The Harris Center for Mental Health and IDD
Transforming Lives

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

Audit Committee Meeting
October 17, 2023
12:00 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, July 18, 2023
(EXHIBIT A-1)

IV. **REVIEW AND TAKE ACTION**

A. FY2024 Compliance Workplan
(EXHIBIT A-2)

V. **REVIEW AND COMMENT**

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

B. Internal Audit FY2023 Q4 Audit Reports
(EXHIBIT A-4 David Fojtik)

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, JULY 18, 2023
MINUTES

Dr. R. Gearing, Committee Chair, called the meeting to order at 12:33 p.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,

Committee Member in Absence: Dr. M. Miller

I. **DECLARATION OF QUORUM**

Dr. Gearing called the meeting to order at 12:33 p.m. noting that a quorum was present.

II. PUBLIC COMMENTS

There were no requests for Public Comment.

III. MINUTES

Approval of Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, May 23, 2023

MOTION: SANTOS SECOND: MOORE

THEREFORE, BE IT RESOLVED that the Minutes of the Board of Trustees Audit Committee Meeting Held on Tuesday, May 23, 2023 as presented under Exhibit A-1, is approved, and recommended to the Full Board for acceptance.

IV. REVIEW AND TAKE ACTION

A. FY24 Internal Audit Plan

MOTION: WOMACK SECOND: SANTOS

THEREFORE, BE IT RESOLVED that the FY24 Internal Audit Plan as presented under Exhibit A-2, is approved, and recommended to the Full Board for acceptance.

V. REVIEW AND COMMENT

A. Internal Audit Report, presented by David Fojtik and included in the July 18, 2023, Audit Agenda Packet under Exhibit A-3.
B. Compliance Department Report, presented by Demetria Martin and included in the July 18, 2023, Audit Agenda Packet under Exhibit A-4.

VI. EXECUTIVE SESSION

There was no Executive Session during the Audit Committee Meeting.

VII. ADJOURN-

MOTION: SANTOS **SECOND: MOORE**
With unanimous affirmative vote
BE IT RESOLVED The meeting was adjourned at 1:10 p.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

Compliance Department

FY24 Work Plan

Presented by: Demetria Luckett, Compliance Director

October 2023

FY 2024 Work Plan

September 2023-August 2024

How We Plan Our Work

We assess relative risks within The Harris Center to identify those areas most in need of attention. Audits and Reviews may be cancelled based on staff availability, changes in the environment, legislation that substantially affects the issue, or similar recent studies that provided definitive results.

Mandatory requirements for Compliance's reviews, as set forth in laws, regulations, or other directives;requests made or concerns raised by Texas Health and Human Services, Office of Inspector General, CARF, top management and performance challenges facing The Harris Center; work performed by other oversight organizations, management's actions to implement Compliance's recommendations from previous reviews; and potential for positive impact.

FY 2024 Work Plan

September 2023-August 2024

Audit Type	Total Number	Total Hours
Billing and Coding Audits (80 Hours per Audit)	10	800
Follow-up Reviews(40 Hours per Audit)	13	520
Comprehensive Reviews (80 Hours per Audit)	44	3520
Operational Reviews (60 Hours per Audit)	4	240
Program Self-Monitoring Reviews (30 Hours Per Review)	4	120
External Audits	1	NA

2023

CORPORATE COMPLIANCE & ETHICS WEEK

November 5–11

We're celebrating Corporate Compliance & Ethics Week

SCCE HCCA

Learn more

Thank you.

EXHIBIT A-3

Compliance Department

FY23 Q4 Audit Reports

Presented by: Demetria Luckett, Compliance Director
October 2023

Summary of Audits Completed

Reporting Period: June 2023 – August 2023

Five (5) Focus Reviews:

1. Mental Health Southeast Community Service Center (SECSC) Plan of Care/Progress Note Review
2. Home and Community-Based Services (HCS) Corrective Action Plan (CAP) Follow-up Review
3. Enhanced Community Coordination (ECC)/ Pre-Admission Screening and Resident Review (PASRR) Corrective Action Plan (CAP) Follow-up Review
4. General Revenue (GR)/Community First Choice (CFC) Corrective Action Plan (CAP) Follow-up Review
5. Texas Home Living (TxHmL) Corrective Action Plan (CAP) Follow-up Review

Summary of Audits Completed

Reporting Period: June 2023 – August 2023

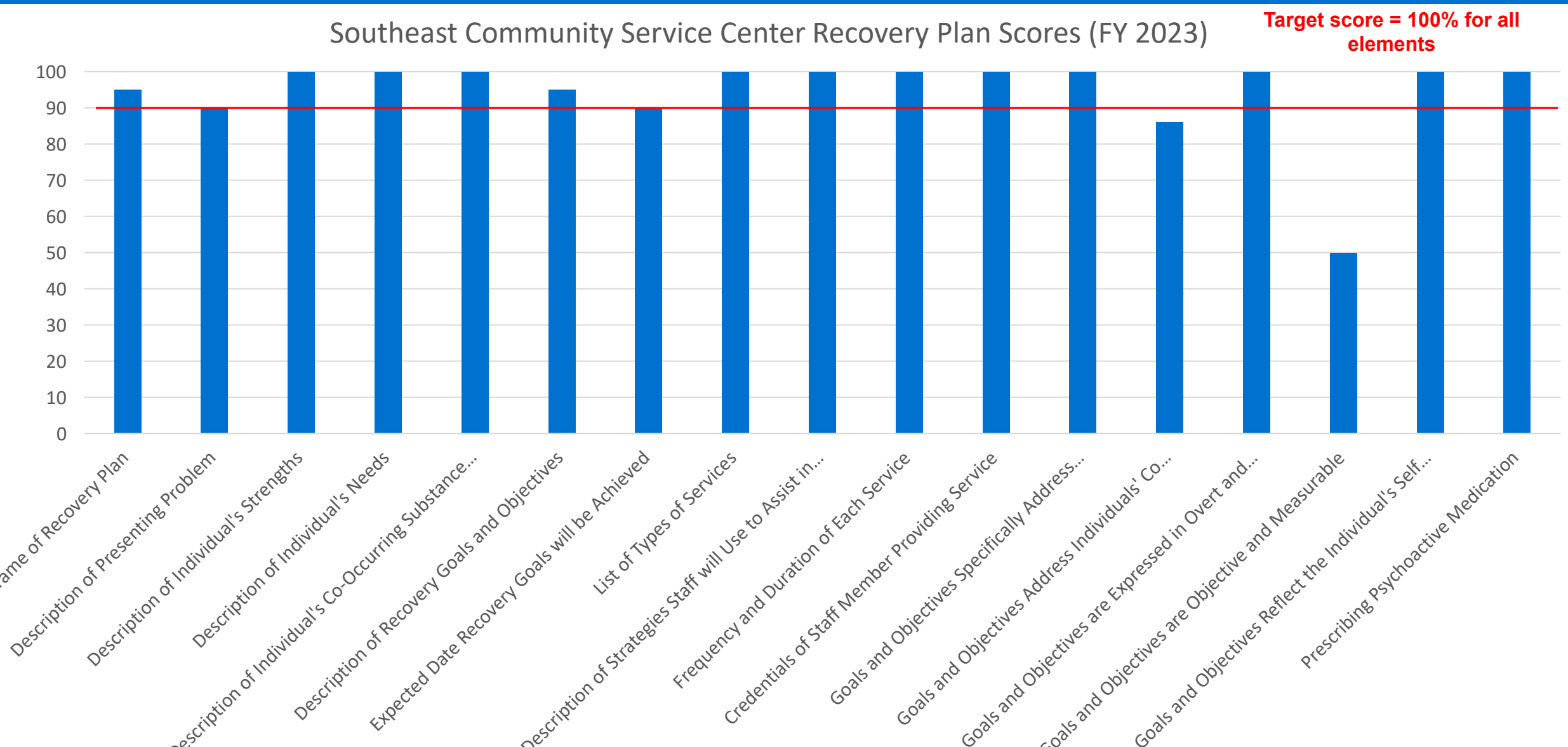
Operational Reviews continued:

6. Cornerstone Family Resource Center Potential Provider Operational Review
7. Mental Health (MH) Division Operational Review
8. Comprehensive Psychiatric Emergency Program (CPEP) Division Operational Review
9. Intellectual Developmental Disability (IDD) Division Operational Review

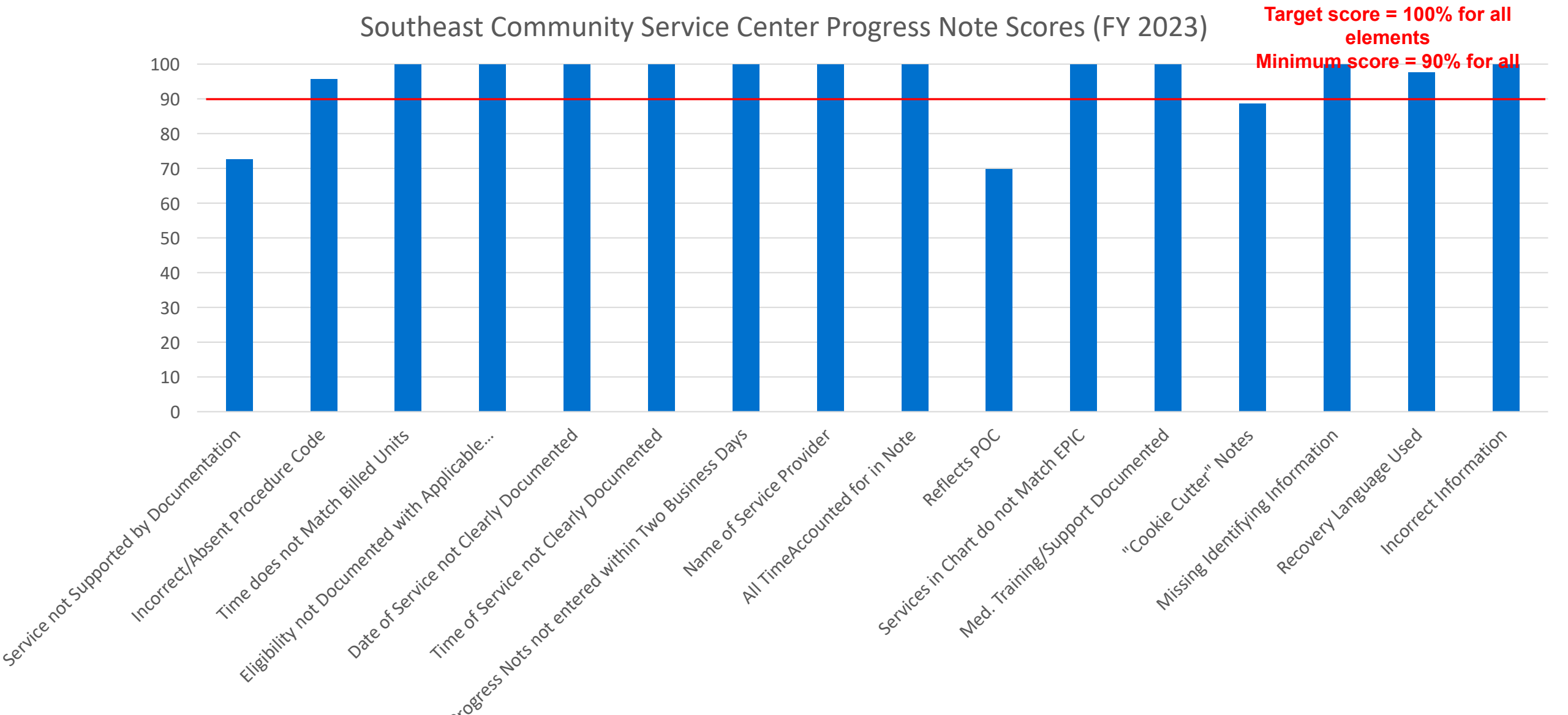
One (1) Comprehensive Review:

10. Comprehensive Psychiatric Emergency Program (CPEP) Hospital to Home

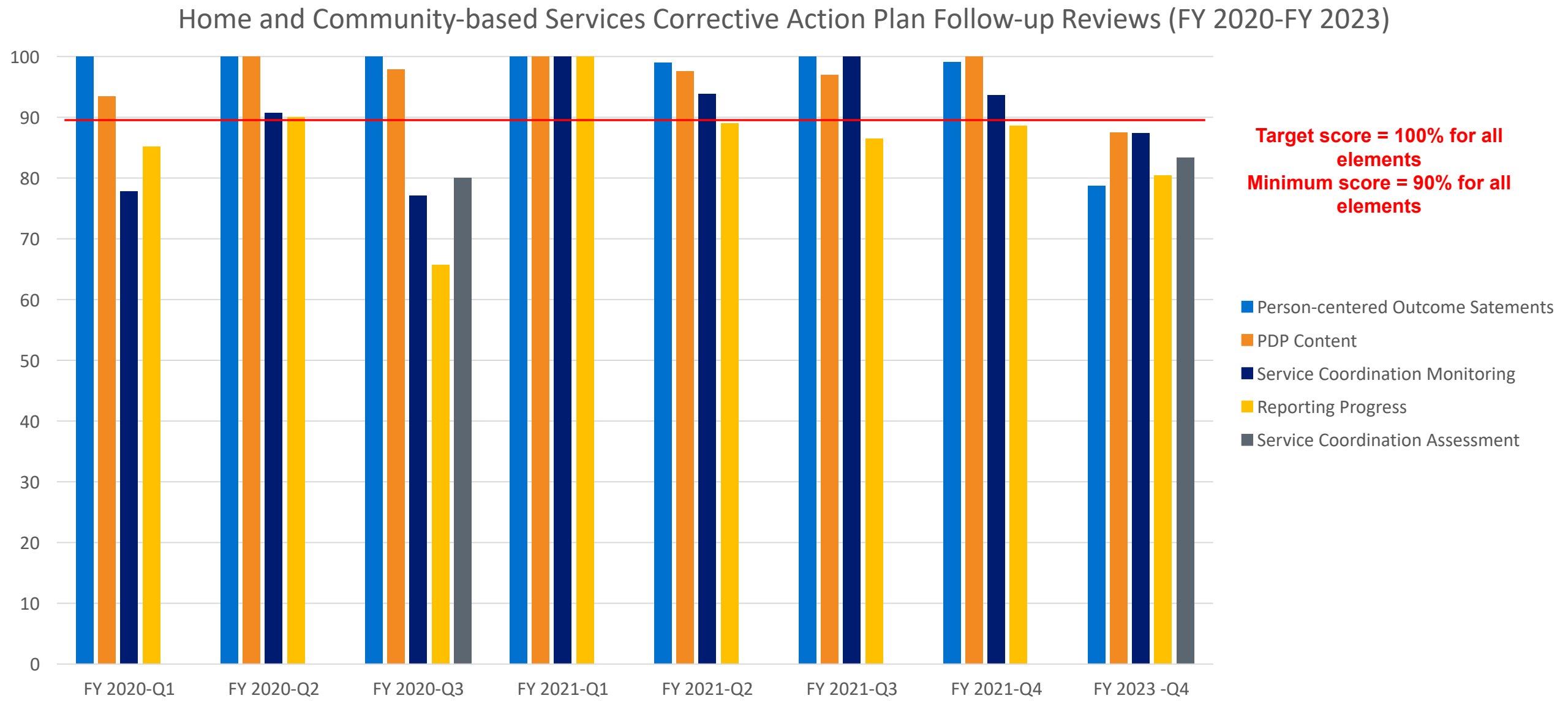
Q4 Key Compliance Take-Aways



Q4 Key Compliance Take-Aways



Q4 Key Compliance Take-Aways



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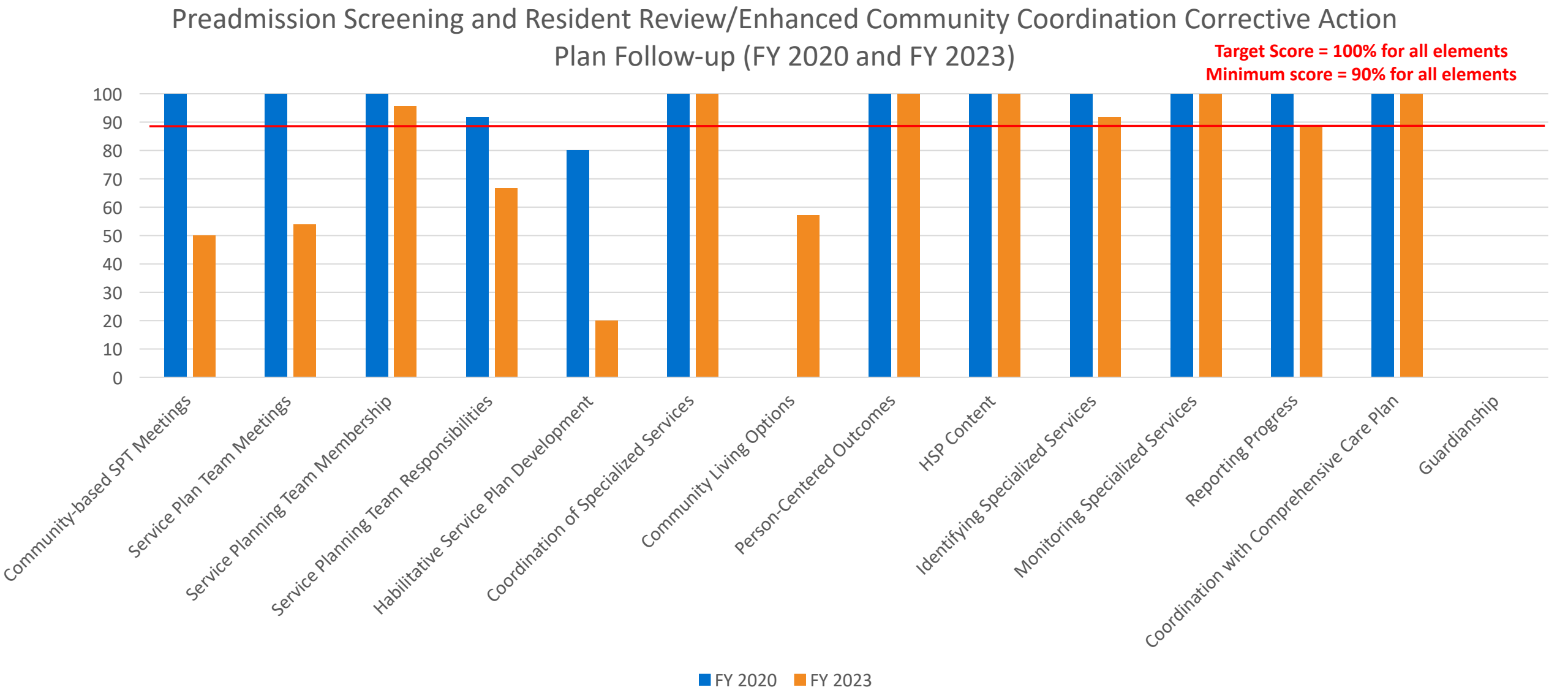

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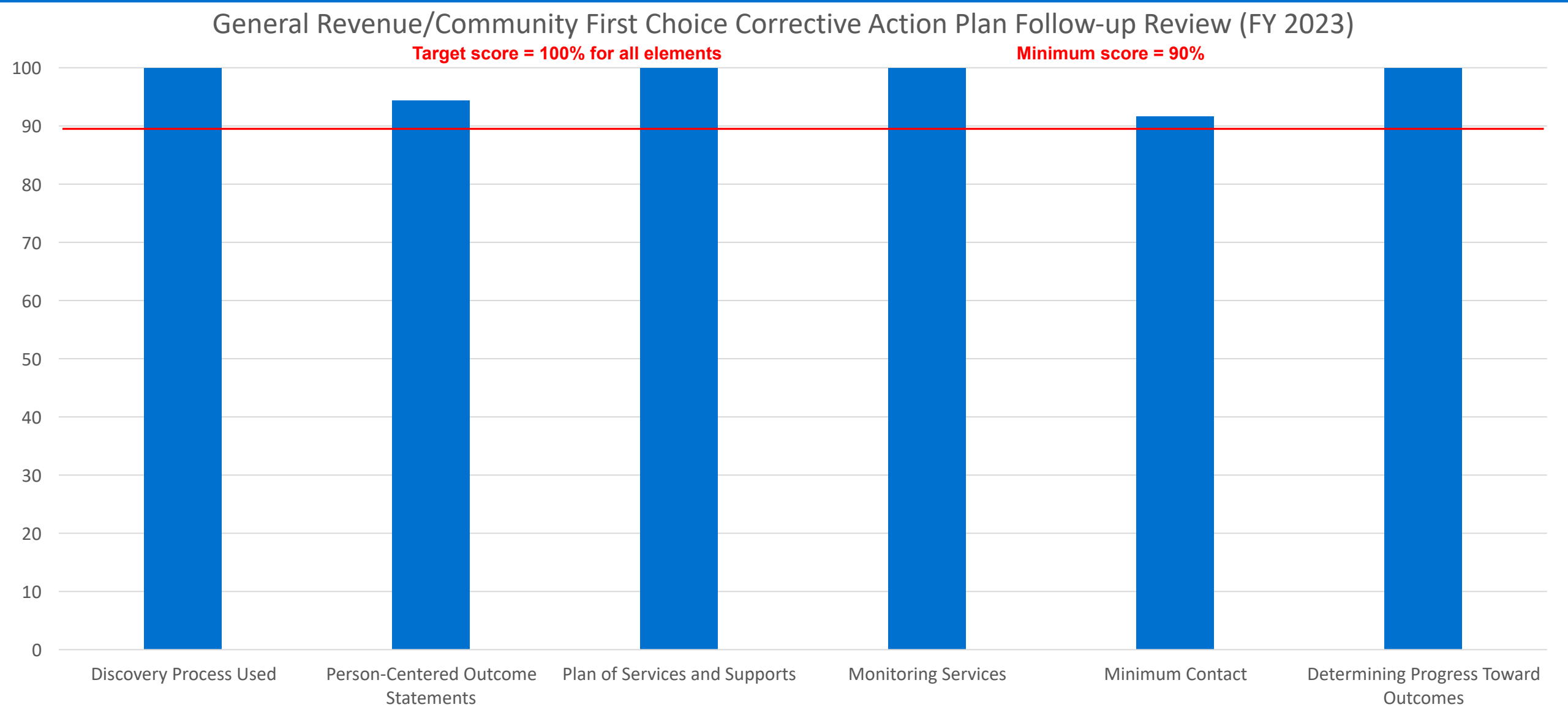

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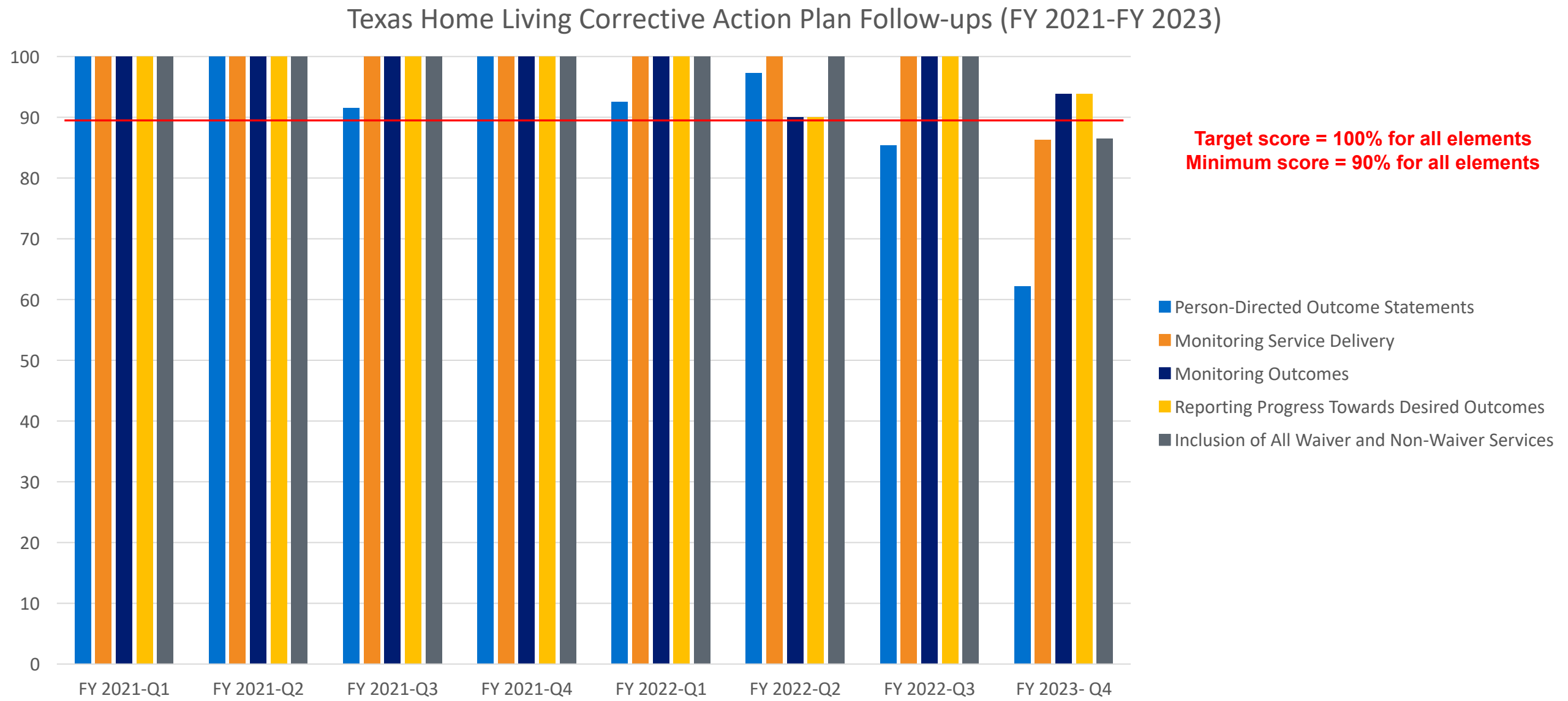

