA Personnel Records										
	TAC 448.601 *Substance Use Program Guide 9 Personnel Requirements and Documentation 1, 2 and 4*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.601? *Registered with the Commission* *Verification of al required credentials with the credentialing authority* *Criminal Background Check* *Pre-employment drug test* *Job description outlining job duties and minimum qualifications* *Annual performance evaluations *Personnel data that includes date of hire, rate of pay and documentation to support pay increases and bonuses *Appropriate screens *Signed documentation of initial and required training - can be stored separately *Disciplinary actions *Health related information must be stored separately with restricted access	1	1	1	1	1	100%	0	
	TAC 448.603© *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *c) Prior to performing their duties and responsibilities, the facility shall provide orientation to staff, volunteers, and students. This orientation shall include information addressing:* *(1) TCADA rules;* *(2) facility policies and procedures;* *(3) client rights;* *(4) client grievance procedures;* *(5) confidentiality of client-identifying information (42 C.F.R. pt. 2; HIPAA);* *(6) standards of conduct; and* *(7) emergency and evacuation procedures.*	1	1	1	1	1	100%	0	
	TAC 448.603(d) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1 and 5*	Ensure staff completed the following trainings within the first 90 days in accordance with SOW i. Motivational interviewing techniques or Motivational Enhancement Therapy; ii. Trauma-informed care; iii. Cultural competency; iv. Harm reduction trainings; v. HIPAA and 42 CFR Part 2 training; and vi. State of Texas co-occurring psychiatric and substance use disorder (COPSD) training located at the following website: www.centralizedtraining.com. *The following initial training(s) must be received within first 90 days of employment and must be completed before the employee can perform a function to which to which the specific training is applicable.* *(1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.* *(2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.* *(A) The initial training shall be three hours in length.* *(B) Staff shall receive annual updated information about these diseases.*	1	0	1	0	1	0%	1	Staff record did not indicate staff received Trauma-informed care or Cultural Competency training.
	TAC 448.603(d) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? Did the Contractor ensure: (3) Cardio Pulmonary Resuscitation (CPR). (A) All direct care staff in a residential program shall maintain current CPR and First Aid certification. (B) Licensed health professionals and personnel in licensed medical facilities are exempt if emergency resuscitation equipment and trained response teams are available 24 hours a day.	1	1	1	1	1	100%	0	
	TAC 448.603(d)(4) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All direct care staff in residential programs and outpatient programs shall receive this training. The face-to-face training shall teach staff how to use verbal and other non-physical methods for prevention, early intervention, and crisis management. The instructor shall have documented successful completion of a course for crisis intervention instructors or have equivalent documented training and experience.*	1	1	1	1	1	100%	0	
	TAC 448.603(d)(6) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses.* *(A) The initial training shall be eight hours in length.* *(B) Staff shall complete eight hours of annual training thereafter.* *(C) The training shall be completed before staff screen or authorize applicants for admission.*	1	0	1	0	1	0%	1	Staff record did not indicate staff received Intake, screening, and admission training.
	TAC 448.603(7) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All personnel responsible for supervising clients in self-administration of medication, who are not credentialed to administer medication, shall complete this training before performing this task.* *(A) Staff shall complete two hours initial one time training.* *(B) The training shall be provided by a physician, pharmacist, physician assistant, or registered nurse before administering medication and shall include:* *(i) prescription labels;* *(ii) medical abbreviations;* *(iii) routes of administration;* *(iv) use of drug reference materials;* *(v) storage, maintenance, handling, and destruction of medication;* *(vi) documentation requirements; and* *(vii) procedures for medication errors, adverse reactions, and side effects.*	1	NA	0	NA	0	N/A	0	
	TRA SOW IV Staff Competencies and Requirements 8-9	Did the Contractor ensure that direct care staff received a copy of the statement of work and SUD requirements as well as reviewed all policies and procedures related to the Program or organization on an annual basis?	1	1	1	1	1	100%	0	
	TRA SOW IV Staff Competencies and Requirements 6	Did the Contractor ensure direct care staff completed **annual** education on HIPAA and 42 CFR Part 2 training?	1	1	1	1	1	100%	0	
	TRA SOW IV Staff Competencies and Requirements 8-9	If the staff person is responsible for planning, directing, or supervising treatment services, did the Contractor ensure they were a QCC and if defined as a clinical "Program Director", did they have at least two (2) years of post-QCC licensure experience providing substance use disorder treatment?	1	NA	0	NA	0	N/A	0	
	TRA SOW IV Staff Competencies and Requirements 10	If the staff person is responsible for Substance Use Disorder counseling were they a QCC, or Chemical Dependency Counselor Intern? Substance use disorder education and life skills trainings provided by counselors or individuals who have been trained in the education. All counselor interns shall work under the direct supervision of a QCC.	1	1	1	1	1	100%	0	

	TRA SOW IV Staff Competencies and Requirements 13	**If the Contractor is an HIV Residential Program** did the Contractor ensure all counseling staff will have one year of experience working with persons living with HIV or the at-risk population? i. Specific training for direct care staff is required annually in harm, risk reduction, and overdose training. ii. The Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Physician's Assistant must have at least two years' experience working with persons living with HIV. All shifts will be staffed with either a LVN or RN. iii. Food service staff will include at least one full time employee who has certification in food service management and the ability to plan and accommodate diets recommended for individuals served by Grantee Contract.	1	NA	0	NA	0	N/A	0	
		Column Comments								
		Filtered Score	12		9	7		**78%**	**2**	
		Overall Score	12		9	7		**78%**	**2**	

End of worksheet

Transfer Data | Transfer | Spell | Add Column | Del Active

Review Period			Client ID Number				Total Reviewed
4/13/2023	Thru	5/5/2023	Program Type	TRF OP	TRF OP	TRF OP	3
Review Number :		23SU13	Begin Service Date	4.22.22	4.14.22	4.22.22	
			End Service Date	6.1.22	5.17.22	8.17.22	
			Discharge Date	6.1.22	5.17.22	8.17.22	
			Reviewer's Initials				

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Observed	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
TRF Screening and Assessment												
	TRF SOW III Service Requirements Screening and Assessment C.1	Did the CMBHS record reflect the Contractor followed applicable rules for Substance Use Disorder (SUD) programs in the TAC regarding Screening and Assessment, as referenced in Eligibility of the SUD Program Guide? **448.801 Screening, 448.802 Admission Authorization and Consent to Treatment** *Screen to determine the type of services to meet the individual's needs with TDI Criteria to guide referral and treatment recommendations as well documentation to support placement decisions* *Date, signature and credentials of the QCC supervising the screening process* *If admission to a detoxification program must be a physician, physician assistant, nurse practitioner, registered nurse or LVN. (The LVN must meet the following criteria - completed training and display competency in the detoxification process, LVN can convey to the physician in person or over the phone, the physician will determine the appropriateness or the physician will examine the client in person and sign the admission within 24 hours of admission.)* *QCC reviewed results of the screen before authorizing admission and the authorization must be documented in the client's file and contain sufficient documentation to support the diagnosis and the placement decision.* *Consent to Treat* *Individuals identified as having an Opioid use disorder informed consent Form 4008 (Youth 13 - 18) Form 4009 (Pregnant Women) and Form 4010 (Adults)*	1	1	1	1	3	3	3	100%	0	
	TRF SOW II Target Population Treatment for Females (TRF) A	Did the Contractor ensure adult pregnant women and women with Dependent Children (including women whose children are in custody of the State) who meet Client Eligibility for System Agency-funded substance use disorder services as stated in the System Agency Substance Use Disorder (SUD) Program Guide were admitted into the TRF program? If the client is under between 18 - 21 years of age	1	1	1	1	3	3	3	100%	0	
	TRF SOW II Target Population Treatment for Women and Children B TAC §448.910h	Did the Contractor ensure clients admitted into Women and Children's treatment facilities meet at least one (1) of the following criteria: A. Be in the third trimester of her pregnancy; and/or B. Have at least one (1) child physically residing overnight with her in the facility; and/or C. Have a referral by Department of Family and Protective Services (DFPS). *Note: DFPS will not allow at least one (1) child to initially reside overnight but DFPS plans to place the child in the facility within the first thirty (30) Service Days of treatment. Please record the reason a client was extended and check with the appropriate Unit for waivers or exceptions.* ***Women and their dependent children shall be treated as unit, and both the woman and her children will be admitted to treatment when appropriate.***	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW III Service Requirements Screening and Assessment C.2	Did the CMBHS record reflect the Contractor conducted and documented the screening through a confidential face-to-face interview unless there is a reasonable and documented justification for an interview by phone?	1	1	1	1	3	3	3	100%	0	
	TRF SOW III Service Requirements Screening and Assessment C.3	Did the Contractor document Financial Eligibility in CMBHS as required in Eligibility of the SUD Program Guide? Did the Contractor ensure HHSC was the payer of last resort if the client has other/outside funding available (i.e. wages insurance, etc.) ***Please note SUD Program Guide 2. Definitions*** *- Financial Eligibility: A screening conducted to determine if a client may receive financial assistance from the HHSC. CMBHS allows for documentation of a client's financial information obtained during the client screening and receive an automated response as to the client's financial eligibility status for services according to the provider type. CMBHS also allows the user to attach digital scans of paper documents to the client's electronic health record so they are easily available for future reference and oversight purposes.*	1	1	1	1	3	3	3	100%	0	
	TRF SOW III Service Requirements Screening and Assessment F.4	Did the Contractor conduct and document a CMBHS SUD Initial Assessment with the client to determine the appropriate levels of care for SUD treatment? The CMBHS assessment will identify the impact of substances on the physical, mental health, and other identified issues including Tuberculosis, Hepatitis B and C, sexually transmitted infection (STI), and Human Immunodeficiency Virus (HIV). i. If client indicates risk for these communicable diseases, did the Contractor refer the client to the appropriate community resources for further testing and counseling? ii. If the client is at risk for HIV, did the Contractor refer the client to pre and post-test counseling on HIV? *Comprehensive psychosocial assessment* *Signed and dated by a QCC within three individual service days of admission* *If, residential did a licensed health professional conduct a health assessment of the client's physical health within 96 hours of admission. The Contractor may accept an outside source completed no more than 30 days before admission or received directly from a transferring facility.*	1	1	1	1	3	3	3	100%	0	
	TRF SOW III Service Requirements Screening and Assessment F.6	If a client is living with HIV, did the Contractor refer the client to the appropriate community resources to complete the necessary referrals and health related paperwork?	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW III Service Requirements Screening and Assessment F.7	Was the assessment signed by a Qualified Credential Counselor (QCC) and filed in the client record within three (3) service days of admission or if the program accepted an evaluation from an outside entity did it meet the criteria for admission and was it completed during the thirty (30) business days preceding admission.	1	NA	NA	NA	0	NA	0	N/A	0	Duplicate question.
Treatment Planning, Implementation and Review												
	TRF SOW III Service Requirements Treatment Planning, Implementation and Review D.1	Did the CMBHS record reflect the Contractor complied with all applicable rules in the TAC for SUD programs as stated in the in the TAC regarding Treatment Planning, Implementation and Review, as referenced in Service Delivery of the SUD Program Guide? **448.804 Treatment Planning, Implementation and Review** *Individualized written plan that identifies services and support to problems and address needs identified on the assessment to include:* *the length of stay, appropriate referrals for services not offered, and when feasible other QCC's or mental health professionals serving the client from referral should participate in the treatment planning process, justification when identified needs are temporarily deferred or not addressed during treatment.* *Treatment plan shall include: goals (based on clients problems/needs, strengths and preferences), objectives (individualized, realistic, measurable, time specific, appropriate for level of care and in behavioral terms), and strategies (types and frequencies of specific services, and interventions needed to help the client achieve the identified goal and appropriate for the level of intensity of the service type and level.* *Plans shall be evaluated on a regular basis and revised as needed (evaluation of client's progress toward each goal and objectives, revision of goals, objectives, and justification for continued length of stay).* *The treatment plan shall identify the client's primary counselor, and shall be dated and signed by the client, and the counselor. When the treatment plan is conducted by an intern or graduate, a QCC shall review and sign the treatment plan.* *Treatment plan shall be completed and filed in the client record within five (5) service days of admission.*	1	0	NA	0	2	0	2	0%	1	Treatment plans did not appear to meet TAC requirements. Specifically, objectives did not appear realistic, measurable, or time specific.
	TRF SOW III Service Requirements Treatment Planning, Implementation and Review D.2	Was there documentation to support active collaboration with clients and family, when appropriate, to develop and implement an individualized, written treatment plan that identifies services and support needed to address problems and needs identified in the assessment? The treatment plan documents the expected length of stay and treatment intensity. Did the Contractor use clinical judgment to assign a projected length of stay for each individual client?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW III Service Requirements Treatment Planning, Implementation and Review D.3	If there was a need for a referral, did the Contractor document referral and referral follow-up in CMBHS to the appropriate community resources based on the individual need of the client?	1	0	NA	0	2	0	2	0%	1	CMBHS client records do not appear to reflect the use of CMBHS referral and referral follow-up functionality to document referrals for identified needs.
Discharge												

	TRF SOW III Service Requirements Discharge E.1	Did the CMBHS record reflect the Contractor compiled with all applicable rules in the TAC regarding Discharge, as referenced in Service Delivery of the SUD Program Guide? **448.805 Discharge** *Individualized plan to sustain recovery and address continuity of care services for the client* *Updated as the client progresses through treatment,* *Family involvement, when appropriate* *Referrals* *Recovery maintenance* *If the client was referred or transferred to another chemical dependency or mental health service provider for continuing care was there evidence that the facility contacted the receiving program before the client was discharged to make arrangements for the transfer? (Coordination of services and activities as well as proper consent with copies of relevant parts of the client's record.*	1	NA	NA	0	1	0	1	0%	1	Discharge plan did not appear to change from initial draft plan or address plan to sustain recovery.
	TRF SOW III Service Requirements Discharge E.2	Did the Contractor develop and implement an individualized discharge plan with the client to assist in sustaining recovery?	1	NA	NA	NA	0	NA	0	N/A	0	Duplicate question.
	TRF SOW III Service Requirements Discharge E.3	Did the contractor document in CMBHS the client-specific information that supports the reason for discharge listed on the discharge report? **A QCC must sign the discharge summary.** Appropriate referrals shall be made and documented in the client record. A client's treatment is considered successfully completed, if the following criteria are met: i. Client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS. ii. All problems on the treatment plan have been addressed iii. CMBHS record reflect the Contractor utilized the treatment plan component of CMBHS to create a final and completed treatment plan version.	1	0	0	1	3	1	3	33%	1	CMBHS client records reflected discharge summaries were not consistently completed.
	TRF SOW III Service Requirements Discharge E.4	Did the Contractor document the client-specific information that supports the reason for discharge listed on the discharge report? **A client's treatment is considered successfully completed**, if both of the following criteria are met: i. Client has completed the clinically recommended number of treatment units (either initially projected or modified with clinical justification) as indicated in CMBHS. ii. All problems on the treatment plan have been addressed. Grantee shall use the Treatment Plan component of CMBHS to create a final and completed treatment plan version. (1) Problems designated as "treat" or "case manage" status shall have all objectives resolved prior to successful discharge. (2) Problems that have been "referred" shall have associated documented referrals in CMBHS. (3) Problems with "deferred" status shall be re-assessed. Upon successful discharge, all deferred problems shall be resolved, either through referral, withdrawal, treatment, or case management with clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components. (4) "Withdrawn" problems shall have clinical justification reflected in CMBHS, through the Progress Note and Treatment Plan Review Components	1	0	NA	1	2	1	2	50%	1	Final treatment plan appeared to have been closed completed instead of closed incomplete due to client not completing treatment.
Additional Requirements												
	TRFSOW III Service Requirements Additional Service Requirements F.4	Did the CMBHS client record reflect the Contractor provided evidenced-based education at minimum on the following topics: (i) Tuberculosis; (ii) HIV; Hepatitis B and C; (iii) Sexually Transmitted Infections/Diseases; and (iv) health risks of tobacco and nicotine product use?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW III Service Requirements Additional Service Requirements F.6	Did the CMBHS client record reflect the Contractor ensure client access to the full continuum of treatment services and provided sufficient treatment intensity to achieve treatment plan goals?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW III Service Requirements Additional Service Requirements F.8	Did the CMBHS record reflect the Contractor provided trauma-informed services that address the multiple and complex issues related to violence, trauma, and substance use disorders?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW III Service Requirements Additional Service Requirements F.9	Did the CMBHS record reflect the Contractor provided overdose prevention and reversal education to all clients?	1	NA	NA	0	1	0	1	0%	1	CMBHS client records did not reflect evidence of overdose prevention and reversal education.
	TRF SOW III Service Requirements Additional Service Requirements F.10	**If the client had an opioid use disorder or used drugs intravenously**, did the CMBHS record reflect specific overdose prevention activities? The Contractor will directly provide the services or refer the client to community support services for overdose prevention and reversal education to all identified at risk clients prior to discharge.	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW III Service Requirements Additional Service Requirements F.11	Did the CMBHS record reflect the Contractor ensure access to adequate and appropriate medical and psychosocial tobacco cessation treatment as follows: i. Assess all clients for tobacco use and all clients seeking to cut back or quit. ii. If the client indicates wanting assistance with cutting back or quitting, the client will be referred to appropriate tobacco cessation treatment.	1	1	1	1	3	3	3	100%	0	
	TRF SOW III Service Requirements Additional Service Requirements F.12	Did the CMBHS record reflect the Contractor provided and documented in CMBHS case management activities as indicated by assessment and treatment plan?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW III Service Requirements Additional Service Requirements F.13	Did the CMBHS record reflect the Contractor provided and documented research-based education on the effects of Alcohol, Tobacco, and Other Drugs (ATOD) on the fetus?	1	NA	NA	0	1	0	1	0%	1	CMBHS client records did not reflect evidence of education on the effects of ATOD on the fetus
	TRF SOW III Service Requirements Additional Service Requirements F.14	Was there evidence to support the Contractor provided and documented an evidenced-based, trauma-informed curriculum in the treatment of women with substance use disorders?	1	NA	NA	NA	0	NA	0	N/A	0	Leave blank. Repeat of line 33.
OUTPATIENT TREATMENT SERVICES ASAM Level 1 Outpatient Services												
	TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.1	Did the CMBHS record reflect the Contractor compiled with TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.904 Requirements for Outpatient Services** *Appropriate for service level with written justification* *Individualized plan based upon comprehensive assessment, educational and process groups, and individual counseling; and* *Progress is regularly assessed by clinical staff to help determine the length and intensity of the program for that client.*	1	1	NA	1	2	2	2	100%	0	
	TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.2	Did the CMBHS record reflect the Contractor provided and documented one hour of group or individual counseling services for every six hours of educational activities?	1	1	NA	1	2	2	2	100%	0	
	TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.3	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	1	NA	0	1	2	1	2	50%	1	CMBHS client records did not consistently reflect that a discharge follow-up was conducted.
	TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.5	Did the CMBHS record reflect the Contractor provided and documented: i. A minimum of one (1) hour per week (or one (1) hour per month for Clients who have been transferred to outpatient after successfully completing a residential level of care) of evidence-based parenting education and document these services; and ii. A minimum of six (6) hours (or two (2) hours for Clients who have been transferred to outpatient after successfully completing a residential level of care) of reproductive health education prior to discharge and document these services.	1	0	NA	0	2	0	2	0%	1	CMBHS client records did not reflect evidence of reproductive health education.
	TRF SOW IV Levels of Care/Service Types Outpatient Treatment Services A.6	Did the CMBHS record reflect the Contractor provide and documented research-based education on the effects of ATOD on the fetus?	1	NA	NA	NA	0	NA	0	N/A	0	Duplicate question.
SUPPORTIVE RESIDENTIAL TREATMENT SERVICES Women ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services												
	TRF SOW IV Levels of Care/Service Types Supportive Residential Treatment Services B.1	Did the CMBHS record reflect the Contractor complied with TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.903(g)(1-2) Requirements Applicable to Residential Services** *Six hours of services each week to include at least 3 hours of chemical counseling (one hour per month shall be individual counseling); and* *Three hours of additional counseling, chemical dependency education, life skills training, and relapse prevention education.* *Gender specific services in **female-only** specialized programs.* *Services address relationship issues, including past or current experiences with sexual, physical and emotional abuse.* *Access to primary medical care, including prenatal and reproductive health education and services.* *Parenting education* *Children receive services to address their needs and support healthily development, including primary pediatric care, early childhood intervention, substance use services and other therapeutic interventions.*	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Supportive Residential Treatment Services B.2	Did the CMBHS record reflect as part of education hours, the Contractor provided: i. A minimum of one (1) hour per week of evidenced-based parenting education; and ii. A minimum of two (2) hours of reproductive health education within thirty (30) Service Days of admission.	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Supportive Residential Treatment Services B.4	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	1				0	NA	0	N/A	0	

SUPPORTIVE RESIDENTIAL TREATMENT SERVICES Women and Children ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services												
	TRF SOW IV Levels of Care/Service Types Supportive Residential for Women and Children C.1	Did the CMBHS record reflect the Contractor compliied with TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.903(g)(1-2) Requirements Applicable to Residential Services** **448.910 Treatment Services for Women and Children** *Six hours of services each week to include at least 3 hours of chemical counseling (one hour per month shall be individual counseling); and* *Three hours of additional counseling, chemical dependency education, life skills training, and relapse prevention education.* *Gender specific services in* ***female-only*** *specialized programs.* *Services address relationship issues, including past or current experiences with sexual, physical and emotional abuse.* *Access to primary medical care, including prenatal and reproductive health education and services.* *Parenting education* *Women and their dependent children shall be treated as a unit, and both the woman and her children will be admitted into treatment when appropriate.* *Children receive services to address their needs and support healthily development, including primary pediatric care, early childhood intervention, substance use services and other therapeutic interventions.*	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Supportive Residential for Women and Children C.3	Did the CMBHS record reflect as part of education hours, the Contractor provided: i. A minimum of two (2) hours per week of evidence-based parenting education and document these services; ii. A minimum of six (6) hours of reproductive health education within thirty (30) service days of admission and document these services; and	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Supportive Residential for Women and Children C.4	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the outpatient treatment services?	1				0	NA	0	N/A	0	
INTENSIVE RESIDENTIAL TREATMENT SERVICES Women ASAM Level 3.5 Clinically Managed High-Intensity Residential Services												
	TRF SOW IV Levels of Care/Service Types Intensive Residential Services D.1	Did the CMBHS record reflect the Contractor compliied with TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.903(g)(1-2) Requirements Applicable to Residential Services** *30 hours of service each week comprised of at least* *ten hours of chemical dependency (one hour of which is individual counseling);* *ten of hours of additional counseling, chemical dependency education, life skills training, relapse prevention education; and* *ten hours of planned, structured activities monitored by staff. Five hours of these services shall occur on the weekends and evenings. Gender specific services in female-only specialized programs.* *Services address relationship issues, including past or current experiences with sexual, physical and emotional abuse.* *Access to primary medical care, including prenatal and reproductive health education and services.* *Parenting education* *Women and their dependent children shall be treated as a unit, and both the woman and her children will be admitted into treatment when appropriate.* *Children receive services to address their needs and support healthily development, including primary pediatric care, early childhood intervention, substance use services and other therapeutic interventions.*	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Intensive Residential Services D.3	Did the CMBHS record reflect as part of education hours, Grantee will provide and document in CMBHS: i. A minimum of two (2) hours per week of evidenced-based parenting education; and ii. A minimum of six (6) hours of reproductive health education within thirty (30) Service Days of admission.	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Intensive Residential Services D.4	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from residential services?	1				0	NA	0	N/A	0	
INTENSIVE RESIDENTIAL TREATMENT SERVICES Women and Children ASAM Level 3.5 Clinically Managed High-Intensity Residential Services												
	TRF SOW IV Levels of Care/Service Types Intensive for Women and Children E.1-2	Did the CMBHS record reflect the Contractor compliied with TAC requirements and as referenced in Service Delivery of the SUD Program Guide? **448.903(g)(1-2) Requirements Applicable to Residential Services** **448.910 Treatment Services for Women and Children** *30 hours of service each week comprised of at least* *ten hours of chemical dependency (one hour of which is individual counseling);* *ten of hours of additional counseling, chemical dependency education, life skills training, relapse prevention education; and* *ten hours of planned, structured activities monitored by staff. Five hours of these services shall occur on the weekends and evenings. Gender specific services in female-only specialized programs.* *Services address relationship issues, including past or current experiences with sexual, physical and emotional abuse.* *Access to primary medical care, including prenatal and reproductive health education and services.* *Parenting education* *Women and their dependent children shall be treated as a unit, and both the woman and her children will be admitted into treatment when appropriate.* *Children receive services to address their needs and support healthily development, including primary pediatric care, early childhood intervention, substance use services and other therapeutic interventions.*	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Intensive for Women and Children E.3	Did the CMBHS record reflect as part of education hours, the Contractor provided: i. A minimum of two (2) hours per week of evidence-based parenting education and document these services; and ii. A minimum of six (6) hours of reproductive health education within thirty (30) Service Days of admission and document these services.	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Intensive for Women and Children E.4	Did the CMBHS record reflect the Contractor completed a discharge follow-up sixty (60) calendar days after discharge from the residential treatment services?	1				0	NA	0	N/A	0	
RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES ASAM Level 3.7 Medically Monitored Withdrawal Management												
	TRF SOW IV Levels of Care/Service Types Residential Detoxification Withdrawal Management Services F.1-2	Did the CMBHS record reflect the Contractor compliied to as referenced in Service Delivery of the SUD Program Guide? **448.902(g-h) Requirements Applicable to Detoxification Services** *Was there documentation to support the medical director or his/her designee (physician assistant, nurse practitioner) authorized all admissions, conducted a face-to-face examination, to include both a history and physical examination of each applicant for services to establish the Axis 1 diagnosis, assess level of intoxication or withdrawal potential, and determine the need for treatment and the type of treatment to be provided to reach a placement decision?* *If the physician determined an admission was not appropriate, was the client transferred to an appropriate service provider?* *If an examination was completed during the 24 hours preceding admission, was it is approved by the program's medical director or designee that met HHS requirements? The program may not require a client to obtain a history and physical as a condition of admission.* *If it was a residential facility, was monitoring conducted, at a minimum every four hours for the first 72 hour and as ordered by the medical director or designee thereafter, dependent upon the client's signs and symptoms?* *Did all detoxification service levels CMBHS monitoring documentation include: changes in mental state, vital signs and response of the client's symptoms?*	1				0	NA	0	N/A	0	
	TRF SOW IV Levels of Care/Service Types Residential Detoxification Withdrawal Management Services F.3	Did the CMBHS record reflect the Contractor compliied with the following additional service delivery requirements: i. Document in CMBHS a Withdrawal Management Intake Form. ii. Document in CMBHS a discharge plan prior to discharge or transfer. iii. Document in CMBHS a discharge follow-up no more than ten (10) calendar days after discharge from withdrawal management services.	1				0	NA	0	N/A	0	
AMBULATORY WITHDRAWAL MANAGEMENT ASAM Level 2 Withdrawal Management												
	TRF SOW IV Levels of Care/Service Types Residential Detoxification Ambulatory Management Services F.3	Did the CMBHS record reflect the Contractor compliied with the TAC requirements and SUD Program Guide for Service Delivery? **448.902(g-i) Requirements Applicable to Detoxification Services** *Was there documentation to support the medical director or his/her designee (physician assistant, nurse practitioner) authorized all admissions, conducted a face-to-face examination, to include both a history and physical examination of each applicant for services to establish the Axis 1 diagnosis, assess level of intoxication or withdrawal potential, and determine the need for treatment and the type of treatment to be provided to reach a placement decision?* *If the physician determined an admission was not appropriate, was the client transferred to an appropriate service provider?* *If an examination was completed during the 24 hours preceding admission, was it is approved by the program's medical director or designee that met HHS requirements? The program may not require a client to obtain a history and physical as a condition of admission.* *Did all detoxification service levels CMBHS monitoring documentation include: changes in mental state, vital signs and response of the client's symptoms?*	1				0	NA	0	N/A	0	
	TRF WITH MAN A.2	Did the CMBHS record reflect the Contractor compliied with the following additional service delivery requirements: i. Document in CMBHS a Withdrawal Management Intake Form. ii. Document in CMBHS a discharge plan prior to discharge or transfer. iii. Document in CMBHS a discharge follow-up no more than ten (10) calendar days after discharge from withdrawal management services	1				0	NA	0	N/A	0	