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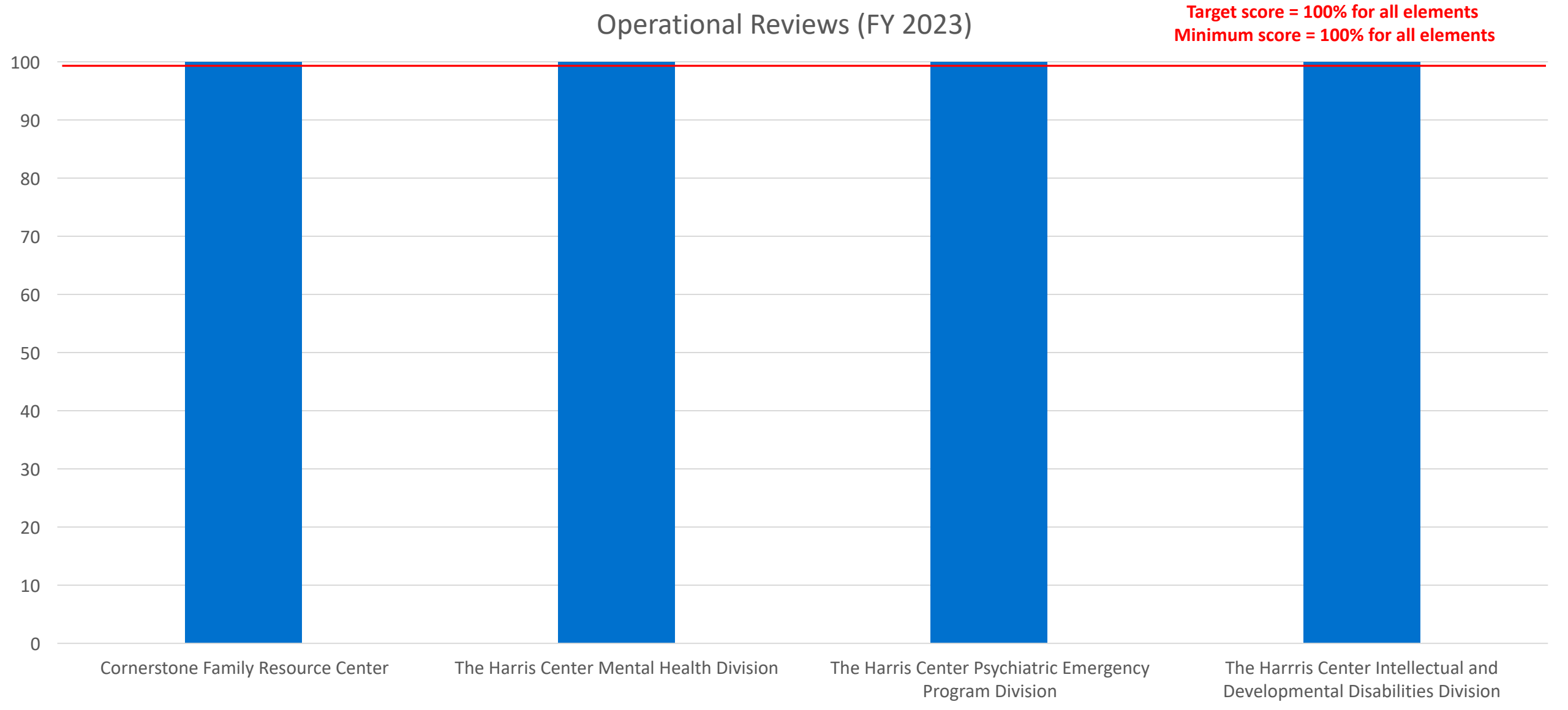
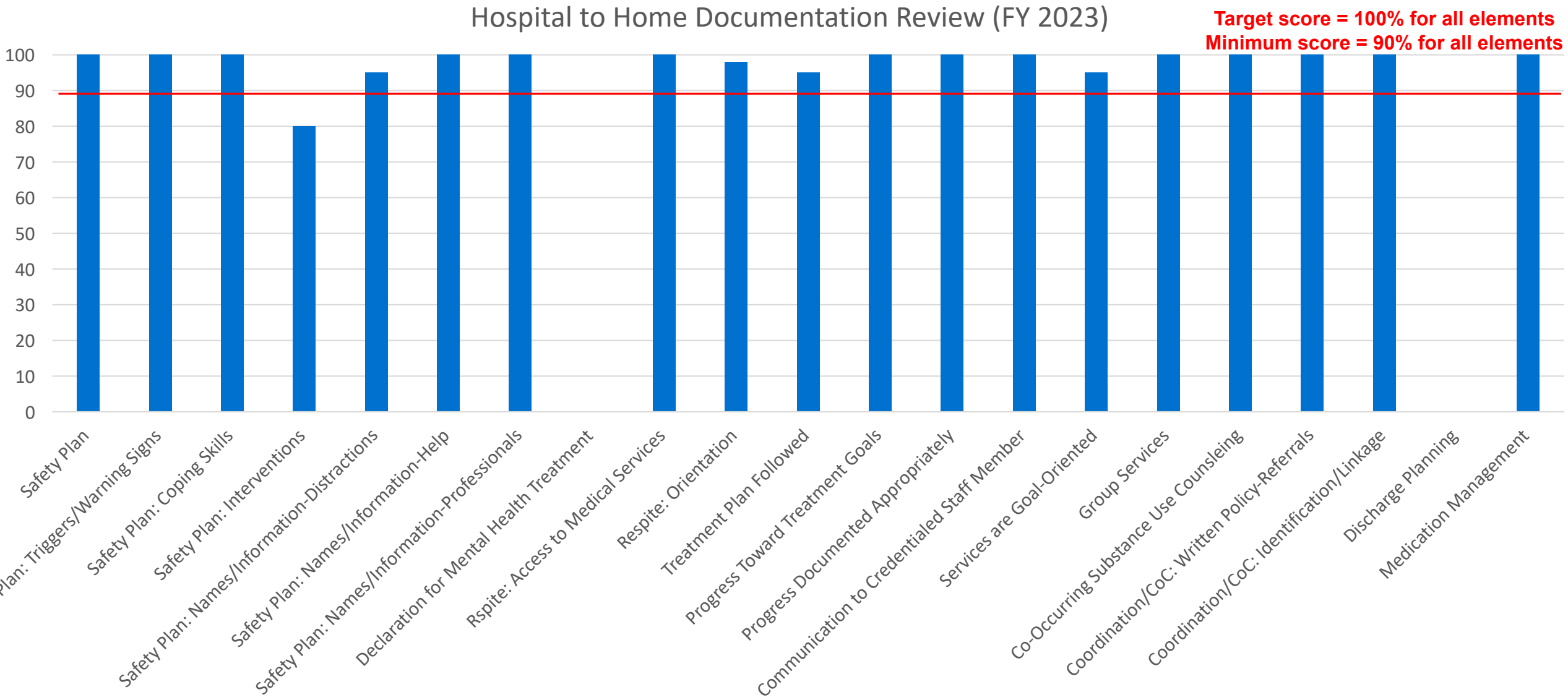


Q4 Key Compliance Take-Aways



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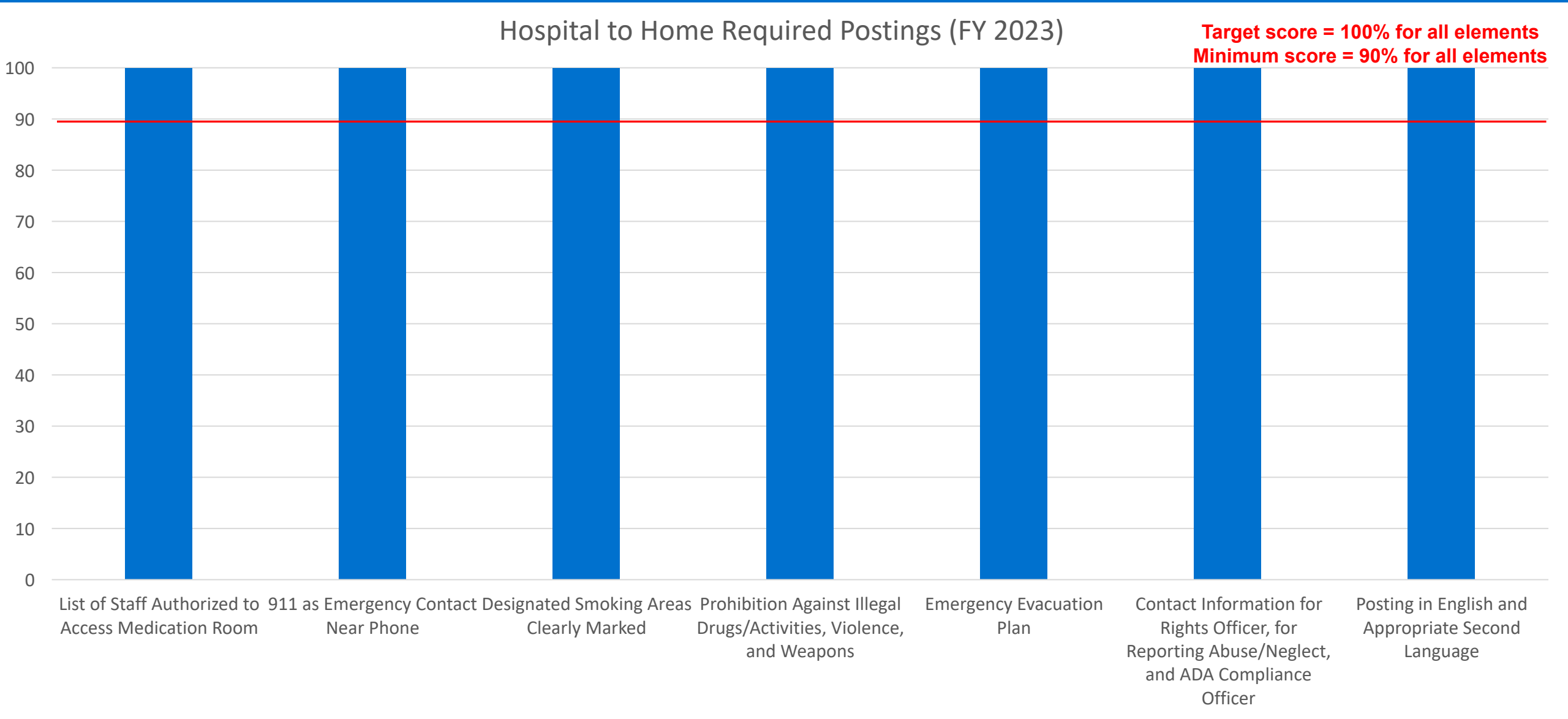
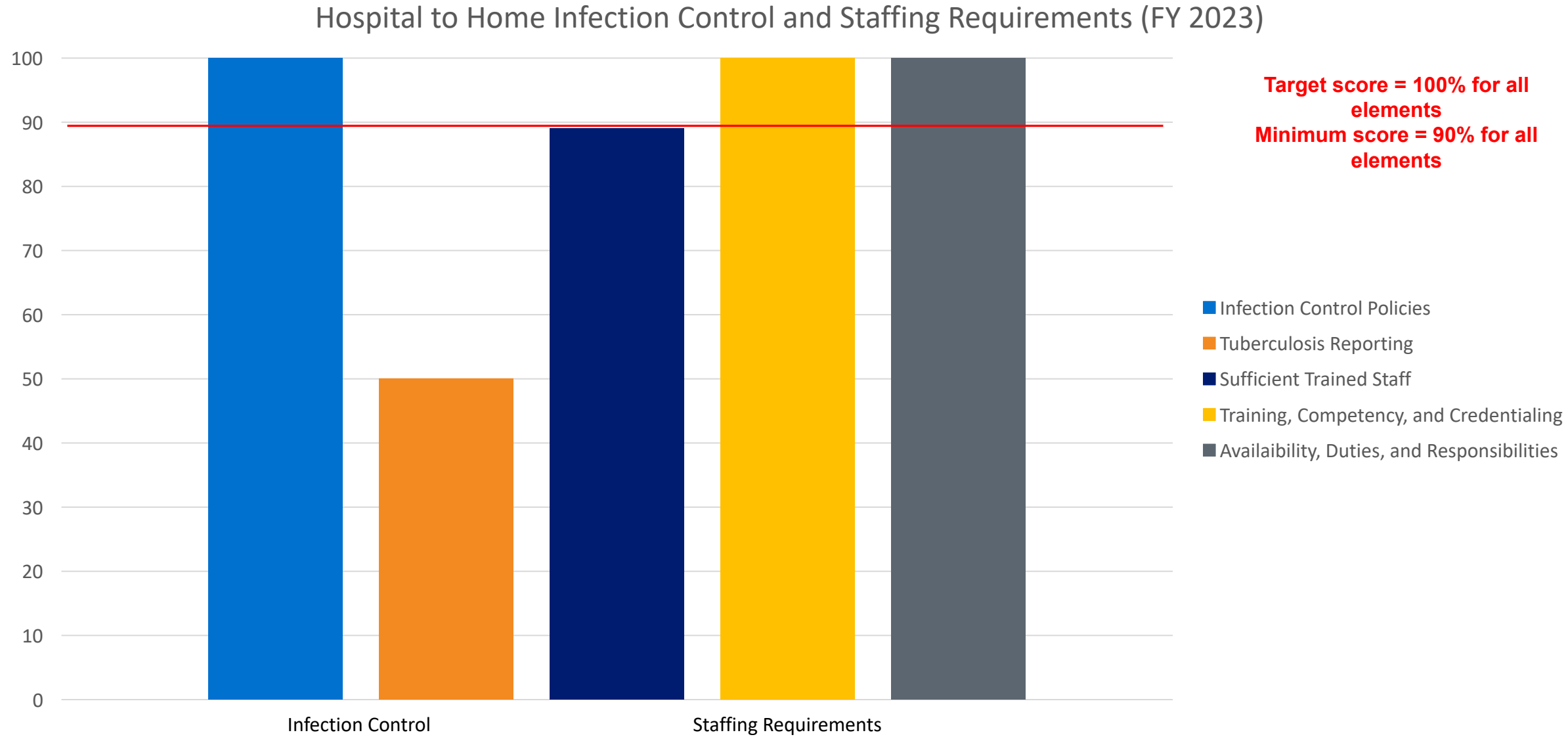
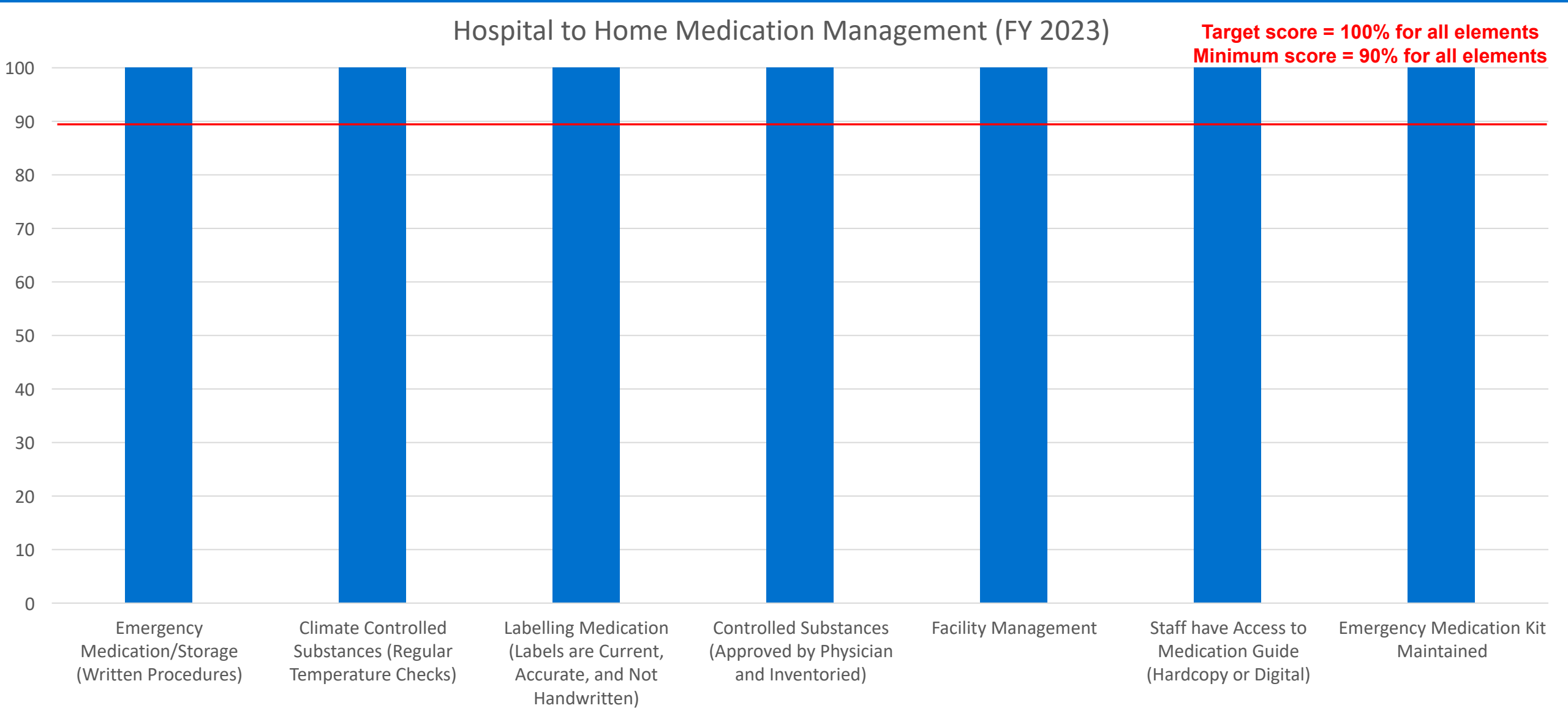


Q4 Key Compliance Take-Aways



Q4 Key Compliance Take-Aways



External Reviews FY 2023 Qtr. 4

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

1. Ciox Health Records Request for Amerigroup 6/7/2023
2. BHS Quality Management 280 FY22 Comp CAP Response SU Approved
3. Suicide Care Initiative (SCI) Site Visit Final Report
4. CIOX Health Records Request for Amerigroup (3) Medicare Risk Adjustment Review 8/23/2023
5. HHSC FY23 Compliance Review Corrective Action Plan (CAP) Approval
6. CIOX Health Records Request Review Cigna 8/25/2023
7. CIOX Health Records Request for Medicare Risk Adjustment Review on behalf of Oscar, Devoted Health, and WellCare clients. 8/28/2023
8. CIOX Health Records Request for Medicare Risk Adjustment Review on behalf of Humana 8/29/2023

Thank you.

EXHIBIT A-4

FY2023 Q4 Audits

Internal Audit Department

David W. Fojtik, CPA, MBA, CIA, CFE
October 17, 2023

FY2023 4th Quarter Reports

Agenda:

Projects to be presented:

- Pharmacy Operations and Inventory Audit (Pharmacy)
- Special Audit Request: Travel Reimbursement Audit (Financial Services)
- Special Audit Request: Fleet Management Audit (Financial Services)
- Status Report: COVID-19 OSAR Reimbursement Program Grant (AMH)
- New Fraud Hotline Reporting Services
- FY2023 Year-End Report – Key Accomplishments

FY2023 4th Quarter Reports

The Audit Terms Observations and Findings Defined:

Internal Audit researched the Audit Terms Observations and Findings for Definitions.
From Jason Fuqua at CBIZ, who performed our recent Quality Assurance Review in 2022:

The current Institute of Internal Auditors (IIA) Standards glossary does not include either term.

The IIA Textbook defines an observation as “A finding, determination, or judgment derived from the internal auditor’s test results from an assurance or consulting engagement.”

The IIA is working on publishing new standards and the new glossary will have some updates. I will review the IIA standards when they are released for additional guidance regarding formal definitions for Observations and Findings.

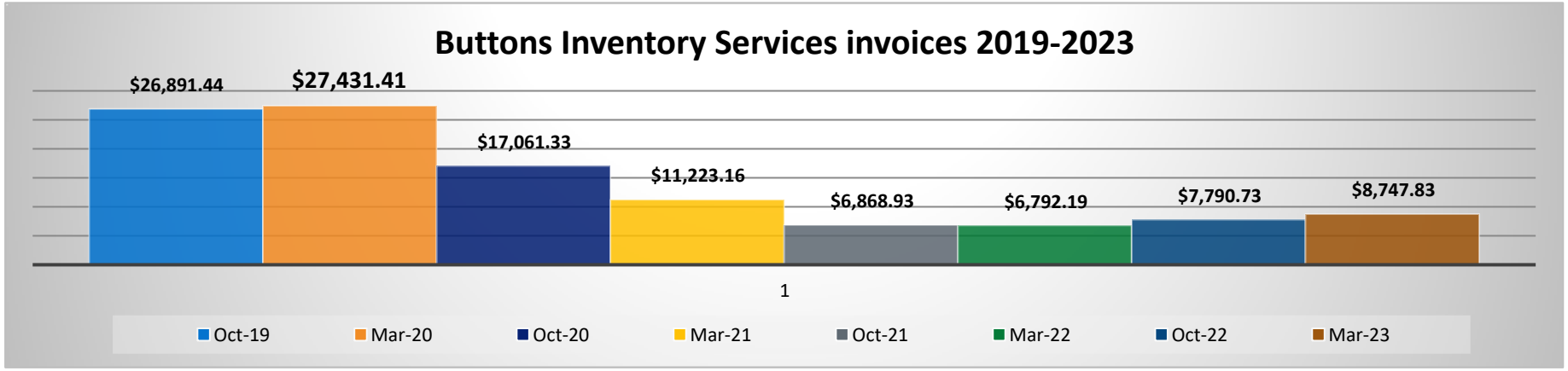
Without formal official definitions, the audit profession regards an Observation as something of note that is informally reported, whereas a Finding is an issue that needs to be included in the report for correction.

FY2023 4th Quarter Reports

Pharmacy Operations and Inventory Audit:

Observation #1 – Internal Audit found that all Pharmacy policies and procedures have been updated and are now easily accessible by employees using the PolicyStat folders on The Harris Center's intranet site.

Observation #2 – Internal Audit noted the invoiced amounts from the Buttons Inventory Service have decreased sharply since the March 2020 invoice. The counts are performed in October and March, as was requested by the Board several years ago. Per Angie Babin, the Senior Director of the Pharmacy Program, "the service charges of the Buttons Inventory Service audits are based on the value of the inventory being counted, so as the inventory values have dropped, so do the inventory audit service charges".



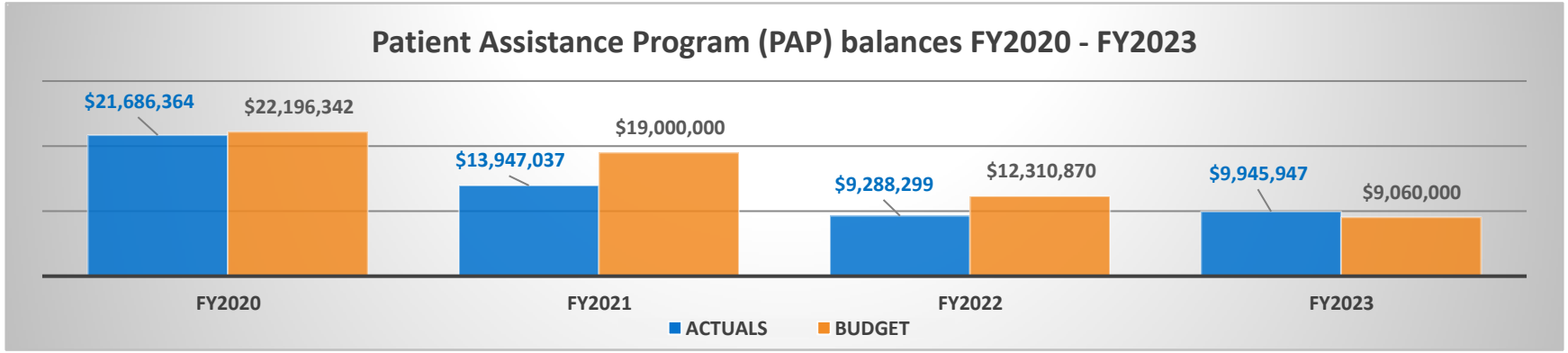
FY2023 4th Quarter Reports

Pharmacy Operations and Inventory Audit:

Observation #3 – Internal Audit noted the Patient Assistance Program FY2022 year-end Actuals per the 2021 and 2022 Annual Comprehensive Financial Reports (ACFRs) have decreased from $13.9 million to $9.3 million, representing a decrease of -$4.7 million, or about -33.4%.

The PAP FY2023 year-end valuations per the Trending Report shows Actuals increased to $9.9 million.

Per Angie Babin, the Senior Director of the Pharmacy Program, “the value of the PAP program continues to fall as medications evolve all the time and overall medication valuations have been falling.”

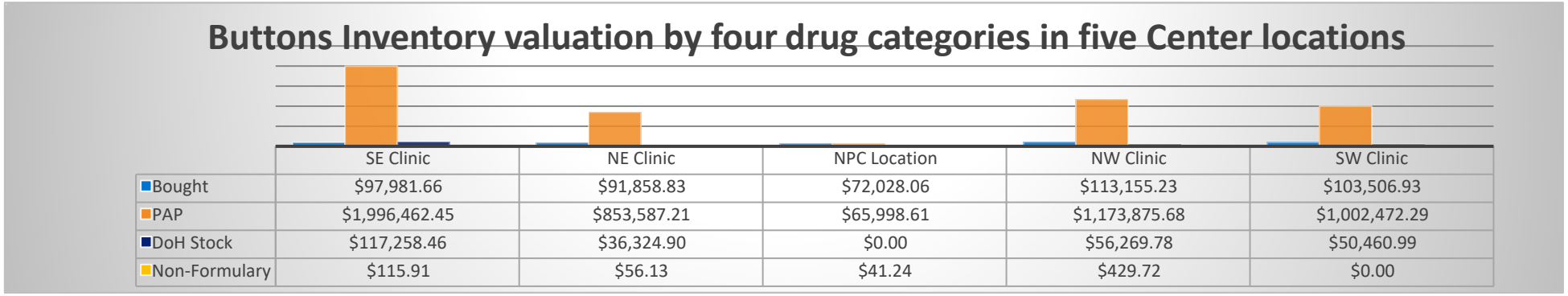


FY2023 4th Quarter Reports

Pharmacy Operations and Inventory Audit:

Observation #4 – Internal Audit noted the Patient Assistance Program (PAP) inventory items are the largest category of items compared with bought stock, Dispensary of Hope (DoH), and non-formularies. These values are based on the hand-count of items performed at pharmacy locations on March 1, 2023.

We noted that PAP item valuations generally represented 85% to 90% of the total inventory value in most of the locations, except for the Neuro Psychiatric Center (NPC), based on its own business model. Per Angie Babin, the Senior Director of the Pharmacy Program, “since patients enroll in the PAP program based on income eligibility, the process is time-consuming and not suited for delivering treatment for the NPC patients, who typically arrive there in severe crisis.”



	SE Clinic	NE Clinic	NPC Location	NW Clinic	SW Clinic
Bought	$97,981.66	$91,858.83	$72,028.06	$113,155.23	$103,506.93
PAP	$1,996,462.45	$853,587.21	$65,998.61	$1,173,875.68	$1,002,472.29
DoH Stock	$117,258.46	$36,324.90	$0.00	$56,269.78	$50,460.99
Non-Formulary	$115.91	$56.13	$41.24	$429.72	$0.00

FY2023 4th Quarter Reports

Special Audit Request: Travel Reimbursement Audit:

Observation #1 – Internal Audit reviewed an ad-hoc travel report for January 2023, and we found that 8.04% of the paid travel reimbursements for the 1st trip of the day were from the employee's reported home address, going back to the employee's home address for lunch, and returning to the employee's home at the end of the day. We compared reported miles in other months: the ratio was 6.24% in October 2022, and 8.63% in April, 2023.

Internal Audit examined Travel Policy FM18A (effective 11/2022) which states: "mileage will be calculated based on distance from main place of employment to travel destination or client site." NOTE - If the employee's home address is identified as their main place of employment, the mileage incurred and reimbursed for the 1st trip of the day to a consumer or other travel destination is correctly calculated. The current online travel reporting system does not track commute miles which are not reimbursable per IRS regulations, however the policy calls for making such calculations.

Internal Audit also evaluated Section G in the FM18B Travel Reimbursements Policy (effective 05/2022) which described a methodology for calculating mileage from the employee's home to the 1st destination as "mileage to the 1st destination minus the mileage from home to their assigned HQ" as per IRS guidelines.

Internal Audit observed that the bulk of the reimbursed miles (90%+) are compliant with the current travel policies and procedures. Internal Audit recommends 1) that management revise the travel policies to use similar language in both policies and 2) provide additional training to assist employees in correctly reporting their monthly travel mileage.

FY2023 4th Quarter Reports

Special Audit Request: Fleet Management Audit:

Observation #1 – In FY2022, the combined costs of operating agency-owned vehicles were $325,165.80. The Enterprise Fleet Management invoices totaled $422,628.45 through August 31, 2022. Therefore, the combined costs of agency-owned vehicles and leased vehicles totaled $747,794.25.

	FY2022	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
Vehicle (Purch,Rent,Maint)	559000	VEHICLE REPAIR/MAINT.	$159.462.13		
	559001	GASOLINE PURCHASES	$156.174.80		
	559002	VEHICLE REPAIRS (ROUTINE)	$9.528.87		
	559091	TRANSPORTATION USE FEE			FY2022
	560000	VEHICLE PURCHASE			ENTERPRISE FM
	561000	VEHICLE RENT			Invoices thru 8/31/22
	FY2022	Total Vehicle (Purch,Rent,Maint)	$325.165.80	B	$422,628.45
			C	TOTAL:	$747,794.25

Source: Financial Services, online Trending Report and Purchase Order Report, at year-end August 31, 2022.

FY2023 4th Quarter Reports

Special Audit Request: Fleet Management Audit:

Observation #2 – In FY2023, the combined costs of agency-owned vehicles totaled $567,578.47, and included vehicle purchases of $250,589.00. The Enterprise Fleet Management invoices totaled $564,430.57. The combined costs of agency-owned and leased vehicles totaled $1,132,009.04.

ACTUAL	FY2023	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
	559000	VEHICLE REPAIR/MAINT.	$167,719.61		
	559001	GASOLINE PURCHASES	$138.755.70		
Vehicle	559002	VEHICLE REPAIRS (ROUTINE)	$10.514.16		FY2023
(Purch,Rent,Maint)	560000	VEHICLE PURCHASE	$250.589.00		ENTERPRISE FM
	561000	VEHICLE RENT			Invoices thru 8/31/23
	FY2023	Total Vehicle (Purch,Rent,Maint)	$567,578.47	A	$564,430.57
			D	TOTAL:	$1,132,009.04

Source: Financial Services, online Trending Report and Purchase Order Review Report, at year-end August 31, 2023.

Included in FY 2023 is the purchase of a Primary Care Van for $250,589.00.

FY2023 4th Quarter Reports

Status Report: COVID-19 OSAR Reimbursement Program Grant:

Observation #1 – Internal Audit collaborated with the Harris Center's Director of Mental Health Projects and Harris Center's Controller on a review process for reviewing reimbursement payments to local OSAR providers.

We used COVID-19 program grant eligibility rules from Texas Department of Health and Human Services (HHSC) documentation and established a working relationship with the HHSC staff and the local OSAR provider called The Council on Recovery. Providers were required to show sales receipts of eligible purchases, and in several instances the review team disallowed reimbursement claims for Amazon shipping or other overnight fees.

In FY2022 and FY2023, the COVID-19 OSAR Reimbursement Program Grant paid out $574,950.40 to OSAR providers in HHSC Region 6 who incurred increased incremental costs in the COVID-19 pandemic period.

The grant ended on August 31, 2023.

FY2023 4th Quarter Reports

New Fraud Hotline Reporting Service:

- As of June 2023, Internal Audit has partnered with a new confidential external hotline fraud reporting service which replaces the prior reporting service. The new hotline service, called Fraud HotLine (www.fraudhl.com), allows users to self-report any fraud, waste, or abuse potential issues 24 hours a day, 365 days a year.
- The service is low-cost ($250 per year) and includes live operator support and an online portal to submit reports confidentially. Users can review report status on the Fraud Hotline website using assigned ReportID.
- The Fraud Hotline contact information will be circulated online on the Center's Harrisphere intranet, and promoted on Fraud Hotline posters that are prominently placed throughout The Harris Center's offices. The printed poster includes a QR code which employees can scan using any personal or agency cell telephone.
- The fraud awareness campaign will continue in observance of International Fraud Awareness Week, November 12 – 18, 2023.

FY2023 4th Quarter Reports

New Fraud Hotline Reporting Service (cont'd):

FY2023 4th Quarter Reports

FY2023 Year-End Report – Key Activities and Accomplishments:

- Internal Audit completed a risk assessment of The Harris Center's key auditable entities in preparing the collection of projects that were listed on the Fiscal Year 2023 Audit Plan. The risk assessment was completed based on input from the Board of Trustees, Senior Management, and Internal Audit's risk assessment tool.
- Internal Audit completed seven (7) Board-approved internal audit projects.
- Internal Audit completed five (5) special audit requests (SARs) and priority special management requests (SMRs) to report on special issues and performed follow-up audits on two (2) Fiscal Year 2022 projects.
- Continued to integrate data analysis and other online tools in order to review complete sets of business data versus traditional sampling tools. This provides management with greater assurance of complete review and includes evaluation of anomalies in the data workflow that can strongly confirm fraudulent activity.
- The entire FY 2023 Year-End Report is presented in the Internal Audit Report Binder.

Questions

EXHIBIT A-5

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: June 1, 2023, through August 31, 2023.

Presenter: Demetria Luckett, Compliance Director

Explanation of Reviews:
The following types of reviews were conducted by Compliance during the 4th 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.

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

Nine (9) Focus Reviews were conducted during the reporting period to ensure regulatory compliance in the following areas: Plan of Care/Progress Note, Operational Reviews, and Corrective Action Plan (CAP).

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

- Southeast Community Service Center (SECSC)

Four (4) Operational Reviews were conducted in accordance with The Compliance Department's Audit Schedule.

- Cornerstone Family Resource Center
- Mental Health (MH) Programs
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intellectual and Developmental Disabilities (IDD) Programs

Four (4) Corrective Action Plan (CAP) Reviews were conducted in accordance with The Compliance Department's Audit Schedule.

- Home and Community Based-Services (HCS)
- Enhanced Community Coordination (ECC)/Pre-Admission Screening and Resident Review (PASRR)
- General Revenue (GR)/Community First Choice (CFC)
- Texas Home Living (TxHmL)

Comprehensive 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 contribute to the number of records reviewed.

One (1) Comprehensive review was conducted to ensure the program complies with Health and Human Services (HHS) Item V: Crisis Respite Services and program guidelines. The following program was reviewed:

- CPEP: Hospital to Home

Other Compliance Activities:

Training/Meeting:

- June 2, 2023: Compliance Staff Meeting (Held weekly unless notified otherwise)
- July 19, 2023: Continuing Medical Education (CME) Ethics: Navigating Healthcare Compliance
- August 9, 2023: Texas Council Risk Management Fund (TCRMF) - Office of Inspector General (OIG) Audits of Community Centers
- Bi-Weekly Policy Stat Meeting (Ongoing)

Other Responsibilities:

- Epic Deficiency Tracking (Ongoing)
- Maintenance of The Harris Center's policy and procedure process and platform (Ongoing)
- Quarterly Tracking of Programs Self-Monitoring (Ongoing)

Q4 Audit Report Summary:

The chart below identifies the reviews conducted by Compliance for Q4 of FY 2023:

Key Takeaways

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
Southeast Community Service Center Plan of Care/Progress Note Focus Review	06/08/2023	06/23/2023	• Treatment plan objectives were not the focus of the service. • A description of the presenting problem was not documented in the plan of care. • The plan of care did not address the person's co-occurring disorder. • The objectives in the plans of care were not measurable. • The expected date by which the recovery goal will be achieved was not documented in plans of care. • Progress notes were not individualized due to evidence of copying and pasting (The Harris Center Procedure Behavioral Health Manual).	Compliance will follow up with the program in 180 days to ensure the program's Plan of Improvement is implemented.
Cornerstone Family Resources Center Operational Review	06/07/2023	08/14/2023	• Accessibility requirements were met. • Appearance requirements were met. • Safety and infectious waste requirements were met. • Patient/consumer/consumer service requirements were met. • Federal/state posting requirements were met. • Confidentiality requirements were met.	Compliance will follow up with IDD Contracts to determine the status of the potential provider.

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
Mental Health Division Operational Review	06/06/2023	08/04/2023	• Accessibility requirements were met. • Appearance requirements were met. • Safety and infectious waste requirements were met. • Patient/consumer/consumer service requirements were met. • Federal/state posting requirements were met. • Confidentiality requirements were met.	Compliance will follow up with the programs in 365 days to ensure compliance with operational review topics.
Home and Community-Based Services Corrective Action Plan Follow-up Review	06/23/2023	07/31/2023	• Several outcome statements were not person-centered. • All waiver and non-waiver services were not included in the PDP/IPC. • Service coordinators were not regularly monitoring services. • There were no discussions concerning how services were critical to the persons served health and safety.	Compliance may conduct a follow-up in 180 days to ensure compliance with the program's corrective action plan.

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
Enhanced Community Coordination/Pre-Admission Screening and Resident Review (PASSR) Corrective Action Plan Follow-up Review	07/03/2023	07/19/2023	• The habilitation service plan (HSP) was not shared with members of the service planning team (SPT) within ten calendar days of an HSP update or renewal. • Documentation did not evidence the progress or lack of progress toward achieving goals and outcomes identified in the JSP from the resident's perspective. The PASSR Comprehensive Service Plan forms were not entered within five (5) business days of the SPT. • The service coordinator did not review and monitor risk factors. • The Community Living Option (CLO) was not addressed with the individual six months after the presentation of the CLO option. • The Managed Care Organization (MCO) service coordinator was not invited to the SPT meeting. • Some records did not have a current guardianship letter on file. • A community-based SPT meeting was not completed at least quarterly.	Compliance will follow up with the programs after HHSC completes its final review. The programs should continue working on corrective actions toward increased compliance before the next annual review.

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
General Revenue/Community First Choice Corrective	07/24/2023	08/04/2023	• Service coordinators did not meet face-to-face with the person served in accordance with the Service Coordination Plan.	Compliance will follow up with the programs after HHSC completes its final review. The programs should continue working on corrective actions toward increased compliance before the next annual review.
Comprehensive Psychiatric Emergency Program Operational Review	06/02/2023	07/10/2023	• Accessibility requirements were met. • Appearance requirements were met. • Safety and infectious waste requirements were met. • Patient/consumer/consumer service requirements were met. • Federal/state posting requirements were met. • Confidentiality requirements were met.	Compliance will follow up with the programs in 365 days to ensure compliance with operational review topics.

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
Hospital to Home Comprehensive Review	07/26/2023	08/24/2023	• Program leadership was unable to provide an updated service contract. • Authorized regulatory standards have not been developed for the program. • The discharge planning process was not initiated at the time of admission. • There was no evidence staff attempted to determine if the person served had an active Declaration for Mental Health Treatment prior to admission. • Several staff did not maintain compliance with the tuberculosis screening guidelines. • Staff were not compliant with training requirements.	Compliance will follow up with the program in 180 days to ensure the program's Plan of Improvement is implemented.
Comprehensive Psychiatric Emergency Program Operational Review	06/02/2023	07/10/2023	• Accessibility requirements were met. • Appearance requirements were met. • Safety and infectious waste requirements were met. • Patient/consumer/consumer service requirements were met. • Federal/state posting requirements were met. • Confidentiality requirements were met.	Compliance will follow up with the programs in 365 days to ensure compliance with operational review topics.

Audit	Review Begin Date	Report Issue Date	Key Findings	Action Plan
Texas Home Living Corrective Action Plan Follow-Up Review	08/04/2023	08/23/2023	• Several outcome statements were not person-centered. • All waiver and non-waiver services were not included in the PDP/IPC. • Service coordinators were not conducting regular monitoring of service provision. • There were no discussions concerning how services were critical to the persons served health and safety. • Several progress notes appeared copied and pasted (e.g., identically misspelled words, awkward phrasing, and references to December 2022 and January 2023 in a progress note dated June 2023).	Compliance will follow up with the programs after HHSC completes its final review. The programs should continue working on corrective actions toward increased compliance before the next annual review.
Intellectual and Developmental Disabilities Operational Review	06/06/2023	08/18/2023	• Accessibility requirements were met. • Appearance requirements were met. • Safety and infectious waste requirements were met. • Patient/consumer/consumer service requirements were met. • Federal/state posting requirements were met. • Confidentiality requirements were met.	Compliance will follow up with the programs in 365 days to ensure compliance with operational review topics.

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:

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1. Ciox Health (A health care information management company) Records Request Review 6/7/2023 - On behalf of Amerigroup, Ciox was hired to complete a records Review of clients receiving services from the Harris Center. CIOX requested 389 charts from MH clinics

requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries. The requested documentation was sent by Health and Information Management (HIM) Release of Information (ROI) Legal, and a confirmation receipt was received upon completion. No further communication has been received.

2. Behavioral Health Services (BHS) Quality Management Corrective Action Plan (CAP) Response Approval for Substance Use. 7/2023. Quality Management (QM) received the attached Corrective Action Plan (CAP) submitted in response to the April 13 – May 5, 2023 review. A follow-up review may be scheduled approximately six months after the proposed implementation date.

3. Suicide Care Initiative (SCI) Site Visit Final Report 7/2023 The Harris Center received an overall 41% of the available points denoting implementation of suicide safe care best practices. Overall, the Harris Center had the highest scores on the Lead element, which reflects the agency's commitment to the Zero Suicide approach through messaging, the establishment of a multi-disciplinary implementation team, and the inclusion of individuals with lived experience in the agency's efforts. The Harris Center had the lowest scores on the Engage element, which reflects the agency's use of suicide safe care practices within a care management plan, and the Transition element, reflecting on protocols to address gaps that can occur during transitions. The overall results show a modest increase in implementation since the previous review (previously 32%).

4. CIOX Health Records Request for Amerigroup Medicare Risk Adjustment Review 8/23/2023. Amerigroup engaged Optum* and CIOX Health• (Ciox) to conduct the medical chart review for seven (7) requested members' medical records for services rendered from January 1, 2022, to December 31, 2023. The documentation requested for this chart review: Progress notes, History and physical, Consult/specialist notes or letters, Operative and pathology notes, Procedure notes/reports, Physical, speech, and/or occupational therapist reports, Emergency department records, and Discharge summary. The requested documentation was sent by HIM ROI Legal and totaled 393 records and a confirmation receipt was received upon completion. No further communication has been received.

5. HHSC FY23 Corrective Action Plan (CAP) Compliance Review. Texas Health and Human Services Commission (HHSC), Community Services, Intellectual and Developmental Disabilities (IDD) Services, Contract Accountability and Oversight (CAO) completed the fiscal year 2023 corrective action plan(s) (CAP) compliance review of The Harris Center for Mental Health and IDD on August 21, 2023. At the conclusion of the CAP compliance review process, report for Quality Assurance (QA), General Revenue and Community First Choice (GR-CFC), Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Preadmission Screening and Residence Review (PASRR) were presented to designated Local Intellectual and Developmental Disability Authority (LIDDA) staff.

   It was determined that The Harris Center for Mental Health and IDD is in compliance with the specific corrections in the QA and TxHmL CAPs. It was determined that The Harris Center for Mental Health and IDD has demonstrated partial compliance with the specific corrections in the GR-CFC, HCS, and PASRR CAPs; however, consultation was provided concerning the implementation of the CAPs. Written comments were included in the reports presented. Subsequent correspondence by the HHSC IDD Services contract manager is forthcoming.

6. CIOX Health Records Request Review 8/25/2023 On behalf of Cigna, Ciox was hired to complete a records Review of clients receiving services from the Harris Center. CIOX requested 46 charts from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries. The requested documentation was sent by HIM ROI Legal, and a confirmation receipt was received upon completion. No further communication has been received.

7. CIOX Health Records Request Review On behalf of Oscar, Devoted Health, and WellCare clients. 8/28/2023 CIOX requested 22 charts from MH clinics requesting specific member medical records for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries. The requested documentation was sent by HIM ROI Legal, and a confirmation receipt was received

upon completion. No further communication has been received.

8. Humana Records Request Review 8/29/2023. Humana requested 1 chart from MH clinic requesting a specific member medical record for the following information: progress notes, History and Physical, Consult/specialist notes or letters, Operative and Pathology notes, Procedure notes/reports, Physical, Speech and/or Occupational Therapist reports, Emergency department records, and Discharge Summaries. The requested documentation was sent by HIM ROI Legal, and a confirmation receipt was received upon completion. No further communication has been received.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet
Adult Mental Health (AMH)
Southeast Community Service Center (SECSC)
Routine
Review Date: June 8, 2023 to June 13, 2023

I. Audit Type:
Routine.

II. Purpose:
The purpose of this review was to assess SECSC 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, 415.5 and Agency Policy & Procedure HIM8B*.

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 (May 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 routinely listed the type of services within each discipline of treatment that will be provided to the persons served. The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment. Each person served had an updated POC in the EHR. Medication, Training, and Support documentation consistently met all documenting requirements. 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 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. Case Management progress notes did not identify the persons served strengths. The description of the presenting problem was not regularly documented in the POCs. The co-occurring substance use objectives were not routinely documented in the POCs. The objectives documented in the POCs were not consistently measurable. The expected date by which the recovery goals will be achieved were not regularly documented in the POCs. The Progress notes were not individualized; there was evidence of copying and pasting.

No audits of this type have been previously conducted.

V. Recommendations:
The SECSC program should review the findings and continue to assess its processes for completing plans of care and progress note documentation to ensure adherence to TAC standards. The SECSC 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.

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Adult Mental Health (AMH)
Southeast Community Service Center (SECSC)
Focus Review

Compliance Auditor(s): Marvin Williams

Review Date: June 8, 2023, to June 13, 2023

Purpose

The purpose of this review was to assess SECSC 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, 415.5 and Agency Policy & Procedure HIM8B.*

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 the 3rd Qtr. of FY 2023 (May 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 routinely listed the type of services within each discipline of treatment that will be provided to the persons served. *TAC §301.353 (e) (1) (F)*
- The POCs regularly included the documentation of psychoactive medication as part of the persons served treatment. *TAC §415.5 (e)*
- Each person served had an updated POC in the EHR. *TAC §301.353 (e)*
- Medication, Training, and Support documentation consistently met all documenting requirements. *TAC §301.353 (a) (1-7)*
- 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*

HARRIS CENTER
Mental Health and IDD

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)*
- Case Management progress notes did not identify the persons served strengths. *HIM8B*
- The description of the presenting problem was not regularly documented in the POCs. *TAC §301.353 (e) (1) (A)*
- The co-occurring substance use objectives were not routinely documented in the POCs. *TAC §301.353 (e) (2) (B)*
- The objectives documented in the POCs were not consistently measurable. *TAC §301.353 (e) (2) (D)*
- The expected date by which the recovery goals will be achieved were not regularly documented in the POCs. *TAC §301.353 (e) (1) (F)*
- The Progress notes were not individualized; there was evidence of copying and pasting. *The Harris Center Procedure Behavioral Health Manual*

History

No audits of this type have been previously conducted.

Recommendations

The SECSC 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, agency training guidelines, and agency policy and procedure. The SECSC 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 July 5, 2023.

Management Response:

See attached Plan of Improvement. PM shared with QM recent training that may contribute to staff providing minimal responses on progress notes under the responses to service provided section. QM and Training department may want to meet to discuss alignment with TAC.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Lance Britt

Vice President of MH Division

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Program Director/Manager

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Compliance Manager / Interim Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Potential Provider Operational Review
Intellectual and Developmental Disabilities (IDD) Division Contracts
Review Date: June 7, 2023

I. Audit Type:
Operational Review

II. Purpose:
This review aimed to conduct an Operational Review to assess a potential provider to ensure the Provider meets agency and regulatory guidelines, city ordinances, and State and Federal laws and promote the best practices in the workplace.

III. Audit Method:
Compliance conducted an onsite Operational Review of Cornerstone Family Resource Center. The operational areas reviewed are identified below: Accessibility, Appearance, Safety and Infectious Waste, Patient/Consumer/Consumer Service, Confidentiality, Required Postings, and Documentation.

IV. Audit Findings/History:
Cornerstone Family Resource Center did not have evidence of office procedures in case of emergencies and no evidence of a first aid kit.

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V. Recommendations:
Compliance recommends that the IDD Contracts department approve this Provider once they have submitted evidence of office procedures in case of emergencies and a first aid kit. Please notify Compliance once the decision has been made to do business with the potential contractors above. There is no Plan of Improvement (POI) needed for this review; however, The IDD Contracts is required to submit a management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report, which must be returned to Compliance within seven (7) business days, by close of business August 23, 2023.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
4th Quarters (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disabilities (IDD) Division Contracts
Potential Provider Review

Compliance Auditor(s): Christopher Webb

Compliance Review: June 7, 2023

Purpose

The purpose of this review was to conduct an Operational Review to assess a potential provider to ensure the Provider meets agency and regulatory guidelines, city ordinances, and State and Federal labor laws and promotes the best practice in the workplace.

Method

Compliance conducted an onsite Operational Review of Cornerstone Family Resource Center. The operational areas reviewed are identified below:

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

Findings

Cornerstone Family Resource Center did not have evidence of office procedures in case of emergencies and no evidence of a first aid kit.

History

No reviews of this type were previously conducted.

Recommendations

Compliance recommends that the IDD Contracts department approve this Provider once they have submitted evidence of office procedures in case of emergencies and a first aid kit. Please notify Compliance once the decision has been made to do business with the potential contractors above. There is no Plan of Improvement (POI) needed for this review; however, The IDD Contracts is required to submit a management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report, which must be returned to Compliance within seven (7) business days, by close of business August 23, 2023.

Signature Page

X Evanthe Collins 8/17/23

Vice President of IDD Division

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Interim Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Operational Review
Mental Health (MH) Division
Review Date: June 16, 2023-August 2, 2023

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace.

III. Audit Method:
Onsite operational reviews were conducted at Sixteen (16) MH facilities: Northeast Community Service Center (NECSC), Northwest Community Service Center (NWCSC), Southeast Community Service Center (SECSC), Southwest Community Service Center (SWCSC), Northwest (NW) Assertive Community Treatment ACT/Forensic Assertive Community Treatment (FACT), Northwest (NW) New Start, Southeast (SE) ACT/FACT, Northeast Youth and Family Center, Southwest Children and Adolescent Services SWCAS) CUP/JJ, Southeast Children and Adolescent Services (SECAS), Youth Empowerment Services (YES) Waiver, Children's Colocation Magnolia Clinic, Pasadena Colocation Center, Colocation Spring Branch, Alief Colocation and Early Childhood Intervention (ECI). For each facility reviewed, the Program Manager 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 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).

IV. Audit Findings/History:
All sixteen (16) facilities met all the criteria within seven days (7) of the review. 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: 4th Quarter (Qtr.) of Fiscal Year (FY) 2023 Mental Health (MH) Division Operational Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: June 16, 2023, to August 2, 2023

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) facilities to ensure the agency meets regulatory guidelines, city ordinances, and State and Federal labor laws and promote the best practice in the workplace.

Method

Onsite operational reviews were conducted at Sixteen (16) MH facilities: Northeast Community Service Center (NECSC), Northwest Community Service Center (NWCSC), Southeast Community Service Center (SECSC), Southwest Community Service Center (SWCSC), Northwest (NW) Assertive Community Treatment ACT/Forensic Assertive Community Treatment (FACT), Northwest (NW) New Start, Southeast (SE) ACT/FACT, Northeast Youth and Family Center, Southwest Children and Adolescent Services SWCAS) CUP/JJ, Southeast Children and Adolescent Services (SECAS), Youth Empowerment Services (YES) Waiver, Children's Colocation Magnolia Clinic, Pasadena Colocation Center, Colocation Spring Branch, Alief Colocation and Early Childhood Intervention (ECI). For each facility reviewed, the Program Manager 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

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

All sixteen (16) facilities met all the criteria within seven days (7) of the review.

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 MH Division is required to sign this report and return it to the Compliance Department by August 15, 2023, acknowledging receipt and review of the information presented in this report.

Signature Page

X Lance Britt

Vice President of MH Division

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Interim Compliance Director

The Harris Center for Mental Health and IDD
Compliance Department
Executive Summary Cover Sheet for the
Home and Community-Based Services (HCS) Corrective Action Plan (CAP) Follow-up Review
Intellectual and Developmental Disabilities (IDD) Division
Review Dates: June 23, 2023-June 30, 2023

I. Audit Type:
Follow-up Review

II. Purpose:
This review was conducted to monitor the IDD Division's HCS Programs' compliance with the CAP submitted to the Texas Department of Health and Human Services Commission (HHSC) concerning service coordination documentation, as outlined in the Texas Administrative Code.