	TRF WITH MAN A.3	Did the CMBHS record reflect the Contractor complied with the TAC applicable ambulatory services requirements; ambulatory detoxification is not a stand-alone service the client is simultaneously admitted to a substance use disorder treatment service while admitted to ambulatory detoxification services.	1				0	NA	0	N/A	0	
		Filtered Score	46				48	35		**73%**	**9**	
		Overall Score	46				48	35		**73%**	**9**	

End of worksheet

Transfer Data | Transfer | Spell | Add Column

		The Harris Center for MHIDD			Del Active							
		Review Period			Program Type(s)	TRA/TRF	Total Reviewed					
		4/13/2023	Thru	5/5/2023	Location	Houston, TX (reg 6)	1					
			Review Number :	23SU13	Reviewer's Initials							

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
TRF Program Requirements										
	TRF SOW III Service Requirements Administrative Requirements A.1, 3-4	Did the Contractor adhere to the most current SUD Program Guide, Level of Care/Service Type licensure requirements and comply with all applicable Texas Administrative Code (TAC) rules adopted by System Agency related to SUD treatment? **Please note:** If the Contractor scored 70% or less on the overall score on the TRF Record Review Tab, it is considered a finding.	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.2	Did the Contractor provide age-appropriate medical and psychological therapeutic services designed to treat an individual's SUD while promoting recovery?	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.5	Did the Contractor document all specified required activities and services in the Clinical Management of Behavioral Health Services (CMBHS) system? Were the documents that required client or staff signature maintained according to TAC requirements and made available to System Agency for review upon request?	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.6	Did the Contractor develop and implement organizational policies and procedures for the following: i. A marketing plan to engage local referral sources and provide information to these sources regarding the availability of SUD treatment and the Client Eligibility criteria for admissions; ii. All marketing materials published shall include Priority Populations for Treatment Programs admissions; iii. Client Retention in services, including protocols for addressing clients absent from treatment and policies defining treatment non-compliance; and iv. All policies and procedures must be provided to System Agency upon request	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.7	Did the Contractor ensure that Program Directors participated in their specific program and service type conference calls as scheduled by System Agency? Program Directors must participate unless otherwise agreed to by System Agency in writing. Grantee executive management may participate in the conference calls.	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.8	Did the Contractor actively attend and share representative knowledge about their system and services at the Outreach, Screening, Assessment, and Referrals (OSAR) quarterly regional collaborative meetings? **Please note:** Participation includes discussion demonstrated via meeting minutes, call and/or sign in sheets.	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.9	Did the Contractor ensure compliance with Client Eligibility requirements to include: Texas eligibility, financial eligibility and clinical eligibility as required in SUD UM Guidelines? **Please note:** *If the Contractor has significant issues related to edibility requirements listed above it is identified as a finding.*	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.11	Did the Contractor develop a local agreement with DFPS local offices to address referral process, coordination of services, and sharing of information as allowed per the consent and agreement form? **Please note:** *The Contractor may not have this MOU due to local issues/rules.*	1	1	1	1	1	100%	0	
	TRF SOW IV Staff Competencies and Requirements 12	Was there documentation to support the Contractor trained staff and developed a policy to ensure that information gathered from Clients is conducted in a respectful, non-threatening, and culturally competent manner?	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.12	Did the Contractor maintain Memorandum of Understanding requirements as stated in SUD Program Guide? *All MOU and Local Agreements must be renewed annually* *Within six months of initial contract execution - (Regional OSAR - Outreach, Screening, Assessment and Referral, LMHA - Local Mental Health Authority, and Local Community Health organizations)* ***OSAR** - report daily capacity and treatment availability, referral process, confidentiality, interim services, waitlist list/waitlist removal, quarterly updates of staff who handles client placement, implementation/expiration dates and signatures of both parties* ***LMHA** - Objectives, roles and responsibilities of each party, scope of services, confidentiality, priority population admission requirements, CMBHS referral/referral follow-up, non-duplication of services, emergency transportation, coordination of services, implementation/expiration dates, and signatures of both parties* ***TRA/TRF/TRY** - Must have an MOU with Recovery Support Services providers in their region: Referrals, coordination (enrollment/engagement/coordination of non-duplication of services, collaboration for improved participant outcomes, implementation/expiration dates, and signature of both parties.* ***TRF RSS/YRC** - Must have a MOU with YRC in their region, if no YRC then an RSS to include: Referrals, follow-up contact (enrollment/engagement/coordination of non-duplication of services, collaboration for improved participant outcomes, implementation/expiration dates, and signature of both parties.* ***COPSD -** When there are multiple HHSC-funded grantees in the same region, grantee shall maintain MOUs with the other COPSD grantees.*	1	1	1	1	1	100%	0	
	TRF SOW III Service Requirements Administrative Requirements A.13	Did the Contractor maintain a list of community resources and document referrals when appropriate to ensure that children of the client have access to services to address their needs and support healthy development including primary pediatric care, early childhood intervention services, and other therapeutic interventions that address the children's development needs and any issues of abuse and neglect?	1	NA	0	NA	0	N/A	0	Due to reviewer oversight, this was not included in this review. Contractor will be notified of this requirement.
		Column Comments								
		Filtered Score	11		8	8		**100%**	**0**	
		Overall Score	11		8	8		**100%**	**0**	

End of worksheet

Transfer Data | Transfer | Spell | Add Column | Del Active

	Review Period			Staff Name				Total Reviewed
	4/13/2023	Thru	5/5/2023	Position	Counselor	Counselor	Counselor	3
		Review Number :	23SU13	Program Type	TRF	TRF	TRF	
				Date of Hire	10.2.17	11.2.17		
				License Type	LCDC	LCDC	LCDC	
				License Expiration	12.31.24	1.31.25	10.31.23	