III. Audit Method:
A random sample of two (2) records from the Electronic Health Record (EHR) was selected for each of the six (6) HCS Teams, and one (1) record from the Enhanced Community Coordination (ECC) Program by entering an Excel formula to identify 13 records randomly. The review utilized a modified version of the HHSC IDD HCS Documentation Review Checklist so that only relevant sections (i.e., Person/Family Directed Services, Person-Directed Planning [PDP] Content, Service Coordination Monitoring and Minimum Contact, Reporting Progress, Service Coordination Assessment, and Community-based SPT Meetings) were present. Program directors were provided detailed information post-review. The audit review and completed debriefing tools were uploaded into the Compliance Shared Folder (SharePoint). The Compliance Department (Compliance) conducted a similar CAP review during the 1st Qtr. FY 2021 and 4th Qtr. FY 2020.

IV. Audit Findings/History:
Compliance noted that service coordinators were not including all HCS and non-HCS services on PDPs and IPCs; were not writing person-centered outcome statements; were not monitoring the delivery of services; did not discuss how services were critical to the client's health and safety, did not develop a backup plan for services determined to be critical, and did not monitor backup plans; did not monitor the outcomes of all services; did not determine if the person-served was or was not making progress towards their desired outcomes; and did not include the Service Coordinator Assessment (Form 8647) in the EHR.

V. Recommendations:
Programs should continue to review documentation for compliance with TAC requirements, provide ongoing training on developing measurable and time-bound outcome statements, ensure SCs include specific statements of progress/lack of progress toward desired outcomes, and regularly review the submitted CAP to ensure corrective actions are being performed. The Vice President of the IDD Division and

The HARRIS CENTER for Mental Health and IDD

Compliance Department Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disability Division (IDD)
Home and Community-Based Services (HCS)
Corrective Action Plan (CAP) Follow-up Review

Compliance Auditor(s): Christopher Beard and Emmanuel Golakai

Review Period: May 10, 2023-June 12, 2023

Purpose

This review was conducted to monitor the IDD Division's HCS Programs' compliance with the CAP submitted to the Texas Department of Health and Human Services Commission (HHSC) concerning service coordination documentation, as outlined in the Texas Administrative Code (TAC) §263.301 (a)(4); §263.401 (b), §263.901 (e)(6, 7, 15, 16); §331.7 (a), (c); and the HHSC HCS Handbook (Section 6820).

Method

A random sample of two (2) records from the Electronic Health Record (EHR) was selected for each of the six (6) HCS Teams, and one (1) record from the Enhanced Community Coordination (ECC) Program by entering an Excel formula to identify 13 records randomly. The review utilized a modified version of the HHSC IDD HCS Documentation Review Checklist so that only relevant sections (i.e., Person/Family Directed Services, Person-Directed Planning [PDP] Content, Service Coordination Monitoring and Minimum Contact, Reporting Progress, Service Coordination Assessment, and Community-based SPT Meetings) were present.

Findings

Detailed findings are provided below.

Strengths

- Service coordinators (SCs) consistently used the discovery process when developing PDPs (§263.901 (e)(6)).
- SCs consistently included the person served/LAR, family members, and relevant others when developing PDPs (§263.901 (e)).
- SCs consistently included descriptions of the desired outcomes (§263.901 (e)).

Areas of Improvement

- Several HCS waiver services and several non-HCS waiver services were not included in the discovery process (§263.901 (e)(6)).
- Outcome statements for services were not person-centered (§263.901).
- Evidence indicating the delivery of several HCS waiver services and several non-HCS waiver services was not included in progress notes (§263.901 (e)(15)).

The HARRIS CENTER for Mental Health and IDD

- The discovery process does not include a discussion concerning the criticality of services, development of backup plans, or evidence SCs approved or monitored backup plans (§263.901 (e)(8)(B), §263.401 (b)).
- Outcomes for services were not monitored by SCs (§263.901 (e)(15)).
- SCs did not specifically indicate if progress/lack of progress was made towards desired outcomes (§263.901 (e)(16)).
- Two (2) records did not contain an SC Assessment (Form 8647; §331.7 (c)).

Observations

- Five (5) progress notes and PDPs contained references to the person served using an incorrect pronoun (e.g., using "she/her" when referring to males and "he/his" when referring to females) or an incorrect name.

History

The Compliance Department (Compliance) conducted a similar CAP review during the 1st Qtr. FY 2021 and 4th Qtr. FY 2020.

Recommendations

Programs should continue to review documentation for compliance with TAC requirements, provide ongoing training on developing measurable and time-bound outcome statements, ensure SCs include specific statements of progress/lack of progress toward desired outcomes, and regularly review the submitted CAP to ensure corrective actions are being performed. The Vice President of the IDD Division and Program Director must sign and return this report to Compliance within seven (7) business days (August 10, 2023).

Management Response

Based on the selected records pulled for review and the timeframe for those IPC/PDPs, all PDP meetings were held prior to the 5/9/2023 correction date and CAP trainings conducted (March 2023-April 2023) to address those deficiencies. Due to the volume of individuals served, we did not retreat in correcting all PDPs (outside of the records selected during the January 2023 audit review). However, PDPs are corrected as revisions are requested by the families and/or providers. For the finding cited-*the discovery process does not include a discussion concerning the criticality of services, development of backup plans, or evidence SCs approved or monitored backup plans*-The Program Director did not agree with this finding and stated 5/23/2023 progress note indicated progress being made. Compliance disagreed, and stated as included statement from family member only stated persons served continues to work on outcome. Compliance further explained this statement could be interpreted as a person made or did not make progress. Again, for this record, the PDP meeting was held prior to the 5/9/2023 correction date and we did not retreat in correcting all PDPs as stated. All SCs received competency-based training based on the January 2023 HHSC audit review on the TAC requirement of Person Directed Planning, including writing HCS/non-HCS person centered outcomes, and justifying all services evidenced by the discovery process - TAC 9.190 (e), progress note documentation training to emphasize the importance of how to properly document delivery of progress/lack of progress and satisfaction of all services listed in the PDP monthly or at least once every 90 days. SC assessment form training was also completed to ensure the appropriate level of monitoring of services based off the frequency indicated in the PDP. To ensure the compliance and in response of addressing the specific issues identified, ongoing monitoring of (2) HCS charts per teams per fiscal quarter will be conducted utilizing the monitoring tool to measure delivery of progress/satisfaction, quality of progress notes, review of PDPs and required documents in EPIC. Any findings will be documented on a review tool with the specific issue addressed, shared with the Program Director, and SC staff who will provide the corrections and updates. If continuance of noted non-compliance by the SC will result in re-training by the SC Mentor.

The HARRIS CENTER for Mental Health and IDD

Signature Page

X Evanthe Collins

Vice President of IDD Division

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Program Director/Manager

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Interim Director of Compliance

The Harris Center for Mental Health and IDD
Compliance Department
Executive Summary Cover Sheet for the
Operational Review of the
Comprehensive Psychiatric Emergency Program (CPEP)

I. Audit Type

Operational Review

II. Purpose

Compliance conducted annual onsite operational reviews to assess The Harris Center for Mental Health and IDD's (The Harris Center) facilities to ensure the agency meets regulatory guidelines, city ordinances, state and federal laws, and to promote best practices within the workplace.

III. Audit Method

Onsite operational reviews were conducted at four CPEP provider facilities: The Navigation Center (Jensen location), 811 Properties (Bowling Green and Cedar Bayou locations), and The Harris Center Independent Living facility. Program managers/designees were provided with an entrance email, a copy of the Operational Review Tool, the date and time of the review, and the auditor's name and contact information. Program managers/designees were also provided with 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 concerning the Operational Reviews was presented to the unit managers post-review and uploaded into the Compliance Department Shared Folder (SharePoint).

IV. Audit Findings/History

The reviewed facilities met all criteria within seven (7) business days of the review. Operational reviews were conducted during the 2nd Qtr. FY 2019 by the Compliance Department.

V. Recommendations

Program managers and designees should remain informed of their facility's operational requirements and continue to comply with regulatory guidelines. The Vice President of the CPEP Division is signed and returned the report to the Compliance Department by July 19, 2023, acknowledging receipt and review of the information presented herein.

The HARRIS CENTER for Mental Health and IDD

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

Compliance Auditor(s): Christopher Beard

Review Period: May 23, 2023-June 12, 2023

Purpose

The review assessed The Harris Center for Mental Health and IDD's (The Harris Center) Comprehensive Psychiatric Emergency Program (CPEP) Division provider facilities' compliance with regulatory facility operational guidelines, city ordinances, state and federal labor laws and to promote best practices within the workplace.

Method

Onsite operational reviews were conducted at four CPEP provider facilities: The Navigation Center (Jensen location), 811 Properties (Bowling Green and Cedar Bayou locations), and The Harris Center Independent Living facility. Program managers/designees were provided an entrance email, a copy of the Operational Review Tool, the date and time of the review, and the auditor's name and contact information. Program managers/designees were also 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 concerning the Operational Reviews was presented to the unit managers post-review and uploaded into the Compliance Department Shared Folder (SharePoint).

Findings

The reviewed facilities met all criteria within the allotted timeframe.

Strengths

- Program managers and designees were knowledgeable of their facilities' daily operations.

Areas of Improvement

- There are no areas of improvement, as facilities were brought into compliance within the allotted timeframe.

Observations

- Program managers and designees were welcoming, cordial, and enthusiastic to receive the Compliance Department's assistance in ensuring their facilities met all criteria.

History

Operational Reviews were conducted during the 2nd Qtr. FY 2019 by the Compliance Department.

The HARRIS CENTER for Mental Health and IDD

Recommendations

Program managers and designees should remain informed of their facility's operational requirements and continue to comply with regulatory guidelines. The Vice President of the CPEP Division is required to sign and return this report to the Compliance Department by July 19, 2023, acknowledging receipt and review of the information presented herein.

Management Response

The HARRIS CENTER for Mental Health and IDD

Signature Page

X 7/10/23

Vice President of CPEP Division

X

Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Corrective Action Plan (CAP) Follow-up Review:
Pre-Admission Screening and Resident Review (PASRR)
Intellectual and Developmental Disability (IDD) Division
Review Dates: July 5- July 7, 2023

I. **Audit Type:**
Corrective Action Plan (CAP) Follow-up Review

II. **Purpose:**
The purpose of this review was to ensure the PASRR documentation is complying with the CAP, as requested by the Health and Human Services Commission (HHSC), and assess the program's documentation for compliance with the Texas Administrative Code (TAC) *§303.602(a)(2); §303.602(a)(4); §303.601(b)(5); §303.601(6)(C); §303.601(c)(1) (B)(i); §303.102(71) (A)(4); §303.504(a)(8); §303.601(b)(11)* and the *HHSC IDD PASRR Handbook 5300; 5320; 3240.*

III. **Audit Method:**
Active records were selected randomly by generating an AFF HC Encounter Data OP Services Details Report for persons served during the 3rd and 4th Qtr. of FY 2023 (May 10, 2023- June 28, 2023). Compliance selected a sample of seven (7) records for the PASRR Program conducting a desk review utilizing the HHSC PASRR Documentation Review tool.

IV. **Audit Findings and History:**
The PASRR documentation reviewed did not evidence that the Habilitation Service Plan (HSP) was shared with members of the SPT within ten (10) calendar days after the HSP is updated or renewed. The PASRR documentation did not evidence the designated resident's progress or lack of progress toward achieving goals and outcomes was identified in the HSP from the designated resident's perspective. The PASRR documentation did not evidence that the PASRR Comprehensive Service Plan (PCSP) forms were entered within five (5) days. The PASRR documentation did not evidence that the SC reviewed and monitored identified risk factors. The PASRR documentation did not evidence that the Community Living Option (CLO) was addressed with the individual six months after the initial presentation of the CLO. The PASRR documentation did not evidence that the Managed Care Organization (MCO) Service Coordinator was invited to the SPT meeting. The PASRR documentation did not evidence that there was a current guardianship letter on record. The PASRR documentation did not evidence that a community-based SPT meeting was completed at least quarterly.

The Compliance Department completed a PASRR CAP Follow-up Review for the 3rd Qtr. of FY 2020 (April 1-30, 2020).

V. **Recommendations:**
The PASRR Program should continue to assess PASRR documentation to ensure that coordination of services, monitoring, planning, and reporting progress is completed in accordance with TAC and HHSC IDD PASRR Handbook. The PASRR Program is not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disability (IDD) Division
Pre-Admission Screening and Resident Review (PASRR)
Corrective Action Plan (CAP) Follow-up Review

Compliance Auditor(s): Coneka Caleb

Review Dates: July 5, 2023- July 7, 2023

Purpose

The purpose of this review was to ensure the PASRR documentation is complying with the CAP, as requested by the Health and Human Services Commission (HHSC), and assess the program's documentation for compliance with the Texas Administrative Code (TAC) *§303.602(a)(2); §303.602(a)(4); §303.601(b)(5); §303.601(6)(C); §303.601(c)(1) (B)(i); §303.102(71) (A)(4); §303.504(a)(8); §303.601(b)(11)* and the *HHSC IDD PASRR Handbook 5300; 5320; 3240.*

Method

Active records were selected randomly by generating an *AFF HC Encounter Data OP Services Details Report* for persons served during the 3rd and 4th Qtr. of FY 2023 (May 10, 2023- June 28, 2023). Compliance selected a sample of seven (7) records for the PASRR Program conducting a desk review utilizing the HHSC PASRR Documentation Review tool.

Findings

The findings from the review are as follows:

Strengths:

- The PASRR documentation reviewed consistently evidenced that the individuals participated to the fullest extent possible in the Service Planning Team (SPT) meetings. ***TAC §303.602(a)(2).***
- The PASRR Program completed the required training, as evidenced by the agenda and sign-in sheets.

Areas of Improvement:

- The PASRR documentation reviewed did not evidence that the Habilitation Service Plan (HSP) was shared with members of the SPT within ten (10) calendar days after the HSP is updated or renewed as required by ***TAC §303.601 (b)(5).***
- The PASRR documentation reviewed did not evidence the designated resident's progress or lack of progress toward achieving goals and outcomes was identified in the HSP from the designated resident's perspective as required by ***TAC §303.601(6)(C).***

- The PASRR documentation reviewed did not evidence that the PASRR Comprehensive Service Plan (PCSP) forms were entered within five (5) days as required by ***HHSC IDD PASRR Handbook 5320.***
- The PASRR documentation reviewed did not evidence that the SC reviewed and monitored identified risk factors as required by the ***TAC §303.602(a)(4)*** and ***HHSC IDD PASRR Handbook 5300.***
- The PASRR documentation reviewed did not evidence that the Community Living Option (CLO) was addressed with the individual six months after the initial presentation of the CLO as required by the ***TAC §303.601(c)(1) (B)(i).***
- The PASRR documentation reviewed did not evidence that the Managed Care Organization (MCO) Service Coordinator was invited to the SPT meeting as required by ***TAC §303.102(71) (A)(4)***.
- The PASRR documentation reviewed did not evidence that there was a current guardianship letter on record as required by ***TAC §303.504(a)(8); §303.601(b)(11)***.
- The PASRR documentation reviewed did not evidence that a community-based SPT meeting was completed at least quarterly as required by ***HHSC IDD PASRR Handbook 3240.***

History

The Compliance Department completed a PASRR CAP Follow-up Review for the 3rd Qtr. of FY 2020 (April 1-30, 2020).

Recommendations

The PASRR Program should continue to assess PASRR documentation to ensure that coordination of services, monitoring, planning, and reporting progress is completed in accordance with TAC and HHSC IDD PASRR Handbook. The PASRR Program is not required to submit a Plan of Improvement (POI). A management response signed by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business July 28, 2023.

Management Response:

Based on the selected records pulled for review and the timeframe for those documents not shared with the SPT members within 10 days of the SPT meetings, monitoring of progress towards the outcome, PCSP not being entered within 5 days, identified risk factors, and SPT was held quarterly were held prior to the 5/9/2023 correction date; however, the CAP training was conducted in April 2023 to address those deficiencies. The PASRR team did not correct all documents that were outside of the records selected during the January 2023 audit review. Moving forward, we are ensuring those deficiencies will not happen after the 5/9/2023. I do not agree with this finding, The PASRR documentation reviewed did not evidence

The HARRIS CENTER for Mental Health and IDD

Signature Page

that the Community Living Option (CLO) was addressed with the individual six months after the initial presentation of the CLO as required by the *TAC §303.601(c)(1) (B)(i). The finding was submitted.*

X Evanthe Collins

Vice President of IDD

X

Program Director/Manager

X

Compliance Director

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Corrective Action Plan (CAP) Follow-up Review:
General Revenue (GR) Community First Choice (CFC)
Intellectual and Developmental Disability (IDD) Division
Review Dates: July 24- July 26, 2023

I. **Audit Type:**
Corrective Action Plan (CAP) Follow-up Review

II. **Purpose:**
The purpose of this review was to ensure the GR CFC documentation is complying with the CAP, as requested by the Health and Human Services Commission (HHSC) and assess the program's documentation for compliance with the Texas Administrative Code (TAC) *§331.5(33) (A-C); §331.21(a)(3); §331.5 (36); §331.11(d)(1); §L.2.556 (b)(c)(d); §L.2.553 (36).*

III. **Audit Method:**
Compliance randomly selected six (6) active records from the GR CFC Closed Encounter Service Coordination Report which was generated by the Data System Manager of IDD from the Electronic Health Record (EHR) for persons served during the 3rd and 4th Qtr. of FY 2023 (May 10, 2023 – July 19, 2023). Compliance conducted a desk review utilizing the HHSC GR CFC Documentation Review tool.

IV. **Audit Findings and History:**
The GR CFC documentation reviewed did not evidence that the Service Coordinator met face-to-face with the individual in accordance with SC Plan.

There are no previous reviews for GR CFC CAP Follow-up Review.

V. **Recommendations:**
The GR CFC Programs should continue to assess GR CFC documentation to ensure that coordination of services, monitoring, planning, and reporting progress is completed in accordance with TAC. The GR CFC Programs should also continue to follow the CAP requirements. The GR CFC Programs are not required to submit a Plan of Improvement (POI). A management response by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disability (IDD) Division
General Revenue (GR) Community First Choice (CFC)
Corrective Action Plan (CAP) Follow-up Review

Compliance Auditor(s): Coneka Caleb

Review Dates: July 24, 2023- July 26, 2023

Purpose

The purpose of this review was to ensure the GR CFC documentation is complying with the CAP, as requested by the Health and Human Services Commission (HHSC) and assess the program's documentation for compliance with the Texas Administrative Code (TAC) *§331.5(33) (A-C); §331.21(a)(3); §331.5 (36); §331.11(d)(1); §L.2.556 (b)(c)(d); §L.2.553 (36).*

Method

Compliance randomly selected six (6) active records from the GR CFC Closed Encounter Service Coordination Report which was generated by the Data System Manager of IDD from the Electronic Health Record (EHR) for persons served during the 3rd and 4th Qtr. of FY 2023 (May 10, 2023 – July 19, 2023). Compliance conducted a desk review utilizing the HHSC GR CFC Documentation Review tool.

Findings

The findings from the review are as follows:

Strengths:

- The GR CFC documentation reviewed evidenced that the outcomes were supported by the discovery information. ***TAC §331.5(33) (A-C)***
- The GR CFC documentation reviewed evidenced that the desired outcomes were identified by the individual, or LAR, or actively involved person on behalf of the individual. ***TAC §331.5(33)(A)***
- The GR CFC documentation reviewed evidenced that the progress or lack of progress in achieving goals or outcomes was documented. ***TAC §331.21(a)(3)***
- The GR CFC Programs completed refresher trainings on writing person-centered outcomes which included guidance on how to utilize the discovery process to ensure the outcomes reflect the individuals'/LARs' desires and preferences as required by HHSC CAP and evidenced by the agenda and sign-in sheets.

Areas of Improvement:

- The GR CFC documentation reviewed did not evidence that the Service Coordinator met face-to-face with the individual in accordance with SC Plan as required by ***TAC §331.5 (36); §331.11(d)(1); §L.2.556 (b)(c)(d); §L.2.553 (36)***

History

There are no previous reviews for GR CFC CAP Follow-up Review.

Recommendations

The GR CFC Programs should continue to assess GR CFC documentation to ensure that coordination of services, monitoring, planning, and reporting progress is completed in accordance with TAC. The GR CFC Programs should also continue to follow the CAP requirements. The GR CFC Programs are not required to submit a Plan of Improvement (POI). A management response by the Vice President of the IDD Division and Program Director/Manager acknowledging receipt of this report must be returned to Compliance within seven (7) business days, by close of business, August 15, 2023.

Management Response:

The GR CFC documentation reviewed did not evidence that the Service Coordinator met face-to-face with the individual in accordance with SC Plan as required by ***TAC §331.5 (36); §331.11(d)(1); §L.2.556 (b)(c)(d); §L.2.553 (36)*** as a result of the family canceling the scheduled meeting for that month. It is also noted that there was a request for a rescheduled meeting for the following month when the family returned to town. This was appropriately evidenced in the Service Coordinator's documentation reviewed by Compliance. Therefore, the Service Coordinator made appropriate and justified attempts to meet with the individual in accordance with the frequency noted in the Person Directed Plan.

Signature Page

X Evanthe Collins

Vice President of IDD

X , PD

Program Director/Manager

X

Compliance Director

The Harris Center for Mental Health and IDD
Compliance Department
Executive Summary Cover Sheet for the
Texas Home Living (TxHmL) Corrective Action Plan (CAP) Follow-up Review
Intellectual and Developmental Disabilities (IDD) Division
Review Dates: August 7, 2023-August 8, 2023

I. Audit Type:
Follow-up Review

II. Purpose:
The review was conducted to monitor the IDD Division's TxHmL Program's compliance with the CAP submitted to the Texas Department of Health and Human Services Commission (HHSC) concerning service coordination assurances, as outlined in the Texas Administrative Code.

III. Audit Method:
A random sample of five (5) Electronic Health Records (EHR) was selected using an Excel formula to identify records randomly. The review utilized a modified version of the HHSC IDD TxHmL Documentation Review Checklist so that only relevant sections (i.e., Developing and Implementing the Person-directed Plan [PDP], Individual Plan of Care [IPC] Development, Monitoring Service Delivery, and Reporting Progress Towards Desired Outcomes) were present. The program director was provided with detailed information post-review. The audit review and completed debriefing tools were uploaded into the Compliance Shared Folder (SharePoint).

IV. Audit Findings/History:
Compliance noted that service coordinators were not including all TxHmL and non-TxHmL services on PDPs and IPCs; were not writing person-centered outcome statements; were not monitoring the delivery of services; did not monitor the outcomes of all services; and did not determine if the person-served was or was not making progress towards their desired outcomes. Compliance conducted similar CAP reviews during the 3rd and 4th Qtrs. FY 2020.

V. Recommendations:
The program should continue to review documentation for compliance with TAC requirements, provide ongoing training on developing measurable and time-bound outcome statements, ensure SCs include specific statements of progress/lack of progress toward desired outcomes, and regularly review the submitted CAP to ensure corrective actions are being performed. The Vice President of the IDD Division and Program Director signed and returned the report to Compliance within seven (7) business days.

HARRIS CENTER
Mental Health and IDD

Compliance Department (Compliance) Review Report
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Intellectual and Developmental Disability Division (IDD)
Texas Home Living (TxHmL)
Corrective Action Plan (CAP) Follow-up Review

Compliance Auditor(s): Christopher Beard

Review Period: August 4, 2023-August 8, 2023

Purpose

This review was conducted to monitor the IDD Division's TxHmL Program's compliance with the CAP submitted to the Texas Department of Health and Human Services Commission (HHSC) concerning service coordination assurances, as outlined in the Texas Administrative Code (TAC) §41.404 (a), (b)(1-2); §262.301 (a)(2); §262.701 (h)(1-5), (q)(1-2), (r)(3); §331.11; and §331.21.

Method

A random sample of five (5) Electronic Health Records (EHR) was selected using an Excel formula to identify records randomly. The review utilized a modified version of the HHSC IDD TxHmL Documentation Review Checklist so that only relevant sections (i.e., Developing and Implementing the Person-directed Plan [PDP], Individual Plan of Care [IPC] Development, Monitoring Service Delivery, and Reporting Progress Towards Desired Outcomes) were present.

Findings

Strengths

- Service Coordinators (SCs) consistently used the discovery process when developing outcomes (§262.701)
- SCs consistently utilized multiple sources of information (e.g., person-served, LAR, and relevant others; §262.701))
- SCs consistently presented information concerning the Consumer Directed Services (CDS) option (§262.701 (q)(1-2))

Areas of Improvement

- Outcome statements were not person-centered (§262.301 (a)(2), 262.701 (h)(2))
- PDPs did not include all waiver and non-waiver services (§262.701 (h)(3))
- Monitoring of outcomes was not conducted for several services (§262.701 (h)(4))
- Delivery of and satisfaction with services was not reported for all outcomes (§262.701 (h)(4), §331.11 (d)(1))
- Progress/lack of progress was not reported for several outcome statements (§262.701 (h)(2))

Observations

- PDPs lacked documentation that services were critical to meeting the individual's health and safety (§262.701 (h)(1)(B))

HARRIS CENTER
Mental Health and IDD

- Several progress notes appeared copied and pasted from previous notes (e.g., words misspelled identically, awkward phrasing, references to December 2022 and January 2023 in the text of the progress note dated June 2023, etc.)

History

Compliance conducted similar CAP reviews during the 3rd and 4th Qtrs. FY 2020.

Recommendations

The program should continue to review documentation for compliance with TAC requirements, provide ongoing training on developing measurable and time-bound outcome statements, ensure SCs include specific statements of progress/lack of progress toward desired outcomes, and regularly review the submitted CAP to ensure corrective actions are being performed. A plan of improvement is not required; however, the Vice President of the IDD Division and Program Director must sign and return this report to Compliance within seven (7) business days (September 1, 2023).

Management Response

Based one of the records pulled for review and the timeframe for that IPC/PDP, it was held prior to 5-9-2023 correction date and CAP trainings conducted (March 2023-April 2023) to address those deficiencies. Due to the volume of individuals served, we did not retreat in correcting all PDP's (outside of the records selected during the January 2023 audit review). However, PDP's are corrected as revisions are requested by the families and/or Providers. **For the finding cited-SC does not indicate person served or LAR desires/wants guardianship, Medicaid, PCP, respite, and employment assistance service outcomes. Educational services are indicated in the PDP but are not being monitored. Employment assistance outcome of "complet(ing) job applications" is not being monitored.** Program Director, after reviewing the Person Directed Plan, SC supported and discussed Guardianship, Medicaid, PCP, and Respite. Compliance explained PD is correct concerning discussion of services. Finding removed. **For the finding cited, The discovery process does not support Medicaid and PCP outcomes. Medicaid and PCP outcome statements are not supported with information in the discovery narrative, and Respite services are delivered as needed; however, there is no indication that these services have been utilized.** After reviewing the Person Directed Plan, The Program Director did not agree with the finding and stated, Reviewing the Person Directed Plan, SC does support Medicaid and PCP Outcomes. ISS was removed from the Person Directed Plan due to being over the CAP (revised on 4-26-2023). Compliance further explained, Progress note observation (i.e., incorrect pronouns) was due to a misreading. See Version 2 of PDP for incomplete sentence. PD and Team Lead stated the incomplete sentence is likely a technological glitch in EPIC. Program was notified after plan year began outcomes 4,7,8, were not authorized; therefore, services were not included. Observation will be removed.

HARRIS CENTER
Mental Health and IDD

Signature Page

X Evanthe Collins 08/28/2023

Vice President of IDD Division

X

Program Director/Manager

X

Interim Director of Compliance

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Operational Review
Intellectual and Developmental Disabilities (IDD)
Review Date: August 14, 2023-August 16, 2023

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) programs to ensure the agency meets regulatory guidelines, city ordinances, and State and Federal labor laws and promote the best practices in the workplace.

III. Audit Method:
The Compliance Department (Compliance) conducted the annual onsite operational reviews at five (5) IDD programs during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2023: IDD Eligibility, IDD Clinical Service, IDD Authority Services, IDD Intensive Needs, and IDD Administration. For each program reviewed, the Program Manager 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's auditor name and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are 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).

IV. Audit Findings/History:
All five (5) programs met all the criteria within seven days (7) of the review. 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 program'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 seven business days, acknowledging receipt and review of the information presented in this report.

The Harris Center for Mental Health and IDD:
The Compliance Department
Executive Summary Cover Sheet for the
Operational Review
Intellectual and Developmental Disabilities (IDD)
Review Date: August 14, 2023-August 16, 2023

I. Audit Type:
Operational Review

II. Purpose:
Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) programs to ensure the agency meets regulatory guidelines, city ordinances, and State and Federal labor laws and promote the best practices in the workplace.

III. Audit Method:
The Compliance Department (Compliance) conducted the annual onsite operational reviews at five (5) IDD programs during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2023: IDD Eligibility, IDD Clinical Service, IDD Authority Services, IDD Intensive Needs, and IDD Administration. For each program reviewed, the Program Manager 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's auditor name and contact information. The programs were provided seven (7) days from the review date to resolve any deficiencies. The operational areas reviewed are 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).

IV. Audit Findings/History:
All five (5) programs met all the criteria within seven days (7) of the review. 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 program'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 seven business days, 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: 4th Quarter (Qtr.) of Fiscal Year (FY) 2023 Intellectual and Developmental Disabilities (IDD) Operational Review

Compliance Auditor(s): Emmanuel Golakai

Review Date: August 14, 2023, to August 16, 2023

Purpose

Compliance conducted annual onsite Operational reviews to assess The Harris Center for Mental Health and IDD (The Harris Center) programs to ensure the agency meets regulatory guidelines, city ordinances, and State and Federal labor laws and promote the best practices in the workplace.

Method

The Compliance Department (Compliance) conducted the annual onsite operational reviews at five (5) IDD programs during the 4th quarter (Qtr.) of the Fiscal Year (FY) 2023: IDD Eligibility, IDD Clinical Service, IDD Authority Services, IDD Intensive Needs, and IDD Administration. For each program reviewed, the Program Manager 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's auditor name and contact information. The programs 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).

Findings

All five (5) programs met all the criteria within seven days (7) of the review.

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 program'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 August 29, 2023, acknowledging receipt and review of the information presented in this report.

Signature Page

X Evanthe Collins 08/18/23

Vice President of IDD 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)
Hospital to Home
Comprehensive Review
Review Date: July 26, 2023, to August 14, 2023

I. Audit Type:
Comprehensive

II. Purpose:
The purpose of this review was to assess Hospital to Home service documentation, facility posting requirements, infection control procedures, medication management standards, and staff trainings for compliance with *Human and Human Services Information Item V: Crisis Respite Standards* and *The Harris Center Policy ACC3B on Guidelines for Personal Safety Plans*.

III. Audit Method:
Active records were randomly selected from the *Affiliated Harris Center Data IP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2023 (March 1, 2023 – May 31, 2023) and the *Organizational Development Staff Training Roster* report. Compliance conducted a desk review, sampling twenty (20) persons served and nineteen (19) staff using the Hospital to Home Comprehensive Review Tool developed by Compliance. 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 that each person served received a unit orientation within twenty-four (24) hours of admission. The program consistently ensured that all postings were prominently displayed. The program demonstrated compliance with all medication control management requirements.
The areas of improvement consist of the *Interventions necessary for personal safety and public safety* section of the safety plan were systematically incomplete. The discharge planning process was not initiated during the persons served admission into the program. The program did not demonstrate an attempt to determine that each person served had an active Declaration for Mental Health Treatment prior to admission. Staff did not maintain regular compliance with the tuberculosis (TB) screening guidelines. Staff were consistently noncompliant with training requirements.
The Hospital to Home Leadership communicated that the program does not have its own set of regulatory standards, the program's daily operations mirror Crisis Respite services; however, the program has created its own operational guidelines, and utilizes the *HHS Item V Crisis Respite Standards* to govern its program. It was also observed during the entrance meeting that workstation computer monitors were visible and not positioned or equipped with privacy screen protectors to prevent unauthorized persons from viewing protected health information (PHI).

No audits of this type have been previously conducted.

V. Recommendations:
The Hospital to Home program should review the findings and continue to assess its operational processes. The Hospital to Home program is required to submit a Plan of Improvement (POI). The Vice President (VP) of the CPEP Division and the Program Manager/Director must return the signed report with a management response to Compliance within seven (7) business days by close of business.

The HARRIS CENTER for Mental Health and IDD

Compliance Department (Compliance) Review Report:
4th Quarter (Qtr.) of Fiscal Year (FY) 2023
Comprehensive Psychiatric Emergency Program (CPEP)
Hospital to Home
Comprehensive review

Compliance Auditor(s): Marvin Williams

Review Date: July 26, 2023, to August 14, 2023

Purpose

The purpose of this review was to assess Hospital to Home service documentation, facility posting requirements, infection control procedures, medication management standards, and staff trainings for compliance with *Human and Human Services Information Item V: Crisis Respite Standards* and *The Harris Center Policy ACC3B on Guidelines for Personal Safety Plans*.

Method

Active records were randomly selected from the *Affiliated Harris Center Data IP Service Details Auditing* report in the Electronic Health Record (EHR) for persons served during the 3rd Qtr. of FY 2023 (March 1, 2023 – May 31, 2023) and the *Organizational Development Staff Training Roster* report. Compliance conducted a desk review, sampling twenty (20) persons served and nineteen (19) staff using the Hospital to Home Comprehensive Review Tool developed by Compliance. 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 Assessment was consistently completed. *HHS Item V: VI. D.3.a*
- Each person served received a unit orientation within twenty-four (24) hours of admission. *HHS Item V: VI.D.3.c.i.(1), (3-5)*
- The program consistently ensured that all postings were prominently displayed within view of staff and persons served. *HHS Item V: VI. D.9.a-i*
- The program demonstrated compliance with all medication control management. *HHS Item V: VI.D.12*

Areas of Improvement:

- The *Interventions necessary for personal safety and public safety* section of the safety plan were systematically incomplete. *The Harris Center: Procedure No. ACC3B Guidelines for Personal Safety Plans*.

- The discharge planning process was not initiated during the persons served admission into the program. *HHS Item V: VI. D.5.c*
- The program did not demonstrate an attempt to determine that each person served had an active Declaration for Mental Health Treatment prior to admission. *HHS Item V: VI. D.3.a*
- Staff did not maintain regular compliance with the tuberculosis (TB) screening guidelines. *HHS Item V: VI. D.11.b.i.ii*
- Staff were consistently noncompliant with training requirements. *HHS Item V: VI.D.2.c.i.ii.iii.iv(1)-(2). v*

Observations

The Hospital to Home Leadership communicated that the program does not have its own set of regulatory standards, the program's daily operations mirror Crisis Respite services; however, the program has created its own operational guidelines, and utilizes the *HHS Item V Crisis Respite Standards* to govern its program. It was also observed during the entrance meeting that workstation computer monitors were visible and not positioned or equipped with privacy screen protectors to prevent unauthorized persons from viewing protected health information (PHI).

History

No audits of this type have been previously conducted.

Recommendations

The Hospital to Home program should review the findings and continue to assess its operational processes. The Hospital to Home program is required to submit a Plan of Improvement (POI). The Vice President (VP) of the CPEP Division and the Program Manager/Director must return the signed report with a management response to Compliance within seven (7) business days by close of business on September 5, 2023.

Management Response:

This is to state Plan of Improvement for the Hospital to Home (H2H) Program. As of 7/27/2023, the H2H Program Manager requested 6160 Administrative Support Services Supervisor purchase privacy screen protectors for all workstation desktop computer monitors to prevent unauthorized persons from viewing protected health information (PHI) during each shift. As of 8/15/2023, the H2H PM implemented H2H Care Coordinators complete Declaration for Mental Health Treatment and Discharge Planning for all new admits withing 24 hours of admission. As of 8/17/2023 during August 2023 Monthly Staffing, the H2H PM provided verbal training and demonstration of how to thoroughly complete all sections of Safety Plan for all new admission in EPIC. Both Program Assistants and Program Manager will help assist with monthly check to ensure all staff maintain compliance with agency yearly required trainings as well as TB Questionnaire before or on due date in The D.E.S.K (Saba). All staff will be requested to sign an

Signature Page

updated copy of Job Performance Expectations to comply with agency Standards of Behavior throughout work environment by 15th of September 2023.

LaCharlotte A. Smith

X

Compliance Manager

CIOX

Outreach ID: 40130425	Site ID: 41482614

Chart Review Request

To:	Neenah	Date:	6/7/2023
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C40130425
- Password: c^d5d3De

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-729-6132

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

Ciox can help you **remove the burden of fulfilling record requests** through:
>>> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records <<<
>>> **Release of Information Services:** Free up your staff's time with a centralized, outsourced approach to audits <<<

To learn more about one of these **NO COST** retrieval options, visit www.cioxhealth.com/betterway

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444944 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 1

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	

The Medical Records provided by this office, as requested on June 2023, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444944 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 1

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	

The Medical Records provided by this office, as requested on June 2023, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444942 2627 CAROLINE ST HOUSTON, TX 77004	Charts 1

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	

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Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444944 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 2

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	
○	○	[redacted]	[redacted]	[redacted]	All Treating Providers	

DOS: Present

Pull chart detail from 01/01/2022 - 12/31/2023

The Medical Records provided by this office, as requested on June 2023, are true and accurate [redacted] records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444943 1502 TAUB LOOP HOUSTON, TX 77030	Charts 3

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

DOS: Present

Pull chart detail from 01/01/2022 - 12/31/2023

The Medical Records provided by this office, as requested on June 2023, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com Username: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CiOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444946 3737 DACOMA ST HOUSTON, TX 77092	Charts 14

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOT[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted] - 12/31/2023
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444946 3737 DACOMA ST [redacted]	Charts 14

PULL	CNA	MEMBER/HEALTH PLAN				
○	○	[redacted]				
		[redacted]				
		[redacted]				

Pull chart detail from 01/01/2022 - 12/31/2023

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Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com Username: [redacted]

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

PL40130425

CIOX HEALTH

PULL LIST [redacted]

PULL CNA MEMBER [redacted]

[redacted]

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 41482614 9401 SOUTHWEST FWY [redacted]	Charts 14

PULL	CNA	MEMBER/HEALTH PLAN				
[redacted]						
○	○	[redacted]				
[redacted]						
[redacted]						

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Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

PL40130425

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

CIOX HEALTH

PULL LIST

Outreach ID: 40130425 Site ID: 40444945
5901 LONG DR
HOUSTON, TX 77087

Charts
53

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
[redacted]						

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444945 5901 LONG DR HOUSTON, TX 77087	Charts 53

PULL CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES

DOS: Present

Pull chart detail from 01/01/2022 - 12/31/2023

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Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password: [redacted]

PL40130425

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

CIOX HEALTH

PULL LIST

Outreach ID: 40130425 Site ID: 40444944
9401 SOUTHWEST FWY
HOUSTON, TX 77074

Charts
293

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]						
[redacted]						
[redacted]						
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[redacted]						
[redacted]						
[redacted]						
[redacted]						

CIOX HEALTH

PULL LIST	Outreach ID: 40130425 Site ID: 40444944 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 293

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: C40130425

Password: c^d5d3De

PL40130425

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

Amerigroup

Medicare Advantage
https://provider.amerigroup.com

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

Amerigroup is committed to improving the quality of care provided to our members and is required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Amerigroup requests your cooperation to facilitate a medical record review of 2022 and 2023 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Optum* and CIOX Health* (Ciox) to conduct the medical chart review. A Ciox representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2022, to December 31, 2023.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress notes
- History and physical
- Consult/specialist notes or letters
- Operative and pathology notes
- Procedure notes/reports
- Physical, speech, and/or occupational therapist reports
- Emergency department records
- Discharge summary

Only if there are no encounter notes for the member, please indicate CNA (chart not available) by the Chart ID along with comments explaining why the chart is not available.

If available, also include:

- *Health Maintenance Form.*
- *Demographics Sheet* (include documentation for name changes, DOB discrepancies).
- *Signature Log* (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent).

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as

* Optum is an independent company providing assessment and reporting services on behalf of Amerigroup. CIOX Health is an independent company providing medical record collection services on behalf of Amerigroup

compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

Thank you in advance for your assistance. If you have any questions related to the scheduling of this review, please contact Ciox at **877-445-9293** Monday through Friday from 7 a.m. to 8 p.m. CT, or at chartreview@cioxhealth.com.

Sincerely,

Amerigroup

Privacy Information

Federal law and related regulations under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the *American Recovery and Reinvestment Act of 2009 (ARRA)* govern the privacy of a patient's protected health information (PHI). These laws establish requirements for the use and disclosure of PHI by physicians/health care professionals, health plans, and health plans' business associates and business associate subcontractors.

HIPAA allows a covered entity, such as a healthcare provider, to disclose PHI to another covered entity, such as a health plan for payment, treatment, or healthcare operations without a member's authorization. Risk adjustment, quality assessment, and improvement activities are such permitted disclosures relating to payment, treatment, or healthcare operations.

In this case, Optum is a business associate of Amerigroup and, consistent with federal law, is conducting chart reviews for the purposes of risk adjustment, quality assessment, and improvement activities on behalf of Amerigroup. Optum has entered into a business associate subcontract with Ciox in accordance with the applicable *HIPAA* and *ARRA* requirements. These agreements allow Optum and Ciox to access and use PHI on behalf of Amerigroup for the purposes of, among other things, risk adjustment, quality assessment, and improvement activities.

Amerigroup

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https://provider.amerigroup.com

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Show All | Refresh | Spell

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

Reviewer Contact Information		Contactor Information		Corrective Action Plan		Review #		23SU13
						CAP Due Date:		6/20/2023
Name/Title:	MG / QM Specialist	Contractor Name:	The Harris Center for MHIDD	Submitted By:	BH	Submission Date:		6/20/2023
Monitoring Entity:	BHS Quality Management, Contract Services	Location:	Houston, TX (region 6)	Approved/Issued By:	MG	Approved Date:		7/18/2023
Phone/Email:	/	Monitoring Period:	FY 2022, 4th Quarter	Returned for Correction By:	MG	Returned Date:		6/30/2023

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	2nd 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)			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 TRA 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. Staff will receive additional training to address areas not in compliance. Re-evaluate corrective action plan in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate action plan in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one assessment and client chart for each staff 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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/28/23, MG Response does not indicate the number of plans will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one treatment plan will be reviewed per TRA staff on a quarterly basis to ensure the information reflected on the discharge plan is accurate. At least one aftercare plan per TRA staff will be reviewed quarterly to ensure appropriate (and different) objectives are developed to	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/28/23, MG Response does not indicate the number of plans will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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	0%	CMBHS client records did not appear to reflect education was provided on these required topics.	Clinical Team Leader (CTL)			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. At least one client chart will be reviewed for each TRA staff on a quarterly basis. Further training will be provided should findings continue to occur.	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/28/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG

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)			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. At least one client chart will be reviewed for each TRA staff on a quarterly basis. Further training will be provided should findings continue to occur.	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/28/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one client chart will be reviewed for each TRA staff on a quarterly basis. Further training will be provided should findings continue to	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/28/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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.	0%	Staff record did not indicate staff received Trauma-informed care or Cultural Competency training.	Clinical Team Leader (CTL)			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.	9/1/2023	Reviewed, 6/28/23, MG	
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)			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.	9/1/2023	Reviewed, 6/28/23, MG	
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.	0%	Treatment plans did not appear to meet TAC requirements. Specifically, objectives did not appear realistic, measurable, or time specific.	Clinical Team Leader (CTL)			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 TRF 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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one assessment and client chart for each TRF staff 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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG

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)			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. At least one treatment plan will be reviewed quarterly per each TRF staff to ensure the information reflected on the discharge plan is accurate. At least one aftercare plan will be reviewed quarterly per each TRF staff to ensure appropriate (and different) objectives are developed to [illegible]	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one discharge summary will be reviewed per TRF staff to ensure client-specific information supporting reason for discharge is [illegible]	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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) At least one final treatment plan will be reviewed per TRF staff on a quarterly basis to ensure the process of properly closing [illegible]	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. Will re-evaluate process in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one client chart will be reviewed for each TRF staff on a quarterly basis. Further training will be provided should [illegible]	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. Re-evaluate plan in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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. At least one client chart will be reviewed for each TRF staff on a quarterly basis to ensure education on the effects of ATOD	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. Re-evaluate plan in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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.	At least 1 discharged case per TRF staff will be reviewed quarterly to ensure follow up was conducted.	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. re-evaluate plan in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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)			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	At least one client chart will be reviewed for each TRF staff on a quarterly basis to ensure required reproductive health education and documentation is being conducted. Further training will be provided should findings continue to occur.	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. Re-evaluate plan in 6 months.	Will begin implementing changes and corrective actions by July 20. Will re-evaluate in 6 months. Plan to have finding corrected within one year.	Reviewed, 6/29/23, MG Response does not indicate the number of client records will be reviewed quarterly or an anticipated timeframe for the finding to be corrected.	Reviewed, 7/18/23, MG
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.	**33%**	**Training records indicated that not all staff received COPSD, ATOD effects on the fetus, and child welfare education training.**	**Clinical Team Leader (CTL)**			**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**	**Reviewed, 6/28/23, MG**	
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.	**0%**	**Training records indicated staff did not receive intake, screening, and admission authorization training.**	**Clinical Team Leader (CTL)**			**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**	**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**	**Reviewed, 6/28/23, MG**	
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)**			**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**	**Reviewed, 6/28/23, MG**	
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)**			**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**	**Reviewed, 6/28/23, MG**	
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)**			**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**	**Reviewed, 6/28/23, MG**	
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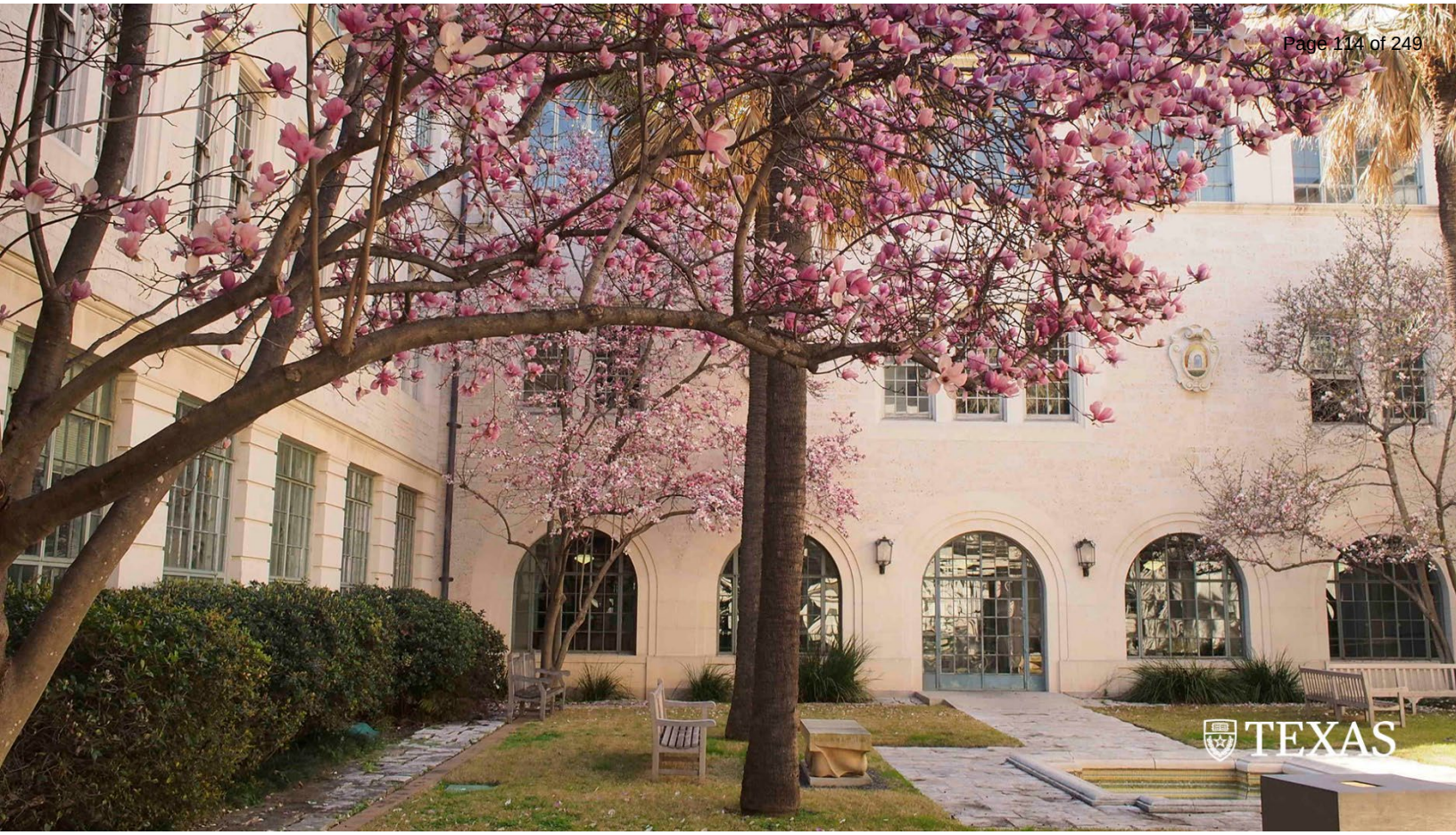


REPORT / SUICIDE CARE INITIATIVE

JUNE 19, 2023

Suicide Safe Care Review:

Harris Center for Mental Health and Intellectual and Developmental Disabilities

The University of Texas at Austin
Texas Institute for Excellence in Mental Health
Steve Hicks School of Social Work

Background

Overview of the Suicide Care Initiative

The Suicide Care Initiative (SCI), led by the Texas Health and Human Services Commission, aims to reduce the number of deaths by suicide in Texas by strengthening the public mental health system's response to individuals with suicide risk. SCI utilizes the Zero Suicide approach, which provides a framework for the implementation of suicide care best practices within health care systems. Zero Suicide is an aspirational belief that suicide deaths within health care systems are preventable; it provides a practical framework for system-wide transformation for safer suicide care.[1] The Zero Suicide framework is organized into seven essential elements:

- Lead system-wide culture change committed to reducing suicides
- Train a competent, confident, and caring workforce
- Identify individuals with suicide risk via comprehensive screening and assessment
- Engage all individuals at-risk of suicide using a suicide care management plan
- Treat suicidal thoughts and behaviors using evidence-based treatments
- Transition individuals through care with warm hand-offs and supportive contacts
- Improve policies and procedures through continuous quality improvement[2]

The Suicide Care Initiative establishes statewide infrastructure to support suicide safer care in Texas. Four Regional Suicide Care Support Centers (RSCSC) have been established to lead and coordinate activities across the 39 community mental health centers in the state. The four lead agencies are Integral Care, located in Central Texas, the Harris Center for Mental Health and IDD, located in Southeast Texas, My Health My Resources (MHMR) of Tarrant County, located in North Texas, and Tropical Texas Behavioral Health, located in South Texas. These four Local Mental Health Authorities (LMHA) pilot sites oversee the development, implementation and evaluation of SCI projects, including

1. Enhancing suicide safer care at each of the RSCSCs through the establishment of the Zero Suicide framework and its practices throughout their entire agency. Each RSCSC will work to become a model program for Zero Suicide implementation in the state.
2. Serving as training and technical assistance hub for community mental health centers throughout their region, providing evidence-based/best practice suicide specific Instructor trainings and coordinating a regional Learning Collaborative focused on implementation of Zero Suicide framework. The RSCSCs will serve as regional champions for safer suicide care, providing guidance on implementation practices and practical strategies for continuously monitoring and adjusting the approach.

The Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin supports the evaluation of the Suicide Care Initiative. The initial funding period for SCI is August 2019 to August 2023.

Methodology

Since the Spring or Summer of 2020, the Texas Health and Human Services Commission (HHSC) and Texas Institute for Excellence in Mental Health (TIEMH) have conducted an annual assessment of implementation of the Zero Suicide framework at the four RSCSCs. The initial measurement documented the status of each organization at the outset of the initiative. In May 2023, this comprehensive assessment was updated to reflect agency activities and progress over the previous year. The Suicide Safe Care Review included interviews of leadership and staff members, a review of policies and other documents, a review of staff training records, and a review of electronic medical records or charts.