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Observed	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
TRF Personnel Records												
	TAC 448.601 *Substance Use Program Guide 9 Personnel Requirements and Documentation 1,2 and 4*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.601? *Registered with the Commission* *Verification of al required credentials with the credentialing authority* *Criminal Background Check* *Pre-employment drug test* *Job description outlining job duties and minimum qualifications* *Annual performance evaluations* *Personnel data that includes date of hire, rate of pay and documentation to support pay increases and bonuses* *Appropriate screens* *Signed documentation of initial and required training - can be stored separately* *Disciplinary actions* *Health related information must be stored separately with restricted access	1	1	1	1	3	3	3	100%	0	
	TAC §448.603	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? **TAC 448.601.c.1 Orientation** Prior to performing their duties and responsibilities, the facility shall provide orientation to staff, volunteers, and students. This orientation shall include information addressing: (1) TCADA rules; (2) facility policies and procedures; (3) client rights; (4) client grievance procedures; (5) confidentiality of client-identifying information (42 C.F.R. pt. 2; HIPAA); (6) standards of conduct; and (7) emergency and evacuation procedures. **Please note:** *All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.*	1	1	1	1	3	3	3	100%	0	
	TAC 448.603(d) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1 and 5*	Did the contractor ensure staff completed the following trainings within the first 90 days in accordance with SOW i. Motivational interviewing techniques or Motivational Enhancement Therapy; ii. Trauma-informed care; iii. Cultural competency; iv. Harm reduction trainings; v. HIPAA and 42 CFR Part 2 training; vi. Alcohol, Tobacco and Other Drugs on the Developing Fetus; vii. Child welfare education viii. State of Texas co-occurring psychiatric and substance use disorder (COPSD) training located at the following website: www.centralizedtraining.com. *The following initial training(s) must be received within first 90 days of employment and must be completed before the employee can perform a function to which to which the specific training is applicable.* *(1) Abuse, Neglect, and Exploitation. All residential program personnel with any direct client contact shall receive eight hours of face-to-face training as described in Figure: 40 TAC §148.603(d)(1) which is attached hereto and incorporated herein as if set forth at length. All outpatient program personnel with any direct client contact shall received two hours of abuse, neglect and exploitation training.* *(2) HIV, Hepatitis B and C, Tuberculosis and Sexually Transmitted Diseases. All personnel with any direct client contact shall receive this training. The training shall be based on the Texas Commission on Alcohol and Drug Abuse Workplace and Education Guidelines for HIV and Other Communicable Diseases.* *(A) The initial training shall be three hours in length.* *(B) Staff shall receive annual updated information about these diseases.*	1	0	0	1	3	1	3	33%	1	**Training records indicated that not all staff received COPSD, ATOD effects on the fetus, and child welfare education training.**
	TAC 448.603(d) *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? Did the Contractor ensure: (3) Cardio Pulmonary Resuscitation (CPR). (A) All direct care staff in a residential program shall maintain current CPR and First Aid certification. (B) Licensed health professionals and personnel in licensed medical facilities are exempt if emergency resuscitation equipment and trained response teams are available 24 hours a day.	1	1	1	1	3	3	3	100%	0	
	TAC 448.603.4 *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All direct care staff in residential programs and outpatient programs shall receive this training. The face-to-face training shall teach staff how to use verbal and other non-physical methods for prevention, early intervention, and crisis management. The instructor shall have documented successful completion of a course for crisis intervention instructors or have equivalent documented training and experience.*	1	1	1	1	3	3	3	100%	0	
	TAC 448.603.6 *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All staff who conduct intake, screening and authorize admission for applicants to receive program services shall complete training in the program's screening and admission procedures. The training shall include two hours of DSM diagnostic criteria for substance-related disorders, and other mental health diagnoses.* *(A) The initial training shall be eight hours in length.* *(B) Staff shall complete eight hours of annual training thereafter.* *(C) The training shall be completed before staff screen or authorize applicants for admission.*	1	0	0	0	3	0	3	0%	1	Training records indicated staff did not receive intake, screening, and admission authorization training.
	TAC 448.603.7 *Substance Use Program Guide 9 Personnel Requirements and Documentation 1*	Did the Contractor adhere to the Personnel practices and Development Requirements located in TAC Chapter 448.603? *All personnel responsible for supervising clients in self-administration of medication, who are not credentialed to administer medication, shall complete this training before performing this task.* *(A) Staff shall complete two hours initial one time training.* *(B) The training shall be provided by a physician, pharmacist, physician assistant, or registered nurse before administering medication and shall include:* *(i) prescription labels;* *(ii) medical abbreviations;* *(iii) routes of administration;* *(iv) use of drug reference materials;* *(v) storage, maintenance, handling, and destruction of medication;* *(vi) documentation requirements; and* *(vii) procedures for medication errors, adverse reactions, and side effects.*	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW IV Staff Competencies and Requirements 2-3	Did the Contractor ensure that direct care staff received a copy of the statement of work and SUD requirements as well as reviewed all policies and procedures related to the Program or organization on an annual basis?	1	0	0	1	3	1	3	33%	1	Training records indicated that not all staff received a copy of the Statement of Work.
	TRF SOW IV Staff Competencies and Requirements 6-7	Did the contractor: 6. Ensure all direct care staff complete annual education on HIPAA and 42 CFR Part 2 training. 7. Ensure all direct care staff complete a minimum of ten (10) hours of training each State Fiscal Year in any of the following areas: i. Motivational Interviewing Techniques; ii. Cultural competencies; iii. Reproductive health education; iv. Risk and harm reduction strategies; v. Trauma Informed Care; vi. Substance exposed pregnancy (such as Fetal Alcohol Spectrum Disorder or DocuSign Envelope ID: 60E83AB2-D4C9-4130-8E87-9164BFD5A4BB HHSC Contract No. HHS000663700239 Page 10 of 20 Amendment No. 1 vi. Neonatal Abstinence Syndrome); viii. Child welfare education; or ix. Suicide prevention and intervention.	1	0	0	NA	2	0	2	0%	1	Training records indicated that not all staff completed 10hrs of annual training.
	TRF SOW IV Staff Competencies and Requirements 8-9	If the staff person is responsible for planning, directing, or supervising treatment services, did the Contractor ensure they were a QCC and if defined as a clinical "Program Director", did they have at least two (2) years of post-QCC licensure experience providing substance use disorder treatment?	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW IV Staff Competencies and Requirements 10	If the staff person is responsible for Substance Use Disorder counseling were they a QCC, or Chemical Dependency Counselor Intern? Substance use disorder education and life skills trainings provided by counselors or individuals who have been trained in the education. All counselor interns shall work under the direct supervision of a QCC.	1	1	1	1	3	3	3	100%	0	
	TRF SOW IV Staff Competencies and Requirements 14	Was there documentation to ensure the Contractor developed and implemented a mechanism to ensure that all direct care staff have the knowledge, skills, and abilities to provide services to women and children, as they relate to the individual's job duties.	1	NA	NA	NA	0	NA	0	N/A	0	
	TRF SOW IV Staff Competencies and Requirements 15	Did the Contractor staff demonstrate through documented training, credentials and/or experience that all direct care staff are proficient in areas pertaining to the needs of and provision of services to women and children?	1	0	0	1	3	1	3	33%	1	Training records do not indicate staff received specialized training.

	Column Comments									
Filtered Score		13				29	18		62%	5
Overall Score		13				29	18		62%	5

End of worksheet

Transfer Data | Transfer | Spell | Add Column | Del Active

Review Period			Staff Name	Program Type - CHW	Total Reviewed
4/13/2023	Thru	5/5/2023	Position	Location - Houston, TX	1
	Review Number :	23SU13	Program Type	Reviewer Initials	
			Date of Hire	N/A	
			License Type	N/A	
			License Expiration	N/A	

Quality Management Indicator	Citation Reference	Questions	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
Substance Use Disorder Community Health Worker (SUD CHW)										
	SUD CHW Eligible Population	Did the Contractor provide services to individuals who use substances, including populations who are marginalized or stigmatized, experiencing housing instability or homelessness, inject substances, live with or at risk of Hepatitis C Virus (HCV) or (Human Immunodeficiency Virus (HIV), experience greater barriers to entering treatment or recovery services, and those seeking to enhance their recovery capital and maintain their recovery from substance use disorders?	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.2 Community Health Services B.1 and Staff Competencies 1, 3 and 6.	Did the Contractor employ six community health workers (CHW) to work in teams (2) in the Community? Did the Contractor also ensure all CHW staff and Program Director who provide services under this Program Attachment: a. were knowledgeable and competent in discussing HIV, HCV, and other communicable diseases associated with substance use and be able to demonstrate ability to discuss sexuality openly and comfortably; b. were knowledgeable and competent in discussing opioid overdose and be able to demonstrate ability to train individuals to use overdose reversal medications and harm reduction materials. Did the Contractor ensure the CHW obtained the Community Health Worker Certification https://www.dshs.texas.gov/mch/chw.shtm within 6 months from date of execution of this contract or start date of employment, whichever is later? All CHW must maintain their certifications in good standing while employed during the duration of this contract and be on file for System Agency review upon request.	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.2 Community Health Services B.1 and Staff Competencies 4	Did the Contractor ensure one of the six CHW was designated to serve as the Program Director? Did the Contractor maintain documentation to ensure the Program Director met the following requirements: a. Meet the competencies to become a Department of State Health Services (DSHS) Certified Community Health Worker; b. Have a minimum of two (2) years of experience in one or more of the following: i. substance use outreach; ii. substance use intervention; or iii. substance use treatment. c. Have a minimum of one (1) year of experience in at least two of the following: i. working with prison populations; ii. working with individuals experiencing housing instability; iii. working with individuals with Substance Use Disorders, HIV/STDs, and/or behavioral health issues; iv. community health work; or v. supervisory experience.	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.3	Did the Contractor ensure the Program Director met the following: Spends 50% of work time delivering services; and Participate in Programmatic conference calls? Additional staff may attend the call, yet the Program Director is required unless agreed in writing by System Agency.	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.4-6	Did the Contractor ensure the CHW had the following: professional messenger bags or side bags to array supplies; health kits were individually packaged for distribution; and agency funded and insured vehicle to conduct activities?	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.8	Did the Contractor maintain documentation that ensured program, policies and procedures did not discriminate against any participant, family member, or supportive ally based on gender, race, religion, age, national origin, disability, sexual orientation, medical condition, HIV Status, or length of time in recovery including those who have returned to use or are currently using substances?	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.9	Did the Contractor maintain documentation to support it provided all services in a culturally, linguistically, and developmentally appropriate manner for individuals, families and significant others as evidenced by: a. the use of CHWs who are indigenous and in recovery; b. pamphlets and other materials for educational and health are written at appropriate literacy levels of the eligible population; c. literature and signage in languages of the eligible populations; d. use of interpreters as appropriate; and e. lobby and office environment welcoming to the eligible population	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.10	Did the Contractor establish and maintain working linkages through Memorandums of Understanding (MOUs) with a network of community and social service agencies serving or having an interest in the eligible population? MOUs will be executed within ninety (90) days after contract execution and shall encourage networking, coordination, and referrals to help address the needs of the priority population, their families, and supportive allies.	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.11	Did the Contractor maintain copies of the signed MOUs on file for System Agency review upon request? All MOUs shall be reviewed annually and updated as needed and shall include at minimum: a. Partnership vision; b. Purpose and concept; c. Partnership goals and desired outcomes; d. Description of participating organizations; e. Methods of partnership roles and responsibilities; f. Provisions to address the non-duplication of services; g. Signatures of both parties; and h. Beginning and end dates.	1	1	1	1	1	100%	0	

	SUD CHW Administrative and Organizational Requirements A.12	Did the Contractor ensure the following Recovery Oriented Values and Principles are stated in policy and adhered to within the contractor's organization: a. Choice and Self Determination: i. provide individuals the opportunity to select supports and services that correspond with their personal preferences and goals; ii. ensure services are self-directed, participant-driven, and reflect goals in multiple life domains; iii. acknowledge an individual's choice for their own pathway to wellness; and iv. be supportive and explore options for the priority population. b. Community Integration: i. provide individuals the opportunity to be involved in community activities and receive support related to community integration that is associated with recovery, health, and wellness; ii. work with the eligible population to identify and connect with a broad spectrum of community-based resources and supports that will assist in achieving their goals and rebuilding their lives within their community; iii. align organizational policies to ensure Community Health Workers have access to transportation and other resources to work with individuals outside of the organizational setting and in the local communities; iv. ensure Community Health Workers engage in assertive outreach in locations and times where the eligible populations are likely to be found; and v. utilize community or social services agency linkages to ensure	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.12	Did the Contractor ensure CHW distributed Opioid Overdose Reversal Kits to: a. individuals eligible for program services who use opioids; b. support systems which may be able to reverse the individuals overdose; or c. eligible individuals who may be in the position to reverse an opioid overdose?	1	1	1	1	1	100%	0	
	SUD CHW Administrative and Organizational Requirements A.13	Did the Contractor document the count of Opioid Reversal kits dispersed to include reports of successful reversals?	1	1	1	1	1	100%	0	
	SUD CHW Community Health Services	Was the evidence the Contractor utilized the System Agency provided Work logs to account for CHW efforts? Work logs will: a. reflect efforts by the CHWs without providing personal identifying information; b. be retained and provided at System Agency request c. be summarized in the System Agency provided Quarterly Report.	1	1	1	1	1	100%	0	
	SUD CHW Community Health Requirements4	Did the Contractor ensure the following guidelines for Community Health Work: a. Outreach Competencies: Minimum Standards for Conducting Street Outreach with Hard To Reach Populations; Addiction Technology Transfer Center (ATTC) http://attcnetwork.org/resources/resource.aspx?prodID=438&rcID=2&regionalcenter=2 ; b. The National Institute on Drug Abuse (NIDA) Community-Based Outreach Model: A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users https://archives.drugabuse.gov/publications/nida-community-based-outreach-model-manual-to-reduce-risk-hiv-other-blood-borne-infections-in-drug c. Ethical Guidelines for the Delivery of Peer-based Recovery Support Services; https://www.naadac.org/assets/2416/whitew2007_the_pro-act_ethics_workgroup.pdf d. Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery Community Services Program: Peer Support and Social Inclusion https://www.samhsa.gov/recovery/peer-support-social-inclusion e. Center for Disease Control (CDC) Social Determinants of Health https://www.cdc.gov/socialdeterminants/	1	1	1	1	1	100%	0	
	SUD CHW Community Health Requirements 5-10	Was there evidence to support tithe Contractor promoted and encouraged entry into substance use disorder and/or mental health services including, intervention, treatment, or recovery by providing referrals, linkage, and support to eligible individuals; Promoted and encouraged entry into medical services, including HIV, HCV, HBV, TB, and Sexually Transmitted Infections (STI) testing or treatment by providing referrals, linkage, and support to individuals in the eligible population; Provided information, referrals, linkage and support to other services and community resources to help individuals in the eligible population improve their lives; Referred eligible individuals to other System Agency-funded programs as appropriate; and Used Motivational Interviewing techniques and skills when appropriate to help individuals enhance their confidence and motivation for change?	1	1	1	1	1	100%	0	
	SUD CHW Community Health Requirements 5-10	Was there evidence to support the Contractor ensured appropriate training on all information, methods, and tools used and distributed by CHWs. Information, methods, and tools shall be based on the latest scientific research and best practices for reducing harms related to substance use. Methods and tools must include, but are not limited to; a. substance use harm reduction tools including syringe cleaning kits with bleach b. Pre-Exposure Prophylactic treatments (PrEP) education and information, c. overdose reversal kits including Naloxone d. condoms, lubricants, and safer sex tools e. wound care kits f. hygiene kits g. Contractor shall ensure that Community Health Workers have these	1	1	1	1	1	100%	0	
	SUD CHW Staff Competencies 5	Did the Contactor maintain documentation to support the Program Director provided each staff member with documented field observations and feedback at least once every six months, which will be provided to System Agency upon request?	1	1	1	1	1	100%	0	
	SUD CHW Financial Assistance	Did the Contractor maintain policies, procedures and support documentation for financial assistance that met the following: Financial assistance will be documented to include: a. Date provided; b. Dollar amount; and c. Item purchased Financial assistance to eligible individuals is not to exceed five percent (5%) of fiscal year award or over 250 per individual in a fiscal term must be approved by the System Agency Financial assistance may include: transportation needs to appointments; prescriptions or medicines needed; vison or hearing needs; clothing or personal hygiene items; assistance for sober housing; employment or educational needs; and other needs not listed that improve the individual's quality of life or ability to successfully engage in services with System Agency written approval. Financial assistance will not be used for, but not limited to, the following: a. Direct cash payment to individuals; b. Meals; c. Payments to attend treatment; or d. Hypodermic needles or syringes for injection drug use.	1	1	1	1	1	100%	0	