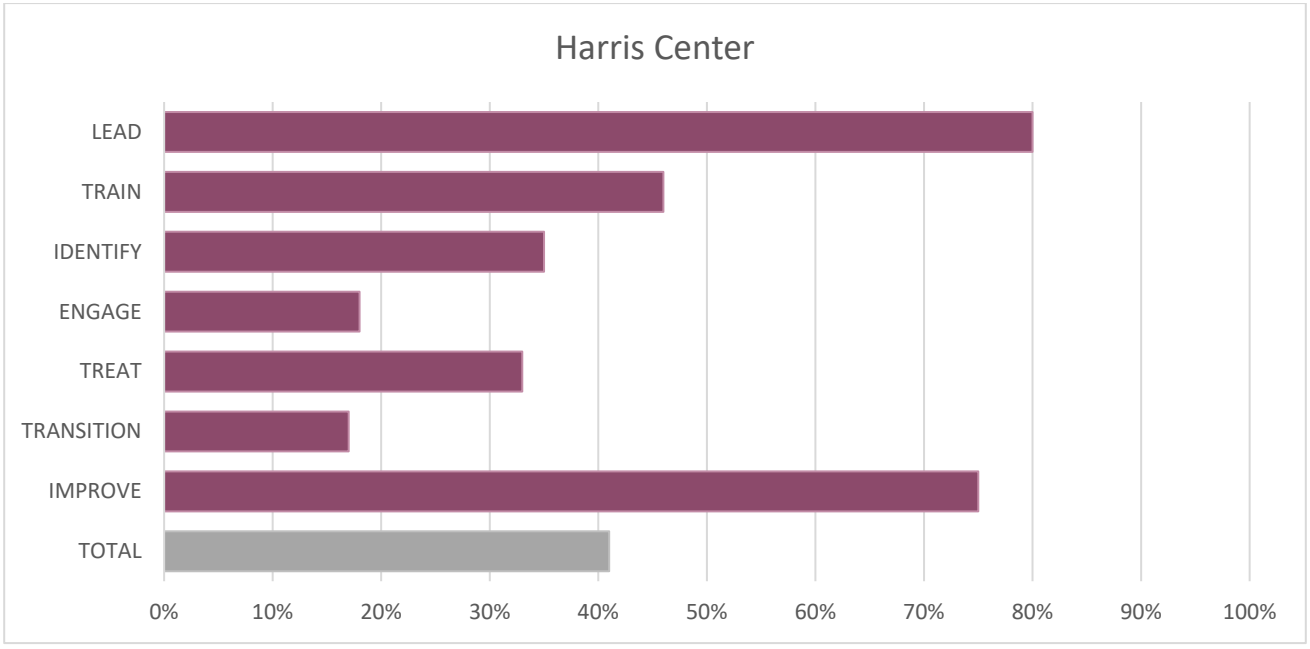
At the Harris Center for Mental Health and IDD, interviews included the agency's Zero Suicide Director and Program Manager, an Adult Services staff member, a Children's Services staff member, a member of the crisis services team, and a representative from Human Resources. The review team also conducted chart reviews on 20 records, reflecting 10 children or adolescents and 10 adults. Records were chosen to reflect individuals served within the organization by crisis response programs, children and adults with no known risk of suicide, and children and adults with known suicide risk.

RESULTS

Overview

The Harris Center received an overall 41% of the available points denoting implementation of suicide safe care best practices. Scores on each element of the Zero Suicide framework are illustrated in Figure 1. Overall, the Harris Center had the highest scores on the Lead element, which reflects the agency's commitment to the Zero Suicide approach through messaging, the establishment of a multi-disciplinary implementation team, and the inclusion of individuals with lived experience in the agency's efforts. The Harris Center had the lowest scores on the Engage element, which reflects the agency's use of suicide safe care practices within a care management plan, and the Transition element, reflecting on protocols to address gaps that can occur during transitions. The overall results show a modest increase in implementation since the previous review (previously 32%). The following sections highlight the findings from each review element. It should be noted that the sample charts relied on recently developed ways of tracking suicide risk and therefore reflected individuals early in care. The limited time period reflected in the charts could have impacted the scoring of the rubric.

Figure 1. Zero Suicide Elements



Lead

The Lead element focuses on establishing the infrastructure needed to implement a successful systems transformation, including an implementation team tasked with planning and overseeing the effort, a plan to communicate the Zero Suicide rationale to staff and provide regular updates, and policies and procedures that formalize suicide care practices. The Harris Center for Mental Health and IDD scored 80% of the available points on the Lead element. The review team noted the following findings:

CORE ELEMENT: LEAD

80%

- The suicide safe care initiative continues to show strong commitment by agency leadership. The agency core values include safety, compassion, and quality. The 2022-2024 agency strategic plan includes a strategy to "develop and implement three clinical care pathways and measure their adherence," "increase the percentage of security officers and medical staff trained in zero suicide," and "increase seven-day face-to-face follow-up rates for HCPC and SMHF discharges.
- The Harris Center has a multi-disciplinary implementation team tasked with suicide safer care best practices. The team includes representatives from medical services, nursing, psychology, forensic services, adult mental health, child and adolescent mental health, access, integrated care, crisis services, peer services, pharmacy, emergency services, IT health record, communications, and health analytics and quality assurance. The team includes multiple leaders with authority to make policy decisions and assign resources.
- The implementation team meets monthly, but attendance is generally not documented. Subcommittees have been established to address each domain of the Zero Suicide framework and meet as needed. A review of team minutes suggests that some subcommittees may not be clear on their area of focus or the long-term objectives of the Zero Suicide implementation efforts. Tasks seemed to be directed towards more active subcommittees, with some teams lacking active participation and regular meetings.
- The implementation team includes more than one representative with lived experience as a suicide loss survivor or suicide attempt survivor.
- There was evidence that some messaging about suicide prevention as a core mission of the agency was shared with staff. The primary messaging was articles within the agency staff newsletters. More recently, the team presented on Zero Suicide to the Child and Adolescent Services staff at one agency clinic. The presentation included messaging around the values and framework of Zero Suicide, opportunities for training and resources (e.g., gun locks, postvention kits). This messaging was not yet frequent or reaching all staff members.

The Harris Center continues to have a strong foundation for the Zero Suicide initiative, and this foundation has enabled the agency to make steady progress on goals. The agency has established a multi-disciplinary implementation team, with diverse representation and key decision-makers. The implementation team has organized into subcommittees, with some committees meeting regularly with clear goals and others less well-established. It may be logical to re-examine the subcommittee structure to ensure each committee has adequate leadership and membership to make progress on clearly defined goals. It may be that a smaller number of committees can more adequately move forward the agency's short-term goals. The agency continues to provide some communications that support the Zero Suicide initiative, but more frequent messaging and messaging to multiple staff members is likely needed. Presentations to specific staffing units holds promise as an effective strategy.

Train

The Train element focuses on building the capacity of the behavioral health workforce to identify and intervene with individuals at risk for suicide. This includes understanding the professional development needs of the workforce, training all staff members in basic skills in identifying suicide risk and intervening to support safety, as well as specialized training specific to a staff member's role in the agency. The Harris Center for Mental Health and IDD scored 46% of the available points on the Train element. This was a slight increase from the previous score of 42%. The review team noted the following findings:

CORE ELEMENT: TRAIN

46%

- The agency completed the Zero Suicide Workforce Survey in September 2019. The survey should be repeated at least every three years.
- Several agency job descriptions reflected the key values of safety, through expectations to reduce symptoms during crises and avoid admission to a more restrictive environment, when possible. One job description lacked this expectation, and the positions did not include an expectation for compassion in care or a similar value.
- The Harris Center had 93% of the staff trained in a suicide gatekeeper training in the sample. Staff receive either SafeTALK or ASIST. The agency reports that there are no current expectations for refresher training.
- The agency provides an annual online suicide prevention training focused on the agency policies and procedures, with compliance for 96% of staff, up from 90% the previous year. The Harris Center reports currently providing training for staff in the use of the Columbia Suicide Severity Rating Scale (C-SSRS) and Patient Health Questionnaire (PHQ-9), although this was not noted in the training records. The agency provides training to support staff in the Safety Planning Intervention (SPI), with 73% of clinical staff having documented training, up from 53% in the previous review. No staff had documented training in a suicide-focused treatment model.
- The agency has started offering training in AS+K about Suicide to Save a Life this year, although none of the staff within the sample had participated.
- The agency offers a few strategies to reduce compassion fatigue, with moderate reach. The agency provides training at new employee orientation on recognizing the warning signs of compassion fatigue and supports the development of a self-care plan. The staff have access to the Headspace app and an Employee Assistance Program (EAP), which can provide individual or group interventions. Staff reported some awareness of resources to combat compassion fatigue and reflected modest engagement in these supports.
- The agency is planning to implement a peer response model to promote resilience after stressful events, as an additional strategy to address compassion fatigue.

The Harris Center continued to advance policies and practices to support a competent workforce. The agency has established expectations for initial gatekeeper training for all staff and has provided training in Safety Planning Intervention to three-quarters of direct care staff. AS+K about Suicide to Save a Life is a new gatekeeper training being offered to staff. The Harris Center has also established most job descriptions with clear responsibilities for supporting the safety of individuals at risk within the least restrictive environment. Areas for potential growth include establishing policies for refresher trainings at a reasonable timeframe. The policies and procedures training is the only training currently required to be repeated. The agency should also continue to work towards establishing other required trainings, as the suicide care pathway is expanded and key staff competencies identified. This could include requirements for training in safety planning, CALM, suicide risk assessment, and one or more evidence-based treatment approaches for suicidal risk (CBT-Suicide Prevention, Collaborative Assessment and Management of Suicidality, Dialectical Behavioral Therapy). While staff noted that the agency strives to address compassion fatigue through a variety of approaches, burnout and compassion fatigue continue to be a challenge. Potential suggestions included reducing the impact of workforce shortages on existing staff and gradually increasing the caseloads for new staff to reduce the risk of overwhelm.

Identify

The Identify element focuses on the capacity of the health care organization to recognize individuals at increased risk of suicide and communicate the elevated risk status to all providers who interact with the individual. The Identify element includes universal screening for suicide risk and a timely assessment and determination of risk for

those who screen positive. The Harris Center for Mental Health and IDD scored 35% of the available points on the Identify element, increased from 10% in the previous review. The review team noted the following findings:

CORE ELEMENT: IDENTIFY

35%

- The Harris Center utilizes a standardized screening tool, with both the Patient Health Questionnaire (PHQ-9) and Columbia Suicide Severity Risk Scale (C-SSRS) embedded within the electronic record system. At least one use of the PHQ-9 or C-SSRS was noted in 85% of the records reviewed (up from 45% previously).
- Regular screening with the C-SSRS was documented in 36% of the charts, a slight increase from the previous review. The primary use of the C-SSRS seemed to occur in conjunction with medication visits.
- The chart review continued to identify some staff misunderstanding of how to complete the C-SSRS accurately. For example, there were instances where items were reflected “yes” in the past one/three months, but “no” in the lifetime. There were also examples where there were not suicidal behaviors noted on the lifetime scale, but previous attempts were noted in documentation. Additionally, while the C-SSRS form in the EHR is excellent, with opportunities to provide narrative description of the assessed elements, staff regularly copied and pasted the same narrative statement into each area of the C-SSRS. There was consistently a need for additional detail about the frequency, duration, and controllability of ideation, the nature of the suicide plan and their intention to act on that plan, and previous suicide behaviors or intent.
- A standardized, same-day risk assessment was conducted 56% of the time, when potential risk was noted. This was an increase from the previous finding of 13%, where risk assessment was only happening at the crisis unit. The standardized risk assessment includes key elements to be assessed, structured as pre-written statements that are clicked when relevant. These elements then populate the risk assessment note. Staff provided little additional context in a narrative format to further detail the nature of the suicide risk factors, protective factors, or mitigating circumstances.
- The agency has strived to develop a standardized risk formulation and language, but it is not yet used consistently within documentation. Additionally, definitions are inconsistent within the training and do not align with the C-SSRS, which may provide further confusion for staff.
- Clear documentation of the risk formulation was not found in any of the records reviewed. The review team looks for narrative that describes what factors were considered in making the determination, the recommended response, and the outcome of that recommendation. Staff generally documented the recommended response, but the rationale for that response and the considerations of least restrictive environment were not documented. In several instances, the recommendation did not align with other documentation, and additional rationale was needed. For example, one record had a C-SSRS at intake with all items scored “yes” and a risk formulation of “appropriate to continue outpatient services. Not an imminent risk of harm to self or others. Consulted with clinical supervisor and do not recommend inpatient." In another example, the risk assessment labelled the individual as “low risk” and the individual was admitted to inpatient care. In both of these examples, documentation of the factors that supported that determination were needed, but not provided.

The Harris Center has established the use of the C-SSRS and PHQ-9 in the agency and incorporated the tool within the electronic health record. These tools were fairly consistently used at the intake appointments, but less consistently as a screener at other timepoints. The agency has developed a standardized risk assessment that is incorporated into the EHR and additional staff have been trained to conduct these assessments when warranted. The number of same-day risk assessments increased significantly since the previous visit. Additional areas of growth include further strengthening staff competencies on completion of the C-SSRS, further clarifying the

definitions of risk determination terminology, and providing guidance on expected narrative documentation to accompany pre-written text and assessment items.

Engage

The Engage element assesses the use of a suicide care management pathway to standardize processes for engaging and maintaining safety for individuals identified with moderate to high levels of suicide risk. The Engage element relies on agency policies that specify the requirements for on-going risk assessment, frequency of contact, safety planning, and response to missed appointments, and other activities that serve to address potential gaps in care for those at risk of suicide. The Harris Center for Mental Health and IDD scored 18% of the available points on the Engage element, an increase from 6% on the previous review. The review team noted the following findings:

CORE ELEMENT: ENGAGE

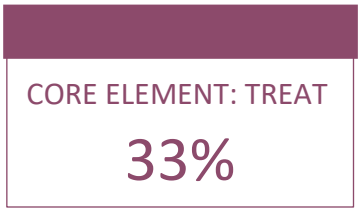
18%

- The Harris Center has begun implementing procedures for responding to individuals at risk of suicide, but only staff responsible for intake have begun implementing at this time.
- The agency has created a standardized mechanism for communicating an individual's level of suicidal risk to other providers, with defined terminology. The risk-level determination is documented at the end of the risk assessment but is not currently incorporated into a flag within the EHR.
- There was evidence of the use of safety plans for individuals at risk in 36% of records, which was a slight improvement from the previous review. Safety plans continued to lack some detail on strategies.
- There was no evidence that safety plans were regularly reviewed from the chart review, although some of the records that were reviewed reflected brief periods of time (e.g. one or two encounters).
- There was evidence of an attempt to limit access to lethal means on 15% of records of individuals with elevated suicide risk. Even when documentation occurred, it frequently appeared to be standard language rather than personalized plans. Many of the records reflected the term "safely stored" in the means safety space, but did not reflect on what means were discussed and how they were stored. In one record, "no access" was reflected in means safety, yet the individual's plan focused on driving their car to a train track.
- Several records reflected a "no harm agreement" was signed, and staff confirmed that no harm agreements are a part of agency processes.
- Twenty-five percent of records of individuals eligible for the pathway had safety plans re-evaluated at subsequent visits. There was no noticeable increase in the frequency of visits for those with elevated risk. or the monitoring and documentation of risk at each visit.
- There were no records reflecting missed appointments in an established pathway client, and so the presence of a same-day follow-up could not be scored.

The Harris Center had made some progress in its initial establishment of the care management pathway. There was an increase in the number of safety plans happening with those at risk for suicide. Additionally, there was a slight improvement in the use and documentation of counseling on lethal means safety. But evidence of other components of the care management plan, beyond the initial risk assessment period are not yet reflected in the review. The agency should begin to further delineate and define these protocols, including standardized psychoeducation, on-going reviews of safety plans and means safety, increased frequency of monitoring (including regular screening), and protocols for responding following missed appointments. The Harris Center should continue strive towards having a flag that identifies individuals at risk of suicide and on the care pathway.

TREAT

The Treat element refers to the use of evidence-based treatments that focus specifically on reducing an individual's risk of suicide, rather than merely targeting treatment for psychiatric diagnoses, such as major depression or Post Traumatic Stress Disorder (PTSD). This element of the Zero Suicide framework also includes supporting treatment in the least restrictive environment, which may include access to alternatives to psychiatric hospitalization. The Harris Center for Mental Health and IDD scored 33% of the available points on the Treat element, which is an increase from the previous review. The review team noted the following findings:

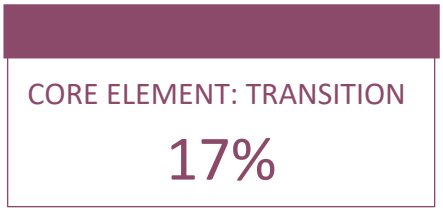


- The Harris Center does not currently offer evidence-based treatment focused on suicidality.
- The Harris Center does not currently assess fidelity to an evidence-based suicide-focused treatment.
- Due to the brief time period reflected in the records that were reviewed, the team was unable to examine the use of other intervention approaches to address suicidality.
- The Harris Center has an array of services and supports that are alternatives to psychiatric hospitalization, allowing some individuals to be served in the least restrictive environment. The agency provides a crisis hotline, mobile crisis outreach, a crisis respite program, and a crisis residential unit. Chart reviews reflected that inpatient hospitalization was still the primary response for individuals at risk, but one physician directed the MCOT team to provide daily contact as a way to support safety between physician visits. While the team did not monitor the client with this frequency, services in LOC 5 by crisis staff or within a pathway to care could provide the necessary level of structure and support to safely maintain more individuals in the least restrictive environment during a crisis period.

The Harris Center has a well-developed crisis response system and an array of services that can support treatment in the least restrictive setting. Areas for potential growth include increasing the number of options for supporting individuals at risk within the least restrictive environment and offering evidence-based outpatient treatment for suicidality.

TRANSITION

Care transitions can be a high-risk period for individuals at risk of suicide; therefore, the Transitions element focuses on the health care organization's capacity to manage risk during periods of transition. This includes supporting individuals transitioning from the emergency department or psychiatric hospitals, as well as supporting individuals who may miss appointments or withdraw from care. The Harris Center for Mental Health and IDD scored 17% of the available points on the Transition element, a slight decrease from the previous review. The review team noted the following findings:



- The agency has an affiliated psychiatric hospital and a Memorandum of Understanding (MOU) with some, but not all, regional hospitals or emergency departments.
- While a continuity of care team is established within the agency, there was no evidence in the selected records of staff conducting care coordination during an individual's hospital stay. In one instance, the MCOT team was involved in the hospitalization and conducted a follow-up contact, during which they supported the scheduling of an appointment.

- No individuals who were discharged from the hospital or emergency room received an appointment within 48 hours. Most were seen with two weeks of the discharge.
- There was no indication that individuals discharged from the hospital or emergency department received priority scheduling for a psychiatric appointment. This was a decrease from the previous review. Most psychiatric visits were three to four weeks from the discharge.
- The agency has shared caring contact cards for individuals at risk following crisis services; however, there was no documentation in the records reviewed to reflect who had received them.

The Harris Center has established some procedures to support individuals during transitions, but has not made noticeable progress in this domain over the year. The agency has MOUs with some local hospitals. Some agency staff are tasked with supporting transitions, but their intervention was not noticeable in the charts that were reviewed by the team. Individuals frequently had to wait to access care upon discharge, with intake appointments three or four weeks after discharge. There was also no process to follow-up with individuals who declined a referral for outpatient care, such as by continuing crisis transition services or sending a caring contact card. The implementation team is piloting a program with peer support specialists supporting individuals during and following a crisis event, but this was not yet noted in the charts reviewed.

IMPROVE

The Improve element focuses on the agency's use of a continuous quality improvement process to foster better outcomes for individuals at risk of suicide. In the Zero Suicide approach, the organization measures fidelity to the specified policies and practices, as well as relevant individual outcomes. The agency is able to rapidly respond to data by enhancing the quality of implementation or adjusting policies and practices. The Harris Center scored 75% of the available points on the Improve element, a marked increase from 38% on the last review. The review team noted the following findings:

CORE ELEMENT: IMPROVE

75%

- The implementation team has developed a data dashboard to provide actionable data metrics to the team. While its use is just beginning, it provides important resources to the team to monitor progress.
- The agency currently examines any deaths by suicide through the death review process. A multi-disciplinary team is tasked with conducting a root cause analysis; however, this data is not yet utilized by the Zero Suicide implementation team for planning or quality improvement processes.
- The agency tracks both suicide attempts and suicide deaths for quality improvement purposes.
- There is some evidence that the implementation uses some data metrics in their work, but the use of actionable data is not yet a key component of the implementation team.

The Harris Center has begun to gather data and review it to inform the Zero Suicide efforts in the agency. The team has recently developed a near-time data dashboard that can be used to examine implementation. The data dashboard should be modified to align with the implementation team's goals, as needed, especially as additional components of the care pathway are defined.

POLICIES TO SUPPORT SUICIDE SAFE CARE

The Zero Suicide approach calls for written agency policies that formalize suicide safe care practices, specify requirements for workforce training, and establish an organizational culture that values safety and compassion. The Suicide/Violence Behavioral Crisis Intervention policy (March 2023) was reviewed.

- The policy provides definitions of different terms utilized within the policy. The implementation team may want to consider aligning the definitions with terms used in the C-SSRS, as that has been a key goal of the widespread use of the C-SSRS. For example, in the current policy suicide behavior is defined as "Includes suicide attempts, suicidal gestures, intentional self-injurious behavior, and/or the development of a plan or strategy for committing suicide. Suicidal behavior involves some overt action or clear indication of developing a specific plan or strategy to injure or kill oneself." The C-SSRS, on the other hand, differentiates between the development of a plan and specific behaviors taken towards that plan (e.g., buying a gun). For another example, the policy defines self-injurious behavior as "Behavior that causes harm, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness. Self-injurious behavior is considered a type of suicidal behavior for reporting purposes." The C-SSRS differentiates self-harm from a suicidal behavior based on whether there was any aspect of the behavior that included an intent to die.
- The policy defines imminent risk as "thoughts of harming oneself and/or others within the last 48 hours" and uses this term to indicate that staff who determine imminent risk and the individual refuses further treatment should contact 911 to request police support (CIT or CIRT if available). This definition seems to not align with other uses of the term, such as Texas statute where it reflects "a substantial risk of serious harm to himself/herself or others" and that "harm is imminent" unless the person is restrained.
- The policy states requirements around documentation of suicide/homicide/crisis assessments and interventions and procedures for applying for an emergency detention order.
- The policy provides a list of trainings that support suicide and homicide precautions. The team should consider adding a training on risk assessment and risk formulation to the list.
- The policy references the Suicide Prevention Care Pathway. While the link could not be reviewed, the term care pathway is not currently being used to describe a suicide care pathway in the way that the Zero Suicide Framework has intended. The policies describing care pathways are describing clinical workflow processes for identifying and intervening with those at risk for suicide, but it does not incorporate the on-going, increased engagement that is expected for a person at increased risk of suicide. The workflows have been an important first step in improving suicide care within the agency and should be expanded upon to include policies surrounding increased monitoring and engagement and care for those identified as at risk for suicide.

RECOMMENDATIONS

The suicide safe care review was conducted in May 2023 at the Harris Center for Mental Health and IDD. This year's review illustrated some additional progress in Zero Suicide implementation, with the overall ratings increasing from 32% to 41%. The implementation team and subcommittees continued to work over the past year, strengthening training requirements, developing initial guidance on risk assessments, aligning forms within the EHR for desired staff activities and data collection, and developing a data dashboard to track progress. The agency has achieved adherence to suicide prevention gatekeeper training and has advanced the percentage of staff trained in safety planning. Additionally, there was an increase in the proportion of records demonstrating universal screening, as well as those reflecting same-day safety planning. Additionally, staff excelled at providing same-day contact with individuals at elevated risk following a missed appointment. Individuals discharged from

the emergency room or hospital also generally had access to a psychiatric appointment within one or two weeks from discharge. The review team offers the following recommendations for next steps in this effort:

- The implementation team may want to revisit the current subcommittee structure to optimize progress on core elements. This may mean reducing the number of subcommittees, creating opportunities for co-leads, ensuring each subcommittee is clear about their goals, and examining teams that need additional membership.
- The implementation team should continue to work to enhance the new risk assessment process through training and coaching of staff. The basic structure is present within the EHR, allowing for the team to focus efforts on strengthening staff's ability to gain knowledge in suicide risk terminology present in the C-SSRS, areas of assessment to fully understand suicide ideation, planning, and intent, and information to understand the nature and risk presented by prior suicide behaviors. Additionally, staff can build skills in documenting a clear risk formulation and appropriate considerations of mitigating factors to make a recommendation. While the agency has created a template that efficiently prompts areas for assessment, staff will still need to provide narrative documentation of information that has impacted the determination of risk and recommended action steps.
- The development of risk assessment training for staff and its initial pilot is a strength that can be built upon. The team should continue to examine and refine risk statuses to provide clear guidance to staff. Currently the criteria for acute risk differ across the three slides, but using the more detailed slide (slide 15), they are:
    - High – potentially lethal suicide attempt/violence or persistent ideation with strong intent or rehearsal
    - Moderate – Suicidal ideation with no plan, intent, or behavior, willingness to maintain a safety plan
    - Low – no current ideations

  The current definitions lack any reference to time, leaving staff to generally focus on the current moment; yet research suggests that a broader time period should be considered in understanding risk. Additionally, the criteria fails to differentiate individuals with active suicidal ideation and some idea of methods or some level of intent (considered moderate on the C-SSRS) with others who have a very specific plan and intent or have recently had a suicide attempt or taken steps toward an attempt (consider high on the C-SSRS). By classifying all individuals with any plan, intent, or behavior as "high risk," individuals who may have been supported outside of inpatient care are likely to be referred.
- Consider terminology around the suicide care pathway to ensure staff understand Zero Suicide components. The current elements labeled as the suicide care pathway reflect procedures for suicide risk screening and assessment. Within Zero Suicide, these are reflected in the Identify element, as they support determining level of risk and making immediate recommendations for the level of care needed. The suicide care pathway describes specific interventions and level of monitoring recommended for an individual who staff believe can be safely supported outside of a more restrictive environment. These include things such as more frequent monitoring, repeated assessment of suicide risk, review and adjustment of the safety plan, protocols to respond when appointments are missed, and interventions known to be effective in addressing suicidality. The implementation team should consider waiting to describe the care pathway until these elements (which occur after the intake appointment) are established.
- The team recommends discontinuing procedures for no harm agreements and replacing with consistent use of safety planning. Additional training and staff coaching should focus on utilizing safety plans for all individuals at elevated risk (unless risk is imminent), providing details and personalization to safety plans, and strengthening proactive means safety discussions. Counseling on access to lethal means should focus

on means that are a part of the individuals plan, as well as firearms, and detail specific strategies to limit access to lethal means. The team should consider requiring training in CALM to support this competency.

- Continue to strengthen the continuity of care program to support individuals in obtaining outpatient appointments rapidly following discharge (ideally within 48 hours). Consider developing protocols to ensure individuals have an existing appointment before they are discharged and that protocols exist to follow-up rapidly if individuals fail to attend the continuity of care appointment.
- As was reflected in the previous review, consider refreshing staff training on the C-SSRS, including the documentation of suicidal behaviors (Item #6) reflecting any history of these behaviors, not limited to "since last visit." Additionally, training should include policies around how elevated risk on the C-SSRS should be considered within an overall risk formulation. These issues have been consistent across the review periods, suggesting a need for further training or support.
- Consider training clinical staff in evidence-based suicide-specific treatment options, such as Collaborative Assessment and Management of Suicidality (CAMS), CBT for Suicide Prevention (CBT-SP), or Dialectical and Behavioral Therapy (DBT). Referral for suicide-focused treatment should be a component of the care management plan. Training in CBT-SP for therapists trained in CBT for depression would allow for greater flexibility in meeting the needs of individuals at increased risk, even if training of non-licensed staff in other models may be necessary to meet the full need.

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Chart Review Request

To:	Unknown	Date:	8/23/2023
Fax Number:	(713) 970-7246	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C42649946
- Password: 15*c23aC

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-729-6132

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

Ciox can help you remove the burden of fulfilling record requests through:
>>> Digital Retrieval: Automate the intake, fulfillment, quality control and delivery of medical records <<<
>>> Release of Information Services: Free up your staff's time with a centralized, outsourced approach to audits <<<

To learn more about one of these NO COST retrieval options, visit www.cioxhealth.com/betterway

AUG 24 2023

RECEIVED

CIOX HEALTH

PULL LIST	Outreach ID: 42649946 Site ID: 34365612 7200 NORTH LOOP E HOUSTON, TX 77028	Charts 3

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	4/30/1950	[redacted]	All Treating Providers	[redacted]
					Pull chart detail from 01/01/2022 - 12/31/2023	
○	○	[redacted]	2/28/1994	[redacted]	All Treating Providers	[redacted]
					Pull chart detail from 01/01/2022 - 12/31/2023	
○	○	[redacted]	4/8/1965	[redacted]	All Treating Providers	[redacted]
					Pull chart detail from 01/01/2022 - 12/31/2023	

The Medical Records provided by this office, as requested on August 2023, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com

Username: [redacted]

Password [redacted]

[redacted]cioxhealth.com

PL42649946

Amerigroup

Medicare Advantage
https://provider.amerigroup.com

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

Amerigroup is committed to improving the quality of care provided to our members and is required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in certain Medicare-covered health plans. Accordingly, Amerigroup requests your cooperation to facilitate a medical record review of 2022 and 2023 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Optum* and CIOX Health* (Ciox) to conduct the medical chart review. A Ciox representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2022, to December 31, 2023.

Notes should include member name, date of visit, and provider signature with credentials.

Please include all of the following medical record documentation available for this chart review:

- Progress notes
- History and physical
- Consult/specialist notes or letters
- Operative and pathology notes
- Procedure notes/reports
- Physical, speech, and/or occupational therapist reports
- Emergency department records
- Discharge summary

Only if there are no encounter notes for the member, please indicate CNA (chart not available) by the Chart ID along with comments explaining why the chart is not available.

If available, also include:

- *Health Maintenance Form.*
- *Demographics Sheet* (include documentation for name changes, DOB discrepancies).
- *Signature Log* (complete and return if progress notes contain handwritten signatures or credentials of provider are not contained in patient information being sent).

Note: Pursuant to CMS requirements, providers' signatures and qualifications are required to validate each medical record.

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as

* Optum is an independent company providing assessment and reporting services on behalf of Amerigroup. CIOX Health is an independent company providing medical record collection services on behalf of Amerigroup.

compiling information for Healthcare Effectiveness Data & Information Set® (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

Thank you in advance for your assistance. If you have any questions related to the scheduling of this review, please contact Ciox at 877-445-9293 Monday through Friday from 7 a.m. to 8 p.m. CT, or at chartreview@cioxhealth.com.

Sincerely,

Amerigroup

Privacy Information

Federal law and related regulations under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the *American Recovery and Reinvestment Act of 2009 (ARRA)* govern the privacy of a patient's protected health information (PHI). These laws establish requirements for the use and disclosure of PHI by physicians/health care professionals, health plans, and health plans' business associates and business associate subcontractors.

HIPAA allows a covered entity, such as a healthcare provider, to disclose PHI to another covered entity, such as a health plan for payment, treatment, or healthcare operations without a member's authorization. Risk adjustment, quality assessment, and improvement activities are such permitted disclosures relating to payment, treatment, or healthcare operations.

In this case, Optum is a business associate of Amerigroup and, consistent with federal law, is conducting chart reviews for the purposes of risk adjustment, quality assessment, and improvement activities on behalf of Amerigroup. Optum has entered into a business associate subcontract with Ciox in accordance with the applicable *HIPAA* and *ARRA* requirements. These agreements allow Optum and Ciox to access and use PHI on behalf of Amerigroup for the purposes of, among other things, risk adjustment, quality assessment, and improvement activities.

CIOX | Outreach ID: 42650577 | Site ID: 43032287

Chart Review Request

To:	Unknown	Date:	8/23/2023
Fax Number:	(713) 970-7246	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:
- Username: C42650577
- Password: b^D3b676

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-729-6132

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
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AUG 24 2023

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RECEIVED

CIOX HEALTH

PULL LIST

Outreach ID: 42650577 Site ID: 43032287
5901 LONG DR
HOUSTON, TX 77087

Charts 2

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
O	O	[redacted]	7/2/1963	[redacted]	All Treating Providers	111340 SE
					Pull chart detail from 01/01/2022 - 12/31/2023	
O	O	[redacted]	5/13/1972	[redacted]	All Treating Providers	438797 SE
					Pull chart detail from 01/01/2022 - 12/31/2023	

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Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com Username: [redacted] Password: [redacted]

PL42650577

Alternatively, fax to 1-972-729-6132. Questions? Email us at chartreview@cioxhealth.com

Amerigroup

Medicare Advantage
https://provider.amerigroup.com

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

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Please include all of the following medical record documentation available for this chart review:

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- Discharge summary

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Sincerely,

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CIOX

Outreach ID: 42648396	Site ID: 40444946

Chart Review Request

To:	Unknown	Date:	8/23/2023
Fax Number:	(713) 970-7246	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C42648396
- Password: fa6A^ffb

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-729-6132

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Phoenix, AZ 85021

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AUG 24 2023

RECEIVED

CIOX HEALTH

PULL LIST

Outreach ID: 42648396 Site ID: 40444946
3737 DACOMA ST
HOUSTON, TX 77092

Charts 2

PULL	CNA	MEMBER/HEALTH PLAN	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	12/22/1980	[redacted]	All Treating Providers	[redacted]
					Pull chart detail from 01/01/2022 - 12/31/2023	
○	○	[redacted]	6/18/1951	[redacted]	All Treating Providers	[redacted]
					Pull chart detail from 01/01/2022 - 12/31/2023	

The Medical Records provided by this office, as requested on August 2023, are true and accurate copies of the records kept in the usual course of business reflecting the medical care provided to patients on the dates indicated in the Medical Records.

Practice Group Administrator/Custodian of Medical Records

Date

Upload to www.cioxlink.com
Username: C42648396
Password: fa6A^ffb

PL42648396

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Amerigroup

Medicare Advantage
https://provider.amerigroup.com

Subject: Time-sensitive request for medical records for Medicare risk adjustment data

Dear Provider:

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We have engaged Optum* and CIOX Health* (Ciox) to conduct the medical chart review. A Ciox representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2022, to December 31, 2023.

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- History and physical
- Consult/specialist notes or letters
- Operative and pathology notes
- Procedure notes/reports
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- Emergency department records
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- *Health Maintenance Form.*
- *Demographics Sheet* (include documentation for name changes, DOB discrepancies).
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Thank you in advance for your assistance. If you have any questions related to the scheduling of this review, please contact Ciox at 877-445-9293 Monday through Friday from 7 a.m. to 8 p.m. CT, or at chartreview@cioxhealth.com.

Sincerely,

Amerigroup

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HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

August 25, 2023

Mr. Wayne Young
Chief Executive Officer
The Harris Center
9401 Southwest Freeway
Houston, TX 77074
Subject: Fiscal Year 2023 Corrective Action Plan Compliance Review

Dear Mr. Young:

Texas Health and Human Services Commission (HHSC), Community Services, Intellectual and Developmental Disabilities (IDD) Services, Contract Accountability and Oversight (CAO) completed the fiscal year 2023 corrective action plan(s) (CAP) compliance review of The Harris Center for Mental Health and IDD on August 21, 2023.

At the conclusion of the CAP compliance review process, report for Quality Assurance (QA), General Revenue and Community First Choice (GR-CFC), Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Preadmission Screening and Residence Review (PASRR) were presented to designated Local Intellectual and Developmental Disability Authority (LIDDA) staff.

It was determined that The Harris Center for Mental Health and IDD is in compliance with the specific corrections in the QA and TxHmL CAPs.

It was determined that The Harris Center for Mental Health and IDD has demonstrated partial compliance with the specific corrections in the GR-CFC, HCS, and PASRR CAPs; however, consultation was provided concerning implementation of the CAPs. Written comments were included in the reports presented.

Subsequent correspondence by the HHSC IDD Services contract manager is forthcoming. Please extend our appreciation to your staff for their cooperation during this CAP Compliance Review. If you have any questions or require additional information, please contact Denice Cadena, Contract Specialist, by email at denice.cadena@hhs.texas.gov.

Sincerely,

X Shurmeka McKenzie, M.S.

Shurmeka McKenzie
Manager
Contract Accountability and Oversight
HHSC IDD Services

SM:dc

cc: Annie Cuba, The Harris Center for Mental Health and IDD
Sarah Flores, Contract Manager, IDD Performance Contracts Unit

Enclosures

**** INSTRUCTIONS FOR PROVIDER OFFICES ****

May 23, 2023

Dear Provider:

Cigna Healthcare is in the process of conducting medical record diagnostic coding reviews as part of its Medicare Advantage risk adjustment process and as part of its commitment to quality patient care and provider support. As you may know, risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to determine payments to Medicare Advantage health plans. This methodology is dependent on accurate and complete diagnosis coding. Reviewing medical chart documentation assists Cigna Healthcare in meeting these requirements.

Our goal is to make this process as unobtrusive as possible. To support this goal, Cigna Healthcare has enlisted the services of **CIOX Health** to retrieve medical records. You will be contacted by CIOX Health to make arrangements convenient for your practice. We will also work with you to minimize disruptions in patient care activities.

Next steps:

- Please anticipate receiving a call from CIOX Health to schedule the chart retrieval
- For each medical record, the following information is needed for dates of service from **January 1, 2022 through Current**:
    - History & Physical
    - Consultation Notes
    - Progress Notes
    - Medication List
    - Enhanced Encounter/360/HMR documents
    - Demographic Sheet
    - Search all EHR **and** Paper Chart formats for date range

Cigna Healthcare has executed a confidentiality agreement with CIOX Health and their employees, so that any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding confidentiality and HIPAA requirements. Should you have any questions regarding this project, please contact the CIOX Health Provider Support Center at 1-877-445-9293.

Cigna Healthcare is conducting this chart review to ensure compliance with CMS guidelines for the submission of accurate information about your patients. Your participation is extremely valuable and necessary.

Thank you for your cooperation with this important activity.

CIOX HEALTH

PULL LIST	Outreach ID: 41095649 Site ID: 39913251 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 46

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]						
[redacted]						
[redacted]						
[redacted]						
[redacted]						
[redacted]						NW
[redacted]						
[redacted]						
[redacted]						
[redacted]						
[redacted]						

CIOX HEALTH

PULL LIST	Outreach ID: 41095649 Site ID: 39913251 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 46

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]						

Pull chart detail from 01/01/2022 - Present

PL41095649

*** Notice of Past Due Request ***

Your Immediate Response is Required

This notice is a follow-up to a previously submitted request for medical record release. If you have not already done so, your immediate attention to address these outstanding records is appreciated.

For questions regarding this notice please contact our provider support team at or chartreview@cioxhealth.com

To fulfill this request for records please use one of the following options.

- For medical record submission via fax, use the fax number on the Provider Packages or our main fax number, 972-729-6174
- For medical record submission via mail, use the address 2222 W. Dunlap Ave Phoenix, AZ 85021
- For medical record submission via provider portal, use the website www.cioxlink.com

CIOX | Outreach ID: 42515198 | Site ID: 42894908

Chart Review Request

To:	Ariel/Medical Records	Date:	8/28/2023
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C42515198
- Password: 3#33c8f7

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-729-6164

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

AUG 28 2023

RECEIVED

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oscar

Dear Medical Records Department,

Oscar has partnered with Ciox Health to facilitate the retrieval of medical records for our members, as part of a Risk Adjustment program. We appreciate your cooperation with this medical record retrieval, which is necessary for compliance with the Centers for Medicare and Medicaid Services (CMS).

Risk Adjustment is a payment methodology used by CMS. Oscar performs ongoing chart reviews to ensure complete documentation of our member's health conditions for submission to CMS and to improve the coordination of their care.

We'll strive to minimize any disruptions in patient care activities. We have executed a Business Associate Agreement with Ciox Health; all information shared during this process will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, including HIPAA requirements. We are not requesting confidential psychotherapy notes.

Below is a list of components requested, if applicable, for encounters from 1/1/2022-present.

We would appreciate your cooperation with this chart retrieval, which is necessary for compliance with CMS. *Records must include patient name, birthdate, and be signed with provider credentials (i.e. MD, DO, etc.)* Below is a list of components requested, if applicable:

- Demographic/Face Sheet
- History & Physical
- Consult Notes
- Progress Notes
- Office notes
- Operative Reports/Procedure Notes
- Signature Log
- Problem list/Medication List
- Chemo/Radiation Reports and Encounters
- Admission/Discharge Summaries for Hospital and SNF facilities
- Physical, Occupational, and other Therapy notes
- Pathology Reports
- Health Assessment Forms
- Emergency Department notes
- Radiology Reports/ Mammogram Reports
- Skilled Nursing Facility (SNF) encounters
- Labs/Laboratory Reports
- Consultation Correspondence (Inpatient and Outpatient)

If you have any questions regarding this project, please call the Ciox Health Provider Support Center at (877) 445-9293. Thank you in advance for your cooperation.

Sincerely,

Bahar Sedarati, MD
Medical Officer
Oscar Insurance

Confidentiality:
We have entered into a Business Associate Agreement ("BAA") with CIOX Health in accordance with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder (collectively "HIPAA"). The BAA allows CIOX Health to perform activities involving the use or disclosure of protected health information ("PHI") on our behalf. HIPAA allows a covered entity to disclose PHI to another covered entity for the health care operations of the entity receiving the information, without a member's authorization or consent, under certain circumstances. We believe that HIPAA permits you to disclose PHI to CIOX Health, our Business Associate, for risk adjustment purposes.

CIOX HEALTH

PULL LIST	Outreach ID: 42515198 Site ID: 42894908 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 5

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
O	O	[redacted]				
O	O					
O	O					
O	O					
O	O					

PL42515198

ciox | **Outreach ID: 42515198** | **Site ID: 42894908**

Chart Review Request

To:	Ariel/Medical Records	Date:	8/28/2023
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
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>>> **Release of Information Services:** Free up your staff's time with a centralized, outsourced approach to audits <<<

To learn more about one of these **NO COST** retrieval options, visit www.cioxhealth.com/betterway

oscar

Dear Medical Records Department,

Oscar has partnered with Ciox Health to facilitate the retrieval of medical records for our members, as part of a Risk Adjustment program. We appreciate your cooperation with this medical record retrieval, which is necessary for compliance with the Centers for Medicare and Medicaid Services (CMS).

Risk Adjustment is a payment methodology used by CMS. Oscar performs ongoing chart reviews to ensure complete documentation of our member's health conditions for submission to CMS and to improve the coordination of their care.

We'll strive to minimize any disruptions in patient care activities. We have executed a Business Associate Agreement with Ciox Health; all information shared during this process will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records, including HIPAA requirements. We are not requesting confidential psychotherapy notes.

Below is a list of components requested, if applicable, for encounters from 1/1/2022-present.

We would appreciate your cooperation with this chart retrieval, which is necessary for compliance with CMS. *Records must include patient name, birthdate, and be signed with provider credentials (i.e. MD, DO, etc.)* Below is a list of components requested, if applicable:

- Demographic/Face Sheet
- History & Physical
- Consult Notes
- Progress Notes
- Office notes
- Operative Reports/Procedure Notes
- Signature Log
- Problem list/Medication List
- Chemo/Radiation Reports and Encounters
- Admission/Discharge Summaries for Hospital and SNF facilities
- Physical, Occupational, and other Therapy notes
- Pathology Reports
- Health Assessment Forms
- Emergency Department notes
- Radiology Reports/ Mammogram Reports
- Skilled Nursing Facility (SNF) encounters
- Labs/Laboratory Reports
- Consultation Correspondence (Inpatient and Outpatient)

If you have any questions regarding this project, please call the Ciox Health Provider Support Center at (877) 445-9293. Thank you in advance for your cooperation.

Sincerely,

Bahar Sedarati, MD
Medical Officer
Oscar Insurance

Confidentiality:
We have entered into a Business Associate Agreement ("BAA") with CIOX Health in accordance with the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder (collectively "HIPAA"). The BAA allows CIOX Health to perform activities involving the use or disclosure of protected health information ("PHI") on our behalf. HIPAA allows a covered entity to disclose PHI to another covered entity for the health care operations of the entity receiving the information, without a member's authorization or consent, under certain circumstances. We believe that HIPAA permits you to disclose PHI to CIOX Health, our Business Associate, for risk adjustment purposes.

CIOX HEALTH

PULL LIST	Outreach ID: 42515198 Site ID: 42894908 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 5

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
O	O	[redacted]	[redacted]	[redacted]	All Treating Providers	Full Chart detail from 01/01/2022 - Present
O	O	[redacted]				
O	O	[redacted]				
O	O	[redacted]				
O	O	[redacted]				

PL42515198

CIOX | Outreach ID: 42021861 | Site ID: 43075557

Chart Review Request

To:	Ariel/Medical Records	Date:	8/28/2023
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C42021861
- Password: F^e7efcc

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-957-2143

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

AUG 28 2023

Ciox can help you **remove the burden of fulfilling record requests** through:
>>> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records <<<
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To learn more about one of these **NO COST** retrieval options, visit www.cioxhealth.com/betterway

DevotedHealth

Date: 03/20/2023
To: Devoted Health Healthcare Providers and Office Managers
From: Devoted Health
Re: CIOX Health Authorized Retrieval of Records for Risk Adjustment Chart Review

Devoted Health is requesting your cooperation by providing access to specific member medical records in your office to facilitate a risk adjustment chart review. As you may know, risk adjustment is the payment methodology used by the Centers for Medicare and Medicaid Services (CMS) for our Medicare Advantage members based on the health status of the member. In order to ensure complete documentation of our member's health conditions and improve coordination of care, it is necessary to perform ongoing risk adjustment chart reviews.

CIOX Health has been engaged by Devoted Health to retrieve medical records selected as part of this chart review. We would appreciate your cooperation with this medical record review and we will work with you to minimize disruptions in patient care activities. Please anticipate receiving a call from CIOX Health to schedule the medical record retrieval.

Please note the items listed below are the components requested, if applicable, for all **dates of service from January 1, 2022 to December 31, 2022**:

- Demographic/Face Sheet
- History & Physical
- Consult Notes
- Progress Notes
- Demographic Sheet
- Problem List
- Signature Log
- Lab & diagnostic test results

Please be aware that Devoted Health has executed a Business Associate Agreement with CIOX Health; and any information shared during this review will be kept in the strictest of confidence, in accordance with all applicable State and Federal laws regarding the confidentiality of patient records including current HIPAA requirements.

Should you have any questions regarding this project, please feel free to call the CIOX Health Provider Support Center at (877) 445-9293. Thank you in advance for your cooperation with this chart review process.

Sincerely,

Devoted

Confidentiality:
Devoted Health has entered into a Business Associate Agreement with CIOX Health in accordance with the privacy regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This agreement allows CIOX Health to perform activities involving the use or disclosure of individually identifiable health information on behalf of Devoted Health. In addition, it only permits CIOX Health to use the information as permitted in accordance with Business Associate Agreement. The regulations promulgated under HIPAA are the federal rules that govern the privacy of an enrollee's protected health information (PHI), and establish requirements for the use and disclosure of PHI by physicians/health care professionals and Devoted Health in connection with their "health care operations" activities. HIPAA allows a covered entity to disclose PHI to another covered entity for the health care operations of the entity receiving the information, without an enrollee's authorization or consent, under certain circumstances. Under this provision, you are permitted to disclose PHI to CIOX, as CIOX Health is a Business Associate of Devoted Health and acting on behalf of Devoted Health.

In adopting this regulation under HIPAA, the Department of Health and Human Services (HHS) explicitly recognized in the preamble to the HIPAA privacy regulations that Devoted Health may need to obtain PHI from physicians and other health care professionals for the plans' quality related activities, accreditation, and performance measures. HHS confirmed that the provision "was intended to allow information to flow from one covered entity to another for activities important to providing quality and effective health care."

CIOX HEALTH

PULL LIST	Outreach ID: 42021861 Site ID: 43075557 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 1

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
○	○	[redacted]				

DOS: 01/04/2022

Pull chart detail from 01/01/2022 - 12/31/2022

PL42021861

ciox | Outreach ID: 42615975 | Site ID: 43645592

Chart Review Request

To:	Ariel/Medical Records	Date:	8/28/2023
Fax Number:	(713) 970-3817	Phone Number:	(713) 970-7000

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

To learn how to reduce the phone calls and faxes from Ciox and eliminate the burden of medical record retrieval in the future, visit www.cioxhealth.com/betterway

Medical records can be submitted through the following options:

1. PROVIDER PORTAL:
Upload the medical records to Ciox's secure provider portal at https://www.cioxlink.com using the following credentials:

- Username: C42615975
- Password: 1d^ddDD5

2. REMOTE EMR Retrieval:
Set up secure remote connection from a provider site's EMR directly to Ciox for timely off-site remote retrieval of records with trained associates at Ciox by contacting

3. ONSITE Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.FAX:
Send secure faxes to 1-972-957-2143

5. MAIL:
Mark "Confidential" on the envelope and mail the medical records to: CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

AUG 28 2023

Ciox can help you **remove the burden of fulfilling record requests** through:
>>> **Digital Retrieval:** Automate the intake, fulfillment, quality control and delivery of medical records <<<
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To learn more about one of these **NO COST** retrieval options, visit www.cioxhealth.com/betterway

May, 2023

RECORDS REQUEST

Dear Provider,

Wellcare is committed to improving the quality of care provided to our members. We are required by the Centers for Medicare & Medicaid Services (CMS) to submit complete diagnostic data regarding our members enrolled in - Wellcare. Accordingly, Wellcare requests your cooperation to facilitate a medical record review of 2022 dates of service for a certain number of your patients enrolled in such plans.

We have engaged Ciox Health to conduct the medical chart review. A Ciox Health representative will work with you to provide retrieval options and a list of the requested members' medical records for services rendered from January 1, 2022, to present.

What does this mean to you?

To limit the administrative burden on your office from other requests for our members' medical records, we may use the records received through this request for other reasons, such as compiling information for Healthcare Effectiveness Data & Information Set (HEDIS) measures and assisting in CMS risk adjustment data validation audits.

Your assistance in helping Ciox Health with this retrieval is greatly appreciated.

Please note the items listed below are the components requested, if applicable, for all dates of service from January 1, 2022, to present:

- Patient Demographic Sheet
- History & physical records, progress notes and consultations
- Discharge record, consult and pathology summaries and reports
- Surgical procedures and operating summaries
- Subjective and objective assessments and plan notes
- Diagnostic testing including but not limited to cardiovascular diagnostic testing reports (EKG, stress test, Holter monitors, Doppler studies), interventional radiology (MRA, catheter angiography, etc.), neurology (EEG, EMG, nerve conduction studies, sleep studies)
- Emergency and Urgent Care records
- Consultation reports
- Specialist Notes
- Procedure notes/reports
- Valid signature with credentials

CIOX HEALTH

PULL LIST	Outreach ID: 42615975 Site ID: 43645592 9401 SOUTHWEST FWY HOUSTON, TX 77074	Charts 6

PULL	CNA	MEMBER/REQUESTER	DOB	CHART ID	PROVIDER	NOTES
O	O	[redacted]				
O	O					
O	O					
O	O					
O	O					
O	O					

Pull chart detail from 01/01/2022 - Present

PL42615975

CIOX HEALTH

Have questions?
Contact CIOX Provider Support
1-877-445-9293

CIOX Health
2222 W. Dunlap Ave
Phoenix, AZ 85021

To Whom It May Concern:

Documentation requirements state that the medical record for each patient visit should include the date and legible identity of the provider including the signature and credential. As part of the chart review process the health plan had requested that you provide a copy of a signature log as noted below.

We have included a template for you to complete prior to beginning the chart review process. The example below provides an area to list all providers who document in your patient's medical records. This includes physicians, physicians' assistants and nurse practitioners.

- **NPI:** Print the provider's National Provider Identifier.
- **Provider Full Name:** Print the provider's name (MD, DO, NP and PA only)..
- **Credential:** Print the provider's credential.
- **Legal Signature:** The provider should sign their legal signature. (full name including credential).
- **Actual Chart Signature Variations:** Sign all possible ways that the provider would normally sign the medical record, including full signature, initials, first initial last name, etc.

A CIOX Health representative will review your signature log prior to executing the chart review to ensure compliance.

It is recommended that you retain this document with your policies and procedure and update it annually or during new staff orientation.

Sample:

Group Name ____ABC Medical Group_____ State __TX_____

NPI	Provider Full Name	Credential	Legal Signature	Actual Chart Signature Variations
1234567890	John Doe	D.O.	John Doe, DO	JohnDoeDO
				JDoeDO
				JDDO

SL42615975

Humana.

8/29/2023

THE HARRIS CENTER FOR MENTAL HEALTH AND IDD
9401 SOUTHWEST FWY

HOUSTON, TX 770742007

RE: Please submit requested medical record(s) for your Humana-covered patient(s)

Dear physician or office administrator:

Humana reviews medical records for its members in an effort to report complete and accurate diagnosis coding to the Centers for Medicare & Medicaid Services (CMS) for our Medicare Advantage members and to the U.S. Department of Health and Human Services (HHS) for our commercial members.