Column Comments							
Filtered Score	18		18	18		**100%**	**0**
Overall Score	18		18	18		**100%**	**0**

End of worksheet

Transfer Data														
Transfer	Spell							Add Column						
				Del Active										
		Review Period		Contractor Name	The Harris Center	The Harris Center	Total Reviewed							
		4/13/2023 Thru 5/5/2023		Contractor Location	SE Clinic 5901 Long Dr.	NE Clinic 7200 N. Loop E. Fwy	2							
		Review Number : 23SU13		Program Type	TRA/TRF	TRA/TRF								
				Walk thru Date	5.4.23	5.4.24								
				Reviewer's Initials										
				If applicable, Subcontractor										

Quality Management Indicator	Program Type	Citation Reference	Questions	Max Score	Observed	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
All Treatment Programs												
Operations	All Treatment Services	§448.505	Were there animals observed onsite? If so, was there documentation to support the animal(s) were properly vaccinated? Additionally were there protocols for how the animal was supervised?	1	1	1	2	2	2	100%	0	
Access to Services	All Treatment Services	§448.506	Were the following posted in English and a second language (appropriate to the population(s): The Client Bill of Rights; The current poster on reporting complaints and violations; and The client grievance procedure?	1	1	1	2	2	2	100%	0	
Operations	All Treatment Services	§448.508	Did the Contactor ensure that all client records and other client identifying information was protected from destruction, loss, tampering and unauthorized access, use or disclosure? Please note: All records should be stored at the facility, locked at all times and accessible only to authorized staff.	1	1	1	2	2	2	100%	0	
Operations	All Treatment Services	§448.505	Does the Contractor have a current certificate of occupancy issued from the local authority? If they do not have a certificate of occupancy, did they maintain documentation to support the locality does not issue certificates of occupancy?	1	1	1	2	2	2	100%	0	
Operations	All Treatment Services	§448.505	If smoking areas were permitted, were they clearly marked and at least 15 feet from any entrance to any building?	1	1	1	2	2	2	100%	0	100% tobacco free
Operations	All Treatment Services	§448.505	Was there evidence the contractor prohibited firearms and other weapons, alcohol, illegal drugs, illegal activities and violence on the program site or during any program activities?	1	1	1	2	2	2	100%	0	
Client Transportation												
Operations	All Treatment Services	§448.510	Did the Contractor maintain insurance on the vehicles used to transport clients? *Please ask for a copy of the insurance card(s) or review it in the vehicle.*	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.510	During the walk-thru and observation was there evidence of use of tobacco products in the vehicles used to transport client(s)?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.510	During the walk-thru and observation of the vehicles used to transport clients, was there a fully stocked first aid kit and an A:B:C: fire extinguisher that were easily available?	1			0	NA	0	N/A	0	
Responding to Emergencies												
Operations	All Treatment Services	§448.707	During the walk-thru and observations, were there emergency numbers posted by all telephones?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.707	During the walk thru and observations, did the facility have fully stocked first aid supplies that were visible. Labeled and easily accessed?	1			0	NA	0	N/A	0	
Medication Room General Provisions, Storage, Inventory and Disposal												
Operations	All Treatment Services	§448.1001	During the walk-thru and observations did the medication room have the phone number of a pharmacy and a comprehensive drug reference manual easily accessible to staff?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1002	During the walk-thru and observations, were prescriptions and over the counter medications, syringes, and needles kept in a locked storage and accessible to staff who are authorized to provide medication?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1002	During the walk-thru and observations, were the medications, syringes and needles stored in their original containers under appropriate conditions?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1002	During the walk-thru and observations, did you observe food or drinks stored in refrigerators where medications were maintained?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1002	During the walk-thru and observations, were the prescription medication in containers labeled by the pharmacy?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1002	During the walk-thru and observations did the Contractor maintain an effective system to track and account for all prescription medication?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1003	Was there evidence to support staff conducted an inspection and ensured the count and storage of all DEA Schedule II, III, and IV prescription medications at least daily using an centralized storage form?	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1003	Please discuss and ensure the following during the walk thru and observation of the medication room: Staff separated unused and outdated medication immediately and disposed of it within 30 days	1			0	NA	0	N/A	0	
Operations	All Treatment Services	§448.1003	Please discuss and ensure the following during the walk thru and observation of the medication room: Methods used for disposal prevented medication from being retrieved, salvaged and used. Two staff members witness and document disposal, including amount of medication disposed and method used.	1			0	NA	0	N/A	0	

Substance Use and Misuse Prevention Services (SUMP)												
Operations	All SUMP	Policy and Procedure Requirements	During the walk-thru and observations, was there signage prohibiting firearms, weapons, alcohol, illegal drugs, illegal activities, and violence in a prominent location?	1			0	NA	0	N/A	0	
Access to Services	All SUMP	Policy and Procedure Requirements	During the walk-thru and observations did the Contractor post the hours and days of operation at all building entrances? **Please note:** *Standard days of operation will reflect a forty (40)-hour workweek, Monday through Friday.*	1			0	NA	0	N/A	0	
Operations	All SUMP	Policy and Procedure Requirements	During the walk-thru and observations did the Contractor post exit diagrams conspicuously throughout program sites? **Please note**: *Except in one-story buildings where all exits are clearly designated as such.*	1			0	NA	0	N/A	0	
HIV Statewide Intensive Residential Treatment Services												
Operations	Statewide HIV Residential	TRA TRF 2022 SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.8	Did the Contractor maintain documentation to support they provided client meals in accordance with recommended nutritional guidelines, specifically adjusted for persons living with HIV? **Please note:** *Please ask to see a client meal menu.*	1			0	NA	0	N/A	0	
Operations	Statewide HIV Residential	TRA TRF 2022 SOW Section V Levels of Care/Service Types HIV Statewide Intensive Residential Treatment Services D.9	During the walk-thru and observations did the Contractor Maintain a clean client living environment in accordance with Universal and Standard Precaution Guidelines prescribed by the Center for Disease Control and Prevention (CDC) including linen care, hand-washing habits, food areas, flooring, and air conditioning located at:https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html.	1			0	NA	0	N/A	0	
			Column Comments									
			Filtered Score	25	**PS Username**	**PS Username**	12	12		**100%**	**0**	
			Overall Score	25			12	12		**100%**	**0**	

End of worksheet

Transfer | Spell | Add Column | Del Active

Sub-Contractor Name		**Total Reviewed**
Program Type and Service Level	OSAR	**1**
Address of Services Provided		
Services Provided	OSAR	
Contract Begin:		
Contract Term		

Quality Management Indicator	Citation reference	Question	Max Score	Observed	Total Expected	Total Observed	Total Applicable Records	Score	Finding Count	Row Comments
Performing Agency's Responsibilities										
	Substance Use Program Guide Provider Requirements Subcontracting 1.A-D and 3	Did the Contractor enter into agreements with subcontractors? If so did the Contractor ensure the following: A. Not enter into agreements with subcontractors that are restricted or otherwise prohibited in the HHSC agreement B. Not subcontract with for-profit organizations under the HHSC agreement without prior written approval from HHSC C. Obtain written approval from HHSC prior to entering into a subcontract agreement equaling or exceeding $100,000.00 and D. Obtain written approval from HHSC before modifying any subcontract agreement to cause the subcontract agreement to exceed $100,000.00? 3. Not enter into an agreement with a subcontractor, at any tier, that is debarred, suspended, had a contract terminated for fault by HHSC, or excluded from or ineligible for participation in federal assistance programs, or if the subcontractor would be otherwise ineligible to abide by the terms of the HHSC agreement.	1	NA	0	NA	0	N/A	0	Contractor renews contract with subcontractor annually. System-agency (HHSC/DSHS) mandated LMHAs to provide the OSAR service or subcontract with the existing OSAR prior to this mandate.
	Substance Use Program Guide Provider Requirements Subcontracting 1.E.	Did the Contractor establish written policies and procedures for competitive procurement and monitoring of subcontractors and develop a subcontracting monitoring plan?	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 1.F.	Does the Contractor monitor subcontractors for both financial and programmatic performance and maintain records of monitoring for HHSC review?	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 2	Did the Contractor's monitoring plan and subsequent documentation support they ensured and were responsible for the performance of the subcontractor?	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 1.G	Did the Contractor submit quarterly monitoring reports to HHSC in a format determined or approved by HHSC when HHSC requests through written notification?	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 1.H-I	Did the Contractor ensure subcontractors were fully aware of the following requirements by state/federal statutes, rules, and regulations and by the provisions of the HHSC agreement: I. Ensure all subcontract agreements are in writing and include the following: a. Name and address of all parties and the subcontractor's Vendor Identification Number) or Employee Identification Number; b. Detailed description of the services to be provided; c. Measurable method and rate of payment and total not-to-exceed amount of the contract; d. Clearly defined and executable termination clause; and e. Beginning and ending dates that coincide with the dates of the contract.	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 4	Did the Contractor include in all its agreements with subrecipients, subcontractors, and solicitations for subrecipient and subcontracts, without modification (except as required to make applicable to the subcontract): A. HHSC Statement of Work; B. HHSC Uniform Terms and Conditions; C. HHSC Special Conditions; D. HHSC Federal Assurances and Certifications; and E. HHSC Non-Exclusive List of Applicable Laws	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 6	Did the Contractor ensure all written agreements with subcontractors incorporate the terms of the HHSC agreement so that all terms, conditions, provisions, requirements, duties and liabilities under the Provider's agreement with HHSC is applicable to the services provided or activities conducted by a subcontractor are passed down to subcontractor. Understand that no provision of the subcontractor agreement creates a privity?	1	1	1	1	1	100%	0	
	Substance Use Program Guide Provider Requirements Subcontracting 5	Did the Contractor ensure all written agreements with subcontractors included a provision granting to HHSC, State Auditor's Office, Office of Inspector General and the Comptroller General of the United States, and any of agency representatives, the right of access to inspect the work and the premises on which any work is performed, and the right to audit the subcontractor?	1	1	1	1	1	100%	0	
	Substance Use Program Guide HHSC Resource HHSC Broadcast Messages	Did the Provider assign one or more staff responsibility for tracking policy updates posted on HHSC's identified platform and disseminating information within the Provider's organization?	1	1	1	1	1	100%	0	
	Substance Use Program Guide System of Record	Did the Contractor use as well as ensure all subcontractors used CMBHS as the system of record for all HHSC SUD treatment contracts? CMHBS is a web-based data management system and electronic health record developed for use by providers and business entities involved with service delivery, management, and oversight. Unless HHSC recognizes an alternative system and provides alternative reporting in an agreement with a given Provider, the Provider must use CMBHS as the system of record.	1	1	1	1	1	100%	0	

	Substance Use Program Guide Organizational Qualifications	Did the Contractor maintain documentation to support the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under the contract? Provider will ensure all assigned duties and responsibilities under the contract are performed by personnel who are properly trained and qualified for the functions contractually required to perform. **Please complete the personnel file tab for key staff and directors as well as the environmental tab.** **Please Note:** *Contractor must maintain information to support subcontractor locations and personnel are properly trained and qualified. Contractor must ensure person responsible for oversight of subcontracted services is qualified.*	1	1	1	1	1	100%	0	
		Column Comments								
		Filtered Score	11	**PS Username**	11	0	11	**0%**	11	
		Overall Score	11		11	0	11	**0%**	11	

HARRIS COUNTY, TEXAS
COMMUNITY SERVICES DEPARTMENT

Thao Costis
Interim Executive Director

8410 Lantern Point Drive
Houston, Texas 77054

April 5, 2023

Mr. Wayne Young
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, Texas 77074

Attn: Mr. LaDarryl Campbell

Re: Community-wide Covid Housing Program (CCHP)- The Harris Center at Dennis Street (COVID-19), Project No. 2020-0048

Dear Mr. Young:

This letter is to inform you that the U. S. Department of Housing and Urban Development (HUD) is scheduled to monitor Harris County Community Services Department's Program Year (PY) 2020 Community Development Block Grant CARES Act (CDBG-CV) program during the period April 24-28, 2023. You are being notified because your agency was awarded CDBG-CV funds during PY2020 and HUD has selected your project for review and may request a sample of program data to review. HUD may also request to meet with your programs' key personnel during the week of April 24-28, 2023. We will notify you as soon as HUD provides specific data requests.

If you have any questions regarding this matter, please contact Natalie Garcia at 832-927-4774.

Sincerely,

Elizabeth R. Winfrey

Elizabeth R. Winfrey
Assistant Director

ERW/ng

Harris County American Rescue Plan
Final Report Monitoring Summary and Quality Improvement Plan

Date: 4/25/2023

Prepared for: Martin Negron
Chief Community Services Officer
Community Services Department
Harris County, Texas

Prepared by: Roselyn Ogbonnaya-Odor
Grants Administration and Monitoring Specialist
Witt O'Brien's

Purpose: Final Report Monitoring Summary for the American Rescue Plan Expenditures by Harris County Community Services Department's Permanent Support Housing Program [CCHP 2.0], specifically The Harris Center for Mental Health and IDD Harris County

Description

The Harris Center for Mental Health and Intellectual and Developmental Disabilities (Harris Center) is a subrecipient to the Coalition for the Homeless on the Community Covid Housing program (CCHP 2.0) – Permanent Supportive Housing (PSH). Harris Center's role is to provide comprehensive behavioral health and support services to help up to 300 people who are housed pursuant to the Emergency Voucher Program in the Act, through vouchers allocated to Harris County Housing Authority and the City of Houston, in addition to individuals identified through homeless encampments by the Coalition for the Homeless, housed at the Temporary Navigation Center or housed through The Way Home programs.

Monitoring Process

For this monitoring engagement, Witt O'Brien's monitoring team selected four of the available six invoices for review and from these four invoices, we selected samples from the following line items for review: payroll, travel cost, client supplies, and rent. Supporting documents were obtained to verify the occurrence, eligibility, and cost reasonableness of each expenditure. There are other areas of the program that have not yet been reviewed by WOB as of the final monitoring report date such as verification of employee credentials. These criteria may be addressed during closeout.

Monitoring Summary and Results

Harris Center Response to Interim Report and Monitoring

Harris Center, the program subrecipient, responded to the quality improvements outlined in the Interim Report and the excel spreadsheet titled "Questions – monitoring review". Harris Center's responses to the Interim Report can be found in a document called Harris County Response to Interim report. Responses to most of the requests made in the Interim report were provided but signed and approved timesheets were not provided for the employees sampled. Please see the "Quality Improvement Plan" section below for additional information on outstanding items that will be needed when this program is being closed out.

Community Services Department Response to Interim Report

The Community Services Department (CSD) has submitted a list of beneficiaries from HMIS to substantiate the KPI reporting. They have uploaded documents from HMIS which outline the number of clients served by the Harris Center and the services provided to each beneficiary. CSD also submitted Service Summaries. These summaries are tables that outline the cumulative number of support provided by Harris Center to date. This is a great overview of services provided to the 70 unduplicated individuals and families served by The Harris Center. These reports help to substantiate the performance reporting outline on the KPIs. This is an important the record retention requirement outline in Uniform Guidance. Furthermore, the reports also help outline internal controls by demonstrating how case managers support the beneficiaries and report it on the system of record. Next monitoring cycle, WOB will request documentation to substantiate the services outlined in the summaries which include referrals, general case management, counseling, home visits, follow-ups, and a host of others.

Quality Improvement Plan

Based on Witt O'Brien's review of documentation provided by the Harris Center, our request is to provide documentation requested and responses to questions asked by Witt O'Brien's. Upon our request, Harris Center did submit a Certificate of Insurance and Conflict of Interest. However, they are for a time after the period of performance reviewed by this monitoring. We are requesting these same documents, but for the period associated with the invoices reviewed. We will resubmit the Question - Monitoring Review workbook which the Harris Center did not respond to in their Interim Report response.

Conclusion and Next Steps

Conclusion

The Harris Center staff was responsive and engaging during the monitoring effort and we look forward to working together during the closeout phase of this engagement. As stated previously, the next desk review will focus on documentation to substantiate services provided and internal controls.

Next Steps
This is the final report for this monitoring engagement. The next step is to hand the program over to the Witt O'Brien's closeout team to resolve remaining quality improvements and ensure all documentation needed to close the program is collected. The monitoring team will work closely with closeout staff to ensure the program package is complete and audit ready.

The following is a list of the remaining outstanding quality improvements to be address during Closeout.

Harris Center

1. Certificate of Insurance – insurance document provided covers the period of 9/1/2022 through 9/1/2023. Please provide a copy of the insurance documents for the period of 9/1/2021 through 9/1/2022.
2. A signed conflict of interest certificate – the document provided is dated 12/14/2022. Please provide a copy signed during the period that work was performed.
3. Copies of signed and approved timesheets and other documents listed on the attached spreadsheet, Questions – monitoring review. Please respond on the workbook directly, as well as providing requested documentation.
    a. Things to consider
        i. Timesheet provided were hard to read.
            1. The timesheets provided are not legible.
        ii. Employee# 200401129 has reported 122 hours on their 2022001B paystub and timesheet.
        iii. We need a definition of "High risk diff"
        iv. We would like Harris Center to further discuss the expense provided for shirts
4. Per review of check copies provided as proof of payment for payroll, Witt O'Brien's, noted that staff name and address were visible on check copies. Witt O'Brien's recommends that PII be redacted on documents before sharing with external parties or staff who don't need access to all the information.

Office of County Administration and Community Services Department
Below is a list of items that were identified during the monitoring. These are items for Harris County to consider in future program Federal Programs.

1. On the invoices reviewed, we noted that there is "Admin Cost" which is 10% of the total invoice amount. WOB recommends providing an outline of what is included in the administrative fee during the contracting process.
2. WOB recommends further discussing how the proportion of spending was divided between program partners.
    a. Explain how Harris County's 24% proportion of the program funding was determined.
3. Please provide us with a copy of the County Travel guidelines.
4. Per review of the Interlocal Agreement, it was noted that throughout the contract, reference is made to 24 CFR 570 which applies to HUD funded programs.

BE WELL, TEXAS

Jennifer Battle
The Harris Center for Mental Health and IDD
9401 Southwest Freeway
Houston, TX 77074

Be Well Texas expands access to compassionate, evidence-based treatment and care for substance use disorder throughout Texas.

RE: EXIT CONFERENCE – Be Well Texas Quality Monitoring-Exit Conference

Good day Jennifer Battle,

The Quality Assurance and Performance Improvement (QAPI) team of Be Well Texas would like to thank you for your cooperation during the recently concluded Quality Audit.

Be Well Texas is a partner of The University of Texas Health Science Center at San Antonio

The completed audit tool with our comments is available upon request.

Type of Audit: Desk Review

To reiterate, the department did a thorough review of all documents submitted by cross-referencing them with available resources.

References Used:

1. Statement of Work/ Signed PSA
2. Texas Administrative Code 25Title Chapter 448
3. Reports and other documents submitted to BWTX

Preliminary Findings	Comments	Final Findings	Due Date for Submission of PIP
No Findings for FY23 Audit	NA	No Findings for FY23 Audit	NA

Once again, we reiterate our appreciation for your professionalism and unrelenting support to our programs as our valued partners towards the realization of our mission and vision.

Respectfully,

MARIBEL G. FERNANDO, MPA LVN
Program Manager, Quality Monitoring
fernandom@uthscsa.edu
Be Well Texas
UT Health San Antonio
5109 Medical Drive
San Antonio, Texas 78229

EXHIBIT A-6

Follow-Up: New Hire Drug and TB Testing Process

(FUNEWHIRE0123)

INTERNAL AUDIT REPORT

July 18, 2023

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

Director, Internal Audit

Executive Summary

FOLLOW-UP: NEW HIRE DRUG AND TB TESTING REVIEW (NEWHIRE0123)

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Finding #1 – Internal Audit found one employee hired September 26, 2022 had a background check performed, but had not completed a pre-employment drug and TB test.

Management Response #1 (Director, Talent Acquisition and Organizational Development): "Thank you for your patience – in meeting with my team, below are the dispositions. It would appear that we did in fact have one employee that we cannot locate a drug screen for (Employee #1-SB)."

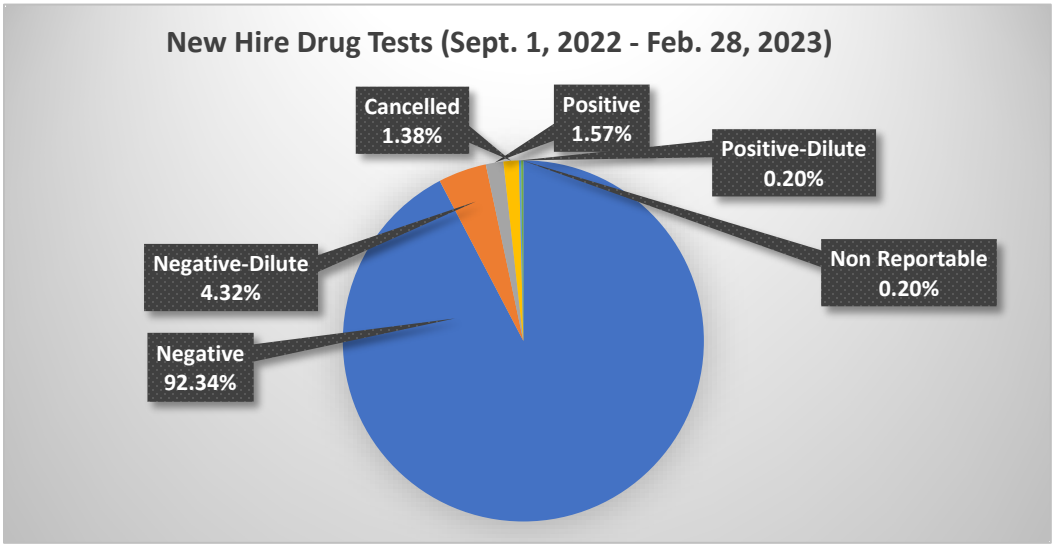
Management Response Update: "Closing the loop on this; [the named] Employee has completed his drug test is clear." *Internal Audit Note: The employee hired on September 26, 2022 completed the drug testing procedure on or about April 20, 2023.*

Observation #1 – Internal Audit obtained a report from Human Resources that shows 521 drug tests were performed between September 1, 2022 and February 28, 2023, which is required as part of the Harris Center's pre-employment testing procedures. This yielded 509 non-duplicated job applicants.

Exhibit I – Breakdown of new hire drug test results, by report result, September 1, 2022 to February 28, 2023

Report Result	Description	Count	% of Total
Negative	Negative for drug use	470	92%
Negative-Dilute	Negative for drug use but specimen appeared diluted	22	4%
Positive	Positive for drug use	8	2%
Cancelled	Test was withdrawn	7	2%
Positive-Dilute	Positive for drug use but specimen appeared diluted	1	0%
Non Reportable	Undefined drug specimen test outcome	1	0%
	Total:	509	100%

Source: "Compare Drug Test applicants to Employee List (Sept. 2022-Febr. 2023)" from NovaHealth/DISA report, April 4, 2023



Source: NOVAHealth/DISA reports, from Human Resources Department, April 2023

Management Response not requested.

TABLE OF CONTENTS

CURRENT PROCESS

This is a follow-up audit review of the Special Management Request established in 2022 to verify that a new employee had been hired but without the completion of the necessary drug and TB testing report. The noted employee was asked to complete the drug and TB testing procedure that yielded a negative results report, which favorably affirmed the employee's compliance with the onboarding process. The lapse of the testing process suggested the Center's administrative failure, not an employee shortcoming.

The Human Resources staff recruiter completes a primary interview with job applicants, which creates the list of qualified candidates who are recommended to the hiring managers for an initial follow-up call. The next step is Human Resources' onboarding process that provides an offer for a position, which if the applicant accepts, is followed by a written chain-of-custody letter. This follow-up letter contains all the specific instructions for the obtaining a drug use specimen test and tuberculosis test.

The Human Resources issues a "chain-of-custody" letter which requires the job applicant to complete a TB test in which a small amount of TB culture is inserted under the skin, which is used to detect the presence of tuberculosis in the body. In some rare cases, the applicant may get a positive outcome through exposure in their health history, for example from a prior work assignment. The Human Resources onboarding contact advised us that positive outcome applicants can submit to a chest x-ray to verify that they are in fact currently free of TB infection, though this is not a common occurrence.

Job applicants with negative outcomes are informed to proceed with the onboarding process, including applicants who receive a "negative-dilute" reading. The Center's practice accepts the "negative-dilute" readings as "negative" outcomes because the test may have suffered minor issues that defaulted to an overall "negative" rating. The majority of "negative-dilute" applicants can pass a subsequent drug test, and last year the Human Resources onboarding contact shared these results with Internal Audit, which shows that several "negative-dilute" applicants tested "negative" in their subsequent follow-up testing.

The pre-employment tests are generally completely performed and reported within 48 hours after the applicant visits the drug testing location. The Harris Center had contracted with the NOVA Healthcare organization in the past to perform the new hire pre-employment drug tests, but now contracts with DISA Inc. who also have numerous testing sites conveniently located throughout Harris County.

The Human Resources staff has improved their onboarding checklist to verify that all the required testing procedures have been undertaken; the Human Resources Department's onboarding contact said that the onboarding process may overlook the full completion of a required test, but this is not usual.

Internal Audit noted that most employees have a single drug test and a TB test performed, so additional tests are not performed, unless they are warranted or specifically requested by the hiring manager. The results of drug specimen tests are retrieved from an agency named DISA, while TB test results are sent separately The Harris Center's Nursing Department and Director of Infection Control. The results are used for the employee's testing records in Kronos and limited to validating that a test was performed.

Human Resources performs a reconciliation of test results to show completion of the applicant's tests. Next, Human Resources establishes a new employee badge and assignment of a pre-numbered parking sticker, required for use in a garage or surface lot location at any Harris Center clinical office location.

SCOPE AND OBJECTIVES

Audit Scope: *This is a follow-up to the New Hire Drug and TB Testing Process for new employees*.

Last year, the Chief Administrative Officer (CAE) had inquired about a newly-hired employee who allegedly was hired without obtaining a pre-employment drug screen and negative tuberculosis test which are both required in the Center's onboarding procedure.

Audit Objectives: The Director of Internal Audit suggested process improvements such as:

1. Distribution of new employee badges only the onboarding staff can verify that is testing was performed and completed by referencing a report created by the testing agency's database.
2. Require a testing date and testing office location code field during the onboarding process to ensure that the onboarding process can affirm that a negative drug test was obtained.

AUDIT RISKS

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

1. Management does not train onboarding process administrators well on how to verify new hire applicants in terms of drug use and tuberculosis status testing as a pre-employment requirement.
2. Management does not oversee the completion of pre-employment checklists to verify that all reported checklist items are reported candidly and confidentially.
3. Management does not maintain adequate record-keeping to certify onboarding meets the minimum hiring standards that are required by The Harris Center.

FIELD WORK

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

1. Meet with the Human Resources contacts in charge of onboarding to review the engagements in pre-employment occurring now, and the onboarding process currently used at The Harris Center.
2. Obtain a sample of the chain-of-custody form provided to applicants that contains instructions about where the applicant can go to obtain the drug specimen and TB pre-employment tests.
3. Review a list of employees hired since December 1, 2022 and compare the hired employee names to applicants listed in a drug testing report to verify outcome (Negative, Negative-Diluted, Positive).
4. Identify if any new hire applicants had undergone and submitted drug usage testing outside Texas, in which case their test results do not transmit to DISA for reporting purposes, so the onboarding process should specify follow-up procedures to obtain the results before hiring.
5. Review the current new hire drug and TB testing procedures checklist and recommend any other process improvements deemed essential for performing improved onboarding results.
6. Contact the Human Resources contacts in charge of onboarding and inquire if any recent applicants rejected submission to the New Hire Drug and TB testing or said they do not agree to the testing.
7. Call Human Resources to obtain drug specimen test history from September 1, 2022 thru February 28, 2023, and compare ratio of outcomes with prior test history (October 2021 thru April 2022).

FINDINGS, OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

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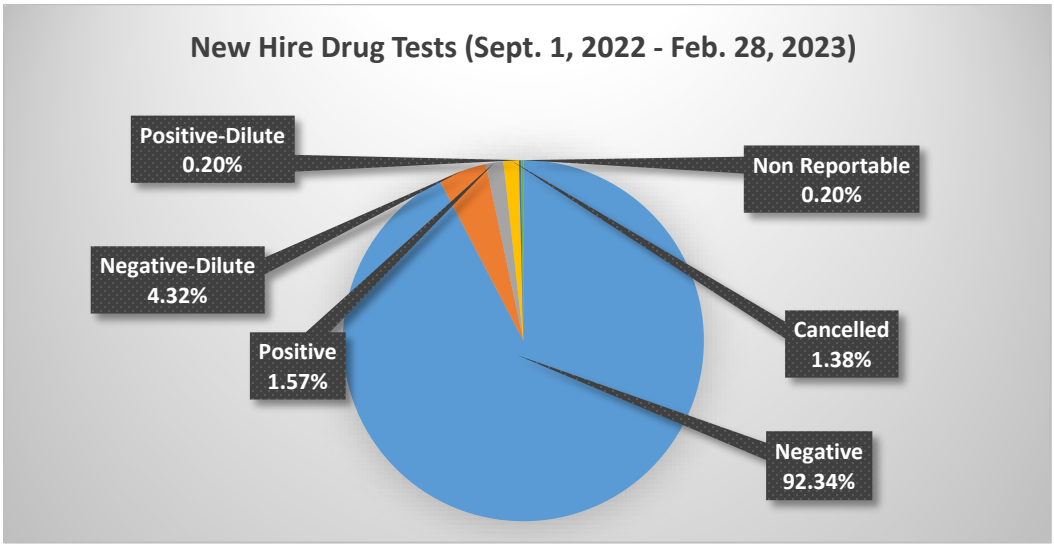

Management Response not requested.

CONCLUSION

Internal Audit believes the current staff in the Center's Human Resources Department are aware of the basic pre-employment testing requirements, and our contacts demonstrated specific knowledge about what it takes to assure quality in processing the onboarding activities for newly-hired employees.

In the Special Management Request report issued last year, we found some issues with the drug testing administrative process, but at the time, the onboarding staffers (who were quite knowledgable) assured Internal Audit that they were putting specific improvements into place, including a "better" checklist of all safeguards and background checks.

In this follow-up report, we found that the current onboarding staff are more knowledgeable about protocols that are required to keep the workplace safe from any issues that might affect the workplace. The Human Resources Department and newly-hired onboarding staff developed the New Hire Checklist to assure that protective procedures are performed consistently on The Harris Center's new applicants.

The Talent Acquisition and Organizational Development unit show the talent and skills for effective recruitment, training, and pre-employment drug testing processes to assure improvements in overall candidate quality, which in turn helps to reduce staff turnover.

The Human Resources Department has undergone reorganization since the Special Management Report was issued last April 2022.

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

SPECIAL MANAGEMENT REQUEST: AGENCY VEHICLE AUCTION SALE PROCESS (SMRAVA0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 - Internal Audit noticed that the Enterprise Leasing procedures include issuing a check for the sales of one or more vehicles, payable to The Harris Center for Mental Health and IDD. However, the actual mailing of the check has been directed to the Transportation Specialist by the Harris Center Mail Room. The Transportation Specialist then forwards the check to Financial Services for posting and processing. From a control standpoint, however, this check should not be routed to the Transportation Specialist because she is the initial actor during the disposition process.

Recommendation: Internal Audit believes the check could be routed to the Attention of the Facility Services Director who can then forward the check to the Transportation Specialist in order to comply with controls over receipt of external payments.

Management Response not required.

Observation #2 – Internal Audit obtained a list of vehicles sold in April, 2022 and compared the auction prices to estimated "Trade-In" values on Carfax.com, using vehicle identification numbers (VIN#s) as reported by the Transportation Department. The vehicles were sold in May and June, 2022.

The Auction Price as Reported in 2022 column totaled $131,231, Internal Audit's research on Carfax.com showed total vehicle trade-in values in 2023 as $114,980, and thus the sales results were $16,251 higher than the expected values found on the Carfax.com website's trade-in calculators in June of 2023.

Exhibit I shows the auction prices versus trade-in values and differences by each of the specific vehicles.

Exhibit I – List of Vehicles on consignment and sold in April, 2022 vs. their estimated trade-in values

#	License Plate #	VIN#	Current Mileage	Year Make & Model	Auction Price as reported in 2022	Trade-In Value on Carfax, June 2023	Valuation Difference
1	DTD0727	1FTVX12538KB54086	198,253	2008 Ford F-150	$2,656.00	$2,770.00	($114.00)
2	DTD0728	1FTVX12558KB54087	137,770	2008 Ford F-150	$1,310.00	$4,490.00	($3,180.00)
3	CBL3002	1FTFX1CF1DKF98895	208,720	2013 Ford F-150	$2,565.00	$4,540.00	($1,975.00)
4	DKM6945	1FTFX1CFXEKD32972	126,432	2014 Ford F-150	$8,285.00	$8,320.00	($35.00)
5	DTD0724	1FTVX12588KB54083	177,940	2008 Ford F-150	$2,810.00	$2,710.00	$100.00
6	BE06888	1GCCS34E388229879	73,990	2008 Colorado PU	$4,535.00	$4,180.00	$355.00
7	6LNCK	1FTNE14W58DB06069	117,865	2008 Ford E-150	$5,310.00	$3,000.00	$2,310.00
8	GTD7335	1GNDM19X03B136804	34,115	2003 Chev Astro	$1,140.00	$5,000.00	($3,860.00)
9	4CKZN	1J8GP28K38W233142	149,451	2008 Jeep Liberty	$815.00	$1,230.00	($415.00)
10	5FMBG	1FMCU0C73CKB71503	133,766	2012 Ford Escape	$1,315.00	$2,940.00	($1,625.00)
11	1FMBP	1FMCU0F79EUA86197	147,092	2014 Ford Escape	$4,705.00	$3,800.00	$905.00
12	4FMBP	1FMCU0F77EUA86196	117,949	2014 Ford Escape	$6,505.00	$4,630.00	$1,875.00
13	3CYKK	1J8GP28KX9W540549	124,437	2009 Jeep Liberty	$1,285.00	$2,620.00	($1,335.00)
14	9GSCF	1FMCU0F72FUB42398	111,371	2015 Ford Escape	$5,855.00	$5,170.00	$685.00
15	7GSCF	1FMCU0F77FUB42400	99,457	2015 Ford Escape	$6,310.00	$7,180.00	($870.00)
16	6GSCF	1FMCU0F79FUB42401	123,619	2015 Ford Escape	$7,005.00	$4,450.00	$2,555.00
17	5GSCF	1FMCU0F70FUB42402	106,173	2015 Ford Escape	$8,855.00	$5,770.00	$3,085.00
18	6GRSB	1FMCU0F7XEUC38360	136,713	2014 Ford Escape	$6,005.00	$3,670.00	$2,335.00

19	3GRSC	1FMCU0F71EUC38361	125,751	2014 Ford Escape	$6,505.00	$4,350.00	$2,155.00
20	8GRSB	1FMCU0F78EUC38356	127,395	2014 Ford Escape	$6,005.00	$4,030.00	$1,975.00
21	4GRSC	1FMCU0F71EUC38358	137,452	2014 Ford Escape	$6,005.00	$3,830.00	$2,175.00
22	CYT2011	1GAHG35U371169132	115,006	2007 Chev 2500	$5,565.00	$4,910.00	$655.00
23	3GSCG	1FBSS31LX8DA58588	37,380	2008 Ford E-350	$13,315.00	$9,400.00	$3,915.00
24	7CKZM	1FBNE31L56DB09500	84,781	2006 Ford E-350	$6,935.00	$5,560.00	$1,375.00
25	4GSCD	1FBNE31L06DB09498	76,099	2006 Ford E-350	$9,635.00	$6,430.00	$3,205.00
				TOTALS:	$131,231.00	$114,980.00	$16,251.00
					$ Difference:	$16,251.00	*Prices are above trade-in prices in most vehicles*
					% Difference:	+14.13%	

Source: "Auction Vehicles 4.22", Transportation Department files, June 2, 2023

Observation #3 – Internal Audit obtained a list of vehicles sold in July, 2022 and compared the auction prices to estimated "Trade-In" values on Carfax.com, using vehicle identification numbers (VIN#s) as reported by the Transportation Department. The vehicles were sold in July and August, 2022.

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Exhibit II shows the auction prices versus trade-in values and differences by each of the specific vehicles.

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2	6GSCD	1FBNE31L96DB20354	76,756	2006 Ford E350 XL	$4,805.00	$7,190.00	($2,385.00)
3	1CYKK	1FBNE31L76DB09501	66,283	2006 Ford E350 XL	$3,355.00	$6,420.00	($3,065.00)
				TOTALS:	$9,820.00	$17,680.00	($7,860.00)
					$ Difference:	($7,860.00)	*Prices are below trade-in prices in most vehicles*
					% Difference:	(44.46%)	

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Observation #4 – Internal Audit obtained a list of vehicles sold in November, 2022 and compared the auction prices to estimated "Trade-In" values on Carfax.com, using vehicle identification numbers (VIN#s) as reported by the Transportation Department. The vehicles were sold in November, 2022.

The Auction Price as Reported in 2022 column totaled $10,285, Internal Audit's research on Carfax.com showed total vehicle trade-in values in 2023 as $10,640, and thus the sales results were $355 lower than the expected values found on the Carfax.com website's trade-in calculators in June of 2023.

Exhibit III shows the auction prices versus trade-in values and differences by one specific vehicle.

Exhibit III – List of Vehicles on consignment and sold in November, 2022 vs. estimated trade-in values

#	License Plate #	VIN#	Current Mileage	Year Make & Model	Auction Price as reported in 2022	Trade-In Value on Carfax, June 2023	Valuation Difference
1	CBL3000	1FTFX1CF3DKF98896	74,915	2013 Ford F-150	$ 10,285.00	$ 10,640.00	($355.00)
				TOTALS:	$10,285.00	$10,640.00	($355.00)
					$ Difference:	($355.00)	*Prices are below trade-in prices in most vehicles*
					% Difference:	(3.34%)	

Source: "Auction Vehicles 11.22", Transportation Department files, June 2, 2023

Special Management Request: Agency Vehicle Auction Sale Process

(SMRAVA0123)

INTERNAL AUDIT REPORT

July 18, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Chief Executive Officer presented this special management request to the Director of Internal Audit recently as several agency owned motor vehicles were to be auctioned off and removed from inventory. The CEO asked Internal Audit to review the written procedure and determine if any of the controls could be hardened to ensure that title transfers are well documented and assure that the sales value of these agency owned vehicles is not diminished by extensive selling periods (that may reduce resale value), or that physical condition or deterioration does not contribute to lower sales prices for these vehicles.

This liquidation of agency-owned motor vehicles began when the Center started its transition to a fleet management program. One of the needs that was identified is that vehicles being retired from inventory would need to be auctioned or sold to a dealership. Enterprise Fleet Management agreed to perform this role to transition the inventory of vehicles, with coordination from the Transportation Department. This process therefore is short-lived and started as early as April 2022, but end sometime in 2025.

Internal Audit noted that each vehicle processed in this transition process is charged $495.00 for a fee that includes the administrative and sales processing charges, but additional transport and towing fees are applied as they are discovered in the vehicle recovery process (from the 9401 garage, for example). Internal Audit reviewed the contract materials and believes the contract terms allows Enterprise to get a reasonable price, but not the necessarily the highest price for a vehicle, and there is no written penalties about how quickly to liquidate a vehicle. Internal Audit found that the negotiated and final sales prices were not always lower than trade-in values we encountered on the Carfax.com website calculator. One possible explanation was the overall shortage of used vehicles at the end of the pandemic period.

in the auction Internal Audit reached out to Financial Services for a copy of the agency vehicle auction procedure and we reached out to the Transportation Department contact responsible for many of the activities for the agency vehicle sales. The Enterprise Lease Management agency is currently managing the fleet program, and the number of leased vehicles has increased to replace agency owned vehicles. Internal Audit expects that the sale of all agency-owned motor vehicles could be completed as early as FY2023, but the Transportation Department contact believes the completion date can run out to 2025.

In June, fifteen (15) agency vehicle transfers were activated. The Harris Center's policy and procedure requires the CEO to sign off on the vehicle titles to initiate the transfer into the auction sales process. The written procedure notes that the Transportation Department contact has access to the vendor's database all the time, but that access may not represent real-time updates nor allow the contact any specific control, knowledge or even approval over the negotiated sales prices in the vehicle's final sale. In summary, we accept the price agreed upon on the sales lot, or later at an auction location. A factor not apparent in the written procedure is the manner in which the Transportation Department contact is notified of specific status changes once these titles have been transferred to the vendor's custody.

It was determined that Internal Audit can review the process to assure that it allows for the contact's reviews, and we assessed if additional steps can be added for more control or oversight in the process. The specific management concern is to assure that agency owned vehicles are not auctioned at too low a price despite their physical condition. Internal Audit can compare transacted priced to one or more of the online website calculators such as Kelley Blue Book or Carfax, but not much else can be performed. Internal Audit called the Enterprise Leasing Management contacts, and we found out that 70% of the vehicles traded into consignment are sold on car lots, 30% sold at auction. The Enterprise contacts stressed that they try to maximize the sales price, and our analysis suggests they meet this sales goal.

The Harris Center's "Agency Vehicle Auction Procedure"

(THIS MATERIAL REPRESENTS WRITTEN PROCEDURES REGARDING LIQUIDATION OF AGENCY VEHICLES THRU ENTERPRISE)

The Harris Center vehicle auction and documentation process is multilevel and involves multiple entities. The time involved, from vehicle pick up to the actual auction, can be up to four months; Jessica Soto, of Transportation Services, is primarily in charge of this process. Enterprise Lease Management is the company the Harris Center contracts with to manage the auction process. Documentation is provided to Fixed Assets after each vehicle is auctioned and payment is received.

The overall process is described in the steps below:

- The decision is made to remove a vehicle from active use and to auction it.
- An Excel spreadsheet is provided to Enterprise to inform them of the vehicles that are ready to be auctioned at the time.
- Enterprise will then provide Transportation Services with a *Consignment Auction Agreement for Sales Customer Owned Vehicles, and Agreement to Sell FM Customer Vehicles forms.*
- Before Jessica Soto sends the prepared documents back to Enterprise, she must have all the titles (of the vehicles to be auctioned) signed off by Wayne Young.
- Once the titles are signed off by Wayne Young, then Todd McCorquodale or Jessica Soto will sign off on all the documents and provide those documents to Enterprise via FED Ex with the titles.
- Enterprise will then schedule for the vehicles to be picked up by multiple vendors (It can take 1-3 weeks to pick up all the vehicles).
- Once Enterprise has scheduled the pickup of vehicles (and they have been picked up), the auction-house vendors start their process to prepare to take the vehicles to the auction.
- *Meanwhile*, once the agency has decided to part with the vehicles (and the initial paperwork has been provided), Transportation Services can access the Enterprise database which contains the list of vehicles to be auctioned (with VIN and other identifying information).
- As the vehicles are auctioned, Enterprise updates its system with ***vehicle sale gains*** (Jessica Soto always has access to that system*).
- The Actual Auction(s) can take up to three months due to scheduling and multiple auction houses involved; all vehicles are not auctioned at the same time (for various reasons such as multiple-auction vendors and various repairs needed before the auction etc.)
- Enterprise provides a payment, in check form, **each time** a vehicle is auctioned.
- Transportation Services provides Fixed Assets for the Paperwork as the vehicles are auctioned and fiscal proceeds have been received.

The documents provided to Fixed Assets are:

- Disposal form (Form D)
- Spreadsheet from the Enterprise database to document the auction(s) and fiscal proceeds from the transaction.
- Memorandum letter (Memo) from Jessica Soto on behalf of the Transportation Services Department listing all the vehicles with a copy of titles to have them removed.

*Michael Hooper and Hayden Hernandez may have access to information

(Note: This written Procedure written by prior CFO, and appears to have been written when Enterprise Lease Management fleet management program had begun in June, 2022, to replace the previous agency-owned vehicle management process.)

SCOPE AND OBJECTIVES

Audit Scope: The Chief Executive Officer submitted request to review the procedures for the process of selling owned motor vehicles that are being retired. The specific request is to assure that vehicles are not being sold at significantly lower prices than market prices would provide.

Audit Objectives: The Chief Financial Officer oversees the vehicle sales process and asked to have Internal Audit review the procedure and auction process for the inclusion of more business controls. This audit is to address several objectives to:

1. Identify the key contacts in the process to determine how well their actions are transparent and possibly can be tightly monitored by the Enterprise Lease Management database tracking system.
2. Develop a process map to show interrelationships between workflows and oversight personnel.
3. Evaluate the potential vulnerabilities of the not being able to track status changes in the transfer processing, or not being able to verify user names, transactions and/or activity histories.

AUDIT RISKS

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

1. Management does not adequately train process owners and other actors on how best to protect the assets that are safeguarded within the current financial workflows at The Harris Center.
2. Management does not adequately review process owners and other actors in terms of tracking transactional activity (transfers, transmittals, etc.) in order to document the department's desired outcomes, which protects the staff from any potential allegations of fraud, waste and abuse.
3. Management does not examine the Center's workflow that includes a contracted firm's service activity in order to adequately identify all actors in the process, including all authorized agents.

FIELD WORK

1. Internal Audit to discuss the workflow with the Transportation Department contact.
2. Obtain current documentation relevant to vehicle liquidation process (such as fixed asset workflow) using spreadsheets of select vehicles offered for sale, and another spreadsheet of any sold vehicles, in order to reconcile for sales reporting of vehicle inventory.
3. Review all Financial Services documentation that outlines controls used in the transfer process and review for any significant issue omissions and opportunities for improvement in control structure.
4. Obtain a list of all signatories in senior management who have current signing authority, and show how documentation is made available to these authorities in the process of vehicle liquidation.
5. Follow how timely updates occur in the vendor database to assure a level of currency and accuracy of database updates, and interview the consignment process contacts at the vendor's organization, and prompt them to learn how the process is working and ask them how it might be improved.
6. Review how vehicles sales proceeds are reported in the Financial Services reporting tools, and verify how such activity may be reported in the monthly financial reports and annual ACFR reports.
7. Perform a reconciliation between the Enterprise Leasing Management database records of the agency-owned vehicles to ascertain that all vehicles reported in the Corporate Radar system have been correctly logged (using VIN# as control point) in the Enterprise database report.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

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CONCLUSION

The Enterprise Lease Management contract includes an agreement to replace all the agency-owned vehicles owned by The Harris Center with leasing fleet vehicles. The disposal process includes taking possession of the vehicles and marketing them in Enterprise sales lots, and ultimately to auto auctions. The transition process began in April 2022 and will likely operate through 2025 due to the shortage of replacement motor vehicles due to the "chip shortage" in the automotive industry. In fact, some vehicle types have been difficult to obtain, and the vehicle replacement cycle takes additional time to complete.

Internal Audit contacted the Transportation Specialist, who is the primary solitary professional who oversees the process and has demonstrated her very diligence in accounting and record-keeping skills. Internal Audit had a short conversation with the primary contacts at Enterprise Lease Management who provided additional service to take custody for selling of the agency-owned vehicles in preparation of replacement with leased vehicles. They demonstrated professionalism in their role and they performed the tasks outlines in the Center's written procedure for the liquidation of these agency-owned vehicles. Internal Audit found that financial workflows can be improved but all control requirements were met.

According to the Financial Services procedure document, the Transportation Department contact has the ability to view the status of vehicles in the consignment database, including the vehicle's pricing. Internal Audit attempted to review the market price using Kelley Blue Book and Carfax.com websites, but specific prices were not cited despite the extensive amount of detail that was requested in the price calculators. Our revised approach to price evaluation was to evaluate how the liquidation vendor sets the prices, and then compare the prices to a number of other third-party used car pricing calculations.

In this current audit, we noted that nearly half of the agency-owned vehicles have been sold by the Enterprise Leasing Management company (as an additional transitional service to leasing customers). The Harris Center entered into the lease agreement in early 2022 but the speed of replacement vehicles has been slowed by a "supply chain" delay issue that began in the COVID-19 pandemic days, specifically the supply of electronic chips, which are routinely used for automobile vehicle manufacture.

Internal Audit viewed the list of vehicles in the process, and we noted that auction prices were not low perhaps because of the shortage of used vehicles, which increased in retail price during the pandemic. The negotiated sales prices were reduced to cover a $495.00 handling fee plus towing charges. Despite the additional charges, most vehicles sold for prices close to or higher than the trade-in values posted by Carfax.com. The Harris Center already consigned 29 vehicles to Enterprise through the end of 2022, and according to The Harris Center's Corporate Radar system (which tracks the fixed assets status), we have 48 more vehicles in inventory, as noted in our review and observations in June of 2023. Internal Audit reconciled vehicles by individual VIN# and noted that all agency-owned vehicles were accurately logged in the Enterprise Leasing Management database report, it was activated in the last week of June, 2023.

Respectfully submitted,

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