Please return the medical record(s) for the time period(s) requested, with the enclosed patient information form, for the patient(s) listed. Return in one of the following ways:

- Upload records to the secure provider upload portal at www.submitrecords.com/humana (instructions enclosed).
- Send via secure fax to **800-205-5840**.
- Send via mail using the enclosed self-addressed, prepaid trackable postage label(s). A new prepaid label is being used. Please discard old labels.

Note: With the ongoing pandemic, Humana can assist with contact-free options to obtain medical records, such as electronic health records (EHRs) and remote access. Please call the phone number listed at the end of this letter for more information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule states in the Safeguards Principle that individually identifiable health information should be protected with reasonable administrative, technical and physical safeguards to ensure its confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure. **Please submit all electronic and hard-copy medical records via a HIPAA-compliant method.**

Please ensure each record includes the section with the physician's or healthcare provider's signature. Do not submit original medical records. Please include the following:

If a physician record (including telehealth visits):		
Anesthesia (commercial patients only)	Consult notes	Demographics sheet
Discharge summary	Diagnostic testing reporting (commercial patients only)	Dialysis (commercial patients only)
History and physical	Infusion testing and reporting (commercial patients only)	Operative reports
Physician or healthcare provider signature and credentials (electronic or handwritten)	Problem list	Progress notes
Signature log*	SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes

If a hospital record (including telehealth visits):		
Admit notes (commercial patients only)	Anesthesia (commercial patients only)	Coding summary (if not on face sheet)
Consult notes	Demographics sheet	Diagnostic testing reports
Discharge summary	Emergency department records	Face sheet
History and physical	Infusion testing and reporting (commercial patients only)	Lab results/pathology reports
Operative reports	Physician orders	Physician or healthcare provider signature and credentials (electronic or handwritten)
Problem list	Progress notes	Signature log*
SOAP notes (subjective, objective, assessment, plan)	Telehealth visits progress notes	

***Note:** Signature logs are not accepted in place of the physician's or healthcare provider's electronic or handwritten signature. Signature logs are used to identify a provider's name if the signature is illegible.

AUG 30 2023

Site ID:62482
158501ALL0223-A

RECEIVED

Humana.

Your patient may also have a CMS open Stars measure or measures. If your patient has an open Stars measure, the measure is indicated on the patient list. For your convenience, we have enclosed the Stars 2023 measure guidelines and checklist, which details the specific chart components and relevant time periods for each measure.

As this request is time-sensitive, your prompt response is appreciated. If you have questions regarding the medical record review process, or if there are discrepancies in the list provided, please contact the Humana record-retrieval call center at 1-866-836-6658, Monday through Friday, 8:30 a.m. to 6:30 p.m., Eastern time.

Thank you for your continued care of our members.

Sincerely,

Katie Sharp

Katie Sharp, Director
Risk Adjustment Retrieval & Coding Operations

Enclosures

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
✓		**Person/Family Directed Services §9.190(e)(6)**	• Initiate, coordinate, and facilitate person-directed planning	For H2, the outcomes associated with the HCS services of RN, LVN, and Host Home were service statements in the PDP dated 6/29/22. For H2, the outcome associated with the HCS service of Dental in the PDP dated 6/29/22 was not supported by the discovery information.	H2-Assigned SC for H2 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically RN, LVN, and HHCC. H2-Assigned SC for H2 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information to support the outcome of Dental.	MET MET
✓		**Person/Family Directed Services §9.190(e)(6)**	• Initiate, coordinate, and facilitate person-directed planning	For H3, the outcomes associated with the non-HCS service of PCP and the HCS service of Day Habilitation were not measurable and observable in the PDP dated 5/18/22. For H3 the outcome associated with the HCS service of Day Habilitation was a service statement in the PDP dated 5/18/22.	H3-Assigned SC for H3 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop measuable observable outcomes. Specifically PCP, DH. H3-Assigned SC for H3 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically Day habilitation.	MET MET
	✓	**Person/Family Directed Services §9.190(e)(6)**	• Initiate, coordinate, and facilitate person-directed planning	For H4, the outcomes associated with the non-HCS services of Orthopedic Specialist, Occupational Therapy, and ENT were service statements in the PDP dated 6/22/22. For H4, the outcomes associated with the HCS service of Host Home did not justify the service in the PDP dated 6/22/22. For H4, the outcomes associated with the non-HCS service of Home Health and the HCS service of Nursing in the PDP dated 6/22/22 were not supported by the discovery information.	H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically Orthopedic Specialist, Occupational Therapy, and ENT. H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the outcome to justify the service in the PDP. Specifically HHCC. H4-Assigned SC for H4 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information to support the outcome of Home Health and Nursing.	MET NOT MET For H4, the outcomes associated with the HCS service of Host Home did not justify the service in the PDP dated 4/27/23. NOT MET For H4, the outcomes associated with the non-HCS service of Home Health were not measurable and observable in the PDP dated 4/27/23.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
✓		**Person/Family Directed Services §9.190(e)(6)**	• Initiate, coordinate, and facilitate person-directed planning	For H5, the outcomes associated with the non-HCS service of PCP and the HCS service of LVN were service statements in the PDP dated 7/12/22. For H5, the outcomes associated with the HCS services of Dietary and RN were not measurable or observable in the PDP dated 7/12/22. For H5, the outcome associated with the non-HCS service of Psychiatry was directed by someone else in the PDP dated 7/12/22.	H5-Assigned SC for H5 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes as necessary. Specifically PCP, and LVN. H5-Assigned SC for H5 along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop measuable observable outcomes. Specifically Dietary and RN. H5-Assigned SC for H along with the SPT (inidividual/LAR/HCS provider) will update the PDP , to revise the discovery information and develop person centered outcomes directed by the individual. Specifically Psychiatry.	MET MET MET
		Person/Family Directed Services §9.190(e)(6)	• Initiate, coordinate, and facilitate person-directed planning	**A SYSTEMIC and MONITORING**	All HCS service coordinators will receive ongoing competency-based training on the TAC requirement of Person Directed Planning, including writing HCS/non-HCS person centered outcomes, and justifying all services evidenced by the discovery process - TAC 9.190 (e). Training will be evidenced through agenda and signature sheets. SCs will have continuous access to the Mentor for additional training and support.	Systemic correction was not verified at this time.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

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

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
✓		**Service Coordination Monitoring §9.190(e)(14)**	• Monitor delivery of HCS program & Non-HCS program services and service coordination	For H4, there was no evidence of monitoring delivery of and satisfaction with the non-HCS services of Gynecologist, Audiologist, and Gastroenterologist during the first 90-day reporting period for the IPC with a begin date of 7/31/22. For H4, there was no evidence of monitoring satisfaction with the non-HCS services of Physical Medicine Specialist and Orthopedic Specialist during the first 90-day reporting period for the IPC with a begin date of 7/31/22.	H4-Future documentation will evidence monitoirng of delivery and satisfaction of all HCS and Non-HCS services during the required 90-day period. H4-Future documentation will evidence monitoirng of satisfaction of all HCS and Non-HCS services during the required 90-day period.	MET MET
✓		**Service Coordination Monitoring §9.190(e)(14)**	• Minimum face-to-face contact	For H5, there was no evidence of service coordination contact during the month of August 2022. The service coordination plan in the PDP date 7/12/22 indicated contacted frequency as monthly.	H5-Future documentation will evidence montiroing based of the frequency indicated in the PDP.	MET
✓		**Service Coordination Monitoring §9.190(e)(15)**	• Document progress toward desired outcomes.	For H4, there was no evidence of reporting progress/lack of progress towards the non-HCS services of Gynecologist, Physical Medicine Specialist, and Gastroenterologist during the first 90-day reporting period for the IPC with a begin date of 7/31/22.	H4-Future documentation will evidence monitoirng of progress/lack of progress of all HCS and Non-HCS services during the required 90-day period.	MET
✓		**Service Coordination Assessment §2.554(a)(c)**	• Service Coordination Assessment determines frequency of Service Coordination	For H3, the Service Coordination Assessment dated 5/18/22 identified the person had a "moderate" level of need for service coordination. However, the person had several unmet outcomes with a "high" level of need.	H3-Assigned SC for H3 will complete the Service Coordination Assessment and mark the LEvel of Need correctly based on the findings of the assessment.	MET

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
		Service Coordination Assessment §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	**A SYSTEMIC and MONITORING**	All HCS Service Coordinators will receive ongoing Progress note documentation training to emphasize the importance of how to properly document delivery, progresss/lack of progress, and satisfaction of all services listed in the PDP monthly or at least once every 90 days. Service Coordination Assessment training will be completed for correctly scoring and marking the Level of Monitoring as well as making sure the PDP is based off the results of SC Assessment. All motniroing will be completed based off the frequency indicated in the PDP. Training will be evidenced through agenda and training documentation/handouts	Systemic correction was not verified at this time.
		Service Coordination Assessment §2.554(a)(c)	• Service Coordination Assessment determines frequency of Service Coordination	**correction is required for each finding in this element**	The assigned Program Director, Team Leader or Designee will ongoingly monitor at least 2 HCS charts per team (for each of the 6 HCS teams) per fiscal quarter to ensure compliance addressing the specific issue identified. The monitoring tool will measure delivery of, progress/lack of progress, and satisfaction with all services at least once every 90 days. The tool indicate if the Level of Monitoring was marked correctly and the PDP was based of the results of the SC Assessment. Any findings will be documented on a review tool with the specific issue addressed and shared with the Program Director or Designee who will provide corrections to the IDD Director.Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the Service Coordinatior Mentor.	Monitoring correction was not verified at this time.
		Community-based SPT Meetings A-4, 2.2.1.1.B.4; HB 6820	• For a person transitioning from a nursing facility SPT meetings are held in the community	**A SYSTEMIC and MONITORING**	All ECC Service Coordinators will receive ongoing training indicating SPT meetings are held in the community.	Systemic correction was not verified at this time.

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for HCS

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
		Community-based SPT Meetings **A-4, 2.2.1.1.B.4; HB 6820**	• For a person transitioning from a nursing facility SPT meetings are held in the community	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will ongoingly use a monitoring tool to review at least 2 HCS charts (for the 1 ECC team), from a variety of ECC Coordinators per fiscal quarter to ensure the SPT meetings are held in the community. Any noted trends of continued non-compliance will require the Service Coordinator to be re-trained by the Service Coordinatior Mentor.	Monitoring correction was not verified at this time.

Please extend our appreciation to your staff for their cooperation during this review. The LIDDA is encouraged to continue working on corrective actions in order to work toward increased compliance prior to the next annual review. If you have any questions or require additional information, please contact Denice Cadena, Contract Specialist, Contract Accountability & Oversight, HHSC IDD Services at denice.cadena@hhs.texas.gov.

Denice Cadena, Facilitator, Contract Specialist
Donna Pendleton, Contract Specialist

TEXAS Health and Human Services

Cecile Erwin Young
Executive Commissioner

2023 Corrective Action Plan Compliance Review
Report of Findings for PASRR

280 - The Harris Center for Mental Health and IDD

August 21, 2023

Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
		Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	For NF1, there was no evidence the SPT determined if the identified outcomes associated with Occupational Therapy and Physical Therapy were being addressed in the SPT meetings dated 4/12/22 and 7/12/22. For NF1, there was no evidence the PCSP for the SPT meeting dated 10/15/22 was entered into TMHP at any time.	NF1, future STP meetings, HC will determine the identified outcomes associated with specialized services of Occupational Therapy and Physical Therapy. NF1, HC will enter PCSP form within 5 calendar days after the SPT meeting in TMHP.	NA- NF1 is no longer in the Nursing Facility.
✓		**Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320**	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	For NF3, there was no evidence the SPT determined if the identified outcome associated with Occupational Therapy was being addressed in the SPT meetings dated 8/10/22 and 11/21/22. For NF3, there was no evidence the SPT discussed NF3's completed Community Living Options (Form 1054) dated 7/19/22 or addressed the barriers to transitioning to the community in the SPT meeting dated 8/10/22.	NF3, future STP meetings, HC will determine the identified outcomes associated with specialozed services of Occupational Therapy. NF3, future SPT meetings, HC will discuss Community Living Options (Form 1054) every 6 months from the initial meeting date. NF3, future SPT meetings, HC will discuss barriers preventing a transition to the community when discussing the Community Living Options (Form 1054) and document.	MET MET
		Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	**A SPECIFIC, SYSTEMIC, and MONITORING**	All PASRR Habilitation Coordinators will receive training based on the TAC requirement for entering PCSPs in TMHP within the designated timeframe. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Service Planning Team Meeting §303.602(a)&(d); 3240; 5300; 5320	·Resident participation in planning ·SPT member responsibilities ·Quarterly SPT meetings	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 PASRR charts for the 1 PASRR team, from a variety of HAB Coordinators per fiscal quarter, results of entering PCSPs form within 5 calendar days after the SPT metting in TMHP, by untilizing the PASRR unit cover sheet. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.
		SPT Membership Requirements §303.102 (61) (A)	·SPT includes all required members and participants	NF1, future SPT meetings, the assigned HC will notify the MCO at least 10 business days prior to SPT meetings to invite them to participate the document in progress notes.	NF1, future SPT meetings, the assigned HC will notify the MCO at least 10 business days prior to SPT meeting to invite them to participate and document in progress note.	NA- NF1 is no long in the Nursing Facility.

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280 - The Harris Center for Mental Health and IDD

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
	✓	**SPT Membership Requirements §303.102 (61) (A)**	·SPT includes all required members and participants	NF3, future SPT meetings, the assigned HC will notify the MCO at least 10 business days prior to SPT meeting to invite them to participate and document in progress note. NF3, HC will follow the guidelines for converting SPT meeting when an Individual or LaR does not want to attend the SPT meeting an document in progress note.	NF3, future SPT meetings, the assigned HC will notify the MCO at least 10 business days prior to SPT meeting to invite them to participate and document in progress note. NF3, HC will follow the guidelines for conventing SPT meeting when an Individual or LAR does not want to attend the SPT meeting and document in progress note.	NOT MET There was no evidence submitted of the habilitation coordinator inviting an MCO to NF3's SPT meeting.
✓		**Habilitation Service Plan Development §303.601(b)(5); §303.601(b)(2); 5200**	Develop and revise HSP	For NF3, there was no evidence the Individual Profile and HSP dated 5/18/22 were shared with members of the SPT and the nursing facility at any time. For NF3, there was no evidence the Individual Profile and HSP dated 8/10/22 were shared with members of the SPT and the nursing facility within 10 days. The plans were shared on 8/23/22. For NF3, there was no evidence the Individual Profile and HSP dated 11/21/22 were shared with members of the SPT and the nursing facility within 10 days. The plans were shared on 12/15/22.	NF3- HC will share the Individual Profile and HSP dated 5/18/2022 with all members of the SPT. Going Forward, the HC will submit the Individual Profile and HSP within the designated timeframes.	MET NA NA
		Habilitation Service Plan Development §303.601(b)(5); §303.601(b)(2); 5200	Develop and revise HSP	**A SPECIFIC, SYSTEMIC, and MONITORING**	All PASRR Habilitation Coordinators will receive training based on the TAC requirement for Nursing facilities to receive the Individual Profile and HSP within the designated timeframe. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Habilitation Service Plan Development §303.601(b)(5); §303.601(b)(2); 5200	Develop and revise HSP	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 PASRR charts for the 1 PASRR team, from a variety of HAB Coordinators per fiscal quarter, results of the Individuals Profile and HSPs are shared with members of the SPT and Nursing facility within 10 days, by untilizing the PASRR unit cover sheet. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
✓		**Coordination with the Individual Profile 5460.1**	Individual Profile describes pertinent information identified by those who know the person best that service providers need to know and do to support the person	For NF3, there was no evidence the habilitation coordinator ensured the risk for injury and pain identified in the Nursing Facility Care Plan were included in the Individual Profile dated 5/18/22.	NF3- The assigned HC will update the Indivdiual Profile with the risk for injury and pain identified on the Nursing Facility Care Plan.	MET
		Coordination with the Individual Profile 5460.1	Individual Profile describes pertinent information identified by those who know the person best that service providers need to know and do to support the person	**A SPECIFIC, SYSTEMIC, and MONITORING**	All PASRR Habilitation Coordinators will receive a training based on the TAC requirement related to the review and monitoring of identified risk factors on the NF care plan. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Coordination with the Individual Profile 5460.1	Individual Profile describes pertinent information identified by those who know the person best that service providers need to know and do to support the person	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 PASRR charts for the 1 PASRR team, from a variety of HAB Coordinators per fiscal quarter. This will include reviewing for documentation that a discussion when held with the individual and SPT to address and review risk factors. The identifed risk factors from the NF care plan should be updated to the IP. Findings will be documented and shared with the Program Director who will ensure corrections are made. Documentation to evidence the completion of the reviews will be shared with the IDD SC Director. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.
✓		**Coordination of Specialized Services §303.601 (3)(A)(B) §303.601 (4); §303.601 (5) 5510**	·Assist with accessing needed specialized services; ·Coordinate other habilitative programs and services; ·Facilitate coordination of HSP and comprehensive care plan	For NF3, there was no evidence the outcomes for Occupational Therapy and Physical Therapy in the HSP dated 5/18/22 were coordinated with the comprehensive care plan/NFSS in TMHP.	NF3- The assigned HC will update the HSP with the outcomes for Occupational Therapy and Physical Therapy that is coordinated with the comprehensive care plan/NFSS in TMHP.	MET

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
		Coordination of Specialized Services §303.601 (3)(A)(B) §303.601 (4); §303.601 (5) 5510	·Assist with accessing needed specialized services; ·Coordinate other habilitative programs and services; ·Facilitate coordination of HSP and comprehensive care plan	**A SPECIFIC, SYSTEMIC, and MONITORING**	All Habilitation Coordinators will receive training based on the TAC requirement related to ensursing the outcomes for specialized services is coordinated with the comprehensive care plan/NFSS in TMHP and HSP.	Systemic correction was not verified at this time.
		Coordination of Specialized Services §303.601 (3)(A)(B) §303.601 (4); §303.601 (5) 5510	·Assist with accessing needed specialized services; ·Coordinate other habilitative programs and services; ·Facilitate coordination of HSP and comprehensive care plan	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 PASRR charts for the 1 PASRR team, from a variety of HAB Coordinators per fiscal quarter, to review specialized services outcome. Findings will be documented on the QA cover sheet and shared with the Program Director who will ensure corrections are made. Documentation to evidence the completion of the reviews will be shared with the IDD SC Director. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.
✓		**HSP Content §303.102 (23)(B)**	· Identifies strengths, preferences, outcomes, psychiatric, behavioral, nutritional management, and support needs	For NF3, there was no evidence the clinical behavioral and mental health needs of NF3 were included in the Individual Profile dated 5/18/22.	NF3- The assigned HC will update the Indivdiual Profile with the Clincial behavioral and mental health needs information identified on the Nursing Facility Care Plan.	MET
✓		**Identifying Specialized Services §303.102(23)(C) 5430**	· Identifies amount, frequency, and duration of each service	For NF3, there was no evidence the need for Occupational Therapy, Physical Therapy, and DME Specialized Mattress were indicated on the Habilitative Assessment dated 1/26/22, even though the services were authorized for NF3.	NF3- HC will evidence in the HAB assessment the need for Occupational Therapy, Physical Therapy, and DME Specialized Mattress.	MET
✓		**Monitoring & Coordination of HSP §303.601 (b)(6)(A)-(B) §303.601 (b)(6)(C) §303.601 (b)(1,9A,10,11) 5850**	·Report progress toward desired outcomes	For NF3, there was no evidence of reporting progress/lack of progress towards the outcome of Occupational Therapy during the third quarter of the HSP dated 2/11/22.	NF3- The HC will meet with NF3 to monitor and document the progress/lackof progress towards the outcome of Occupational Therapy quarterly.	MET
		Transition Plan Development §303.701 (b) (d) (e) (f) (g) 6100, 6200, 6300	Develop, plan, and revise the Transition Plan	For NF6, there was no evidence the fourth quarterly SPT meeting was held at any time.	NF6- The finding cannot be corrected.	NA- NF6 is no long in the Nursing Facility.

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
		Transition Plan Development §303.701 (b) (d) (e) (f) (g) 6100; 6200; 6300	Develop, plan, and revise the Transition Plan	**A SPECIFIC, SYSTEMIC, and MONITORING**	The ECC coordinator will receive training based on the TAC reqiuirement of conducting quarterly SPT meetings. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Transition Plan Development §303.701 (b) (d) (e) (f) (g) 6100; 6200; 6300	Develop, plan, and revise the Transition Plan	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 ECC charts for 1 ECC team, from a variey of ECC Coordinators per fiscal quarter. This will include reviewing that the individual and/or family and HCS provider are invited to attend the SPT meetings. Findings will be documented and shared with the Program Director who will ensure corrections are made. Documentation to evidence the completion of the reviews will be shared with the IDD SC Director. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.
		Post-Move Monitoring §303.702; 3240	Conduct required post-transition monitoring activities	For NF6, there was no evidence the service coordinator/enhanced community coordinator addressed the gaps in care for the shower chair. The transition plan indicated this was essential for NF6, and the post move held on 2/8/22 indicated it had not been delivered yet. There was no evidence of a follow up to determine if the shower chair was received.	NF6- Moving forward, if the essential supports are not evidence at the pre-site review, the ECC coordinator will follow up with the Nursing Facility and document.	NA
		Post-Move Monitoring and Protecting Health 3240; 6820	For one year after diversion/transition, the SC/ECC must: ·Inquire about health concerns ·Convene the HCS SPT to add services/revise the PDP when needed ·Ensure timely assessments, as necessary ·Record health care status to identify when changes in status occur ·Conduct HCS service planning and monitoring ·Review implementation plans and provider records ·Visit service delivery sites, as needed ·Monitor critical incidents	For NF6, there was no evidence an assessment for Dietary, as indicated on the HCS PDP (Form 8665) dated 2/4/22, was completed at any time.	NF6- HCS provider did not complete an assessment for Dietary. Moving forward, the ECC coordinator will review services that is stated on the initial PDP and IPC and will follow up monthly and document.	NA

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
		Community-based SPT Meetings §303.701 (c)(1-3); 3240	The HCS SPT meets at least quarterly and ensures the person participates in the SPT meetings to the fullest extent possible	For NF7, there was no evidence a quarterly community-based SPT meeting, due in June 2022, was held at any time.	NF6- The finding cannot be corrected.	NA
		Community-based SPT Meetings §303.701 (c)(1-3); 3240	The HCS SPT meets at least quarterly and ensures the person participates in the SPT meetings to the fullest extent possible	**A SPECIFIC, SYSTEMIC, and MONITORING**	The ECC coordinators will receive training based on the TAC reqiuirement of conducting quarterly SPT meetings. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Community-based SPT Meetings §303.701 (c)(1-3); 3240	The HCS SPT meets at least quarterly and ensures the person participates in the SPT meetings to the fullest extent possible	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at least 2 ECC charts for the 1 ECC team, from a variety of ECC Coordinators per fiscal quarter. This will include reviewing that the individual and/or family and HCS provider are invited to attend the SPT meetings. Findings will be documented and shared with the Program Director who will ensure corrections are made. Documentation to evidence the completion of the reviews will be shared with the IDD SC Director. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.

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280 - The Harris Center for Mental Health and IDD

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Met	Not Met	Elements for Review	Expectations	Finding	Corrective Action Plans	Comments
		Guardianship §303.504 (a); §303.601 (b)(11)	Determine, at least annually, if the letters of guardianship are current; if appropriate Make a referral of guardianship, if appropriate	For NF6, the Letters of Guardianship in the record expired on 5/7/22, and there were no documented attempts to obtain updated paperwork.	NF6- Findings cannot be corrected.	NA
		Guardianship §303.504 (a); §303.601 (b)(11)	Determine, at least annually, if the letters of guardianship are current; if appropriate Make a referral of guardianship, if appropriate	**A SPECIFIC, SYSTEMIC, and MONITORING**	All ECC coordinators will receive training based on the TAC requirment related to obtaining the current guardianship letter. Training will be evidenced through an agenda and attendance sheet.	Systemic correction was not verified at this time.
		Guardianship §303.504 (a); §303.601 (b)(11)	Determine, at least annually, if the letters of guardianship are current; if appropriate Make a referral of guardianship, if appropriate	**correction is required for each finding in this element**	The assigned Program Director, Team Leader, or Designee will review at 2 ECC charts for the 1 ECC team, from a variety of ECC Coordinators per fiscal quarter. This will include reviewing for documentation that a discussion was held with the individual, family, and HCS provider to address guardianship. Any noted trends of continued non-compliance will require the HAB Coordinator to be re-trained by the SC Mentor.	Monitoring correction was not verified at this time.

Please extend our appreciation to your staff for their cooperation during this review. The LIDDA is encouraged to continue working on corrective actions in order to work toward increased compliance prior to the next annual review. If you have any questions or require additional information, please contact Denice Cadena, Contract Specialist, Contract Accountability & Oversight, HHSC IDD Services at Denice.cadena@hhs.texas.gov.

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Report of Findings for QA

280 - The Harris Center for Mental Health and IDD

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

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Report of Findings for TxHmL

280 - The Harris Center for Mental Health and IDD

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Met	Not Met	Elements for Review	Expectations	Findings	Corrective Action Plan	Comments
✓		**§9.583(h) Service Coordinator Assurances**	(2) coordinates the development and implementation of the individual's PDP;	For T3, the outcomes associated with the non-TxHmL service of PCP and the TxHmL service of Dental in the PDP dated 6/6/22 were not supported by the discovery information. For T3, the outcome associated with the CFC service of PAS/HAB in the PDP dated 6/6/22 was developed by someone other than the individual.	T3 The SPT meeting with the individual/LAR, the SC will update the PDP, to revise the discovery information to support the outcome of non TXHML services of PCP and the TXHML services of Dental. T3 The SPT meeting with the individual/LAR, the SC will address discovery information to support outcomes for the non-TXHML service of PCP and the TXHML service of Dental to make them an outcome.	MET MET
✓		**§9.583(h) Service Coordinator Assurances**	(2) coordinates the development and implementation of the individual's PDP;	For T4, the outcome associated with the non-TxHmL service of PCP was a service statement in the PDP dated 5/18/22.	T4 The SC will convene an SPT meeting with the individual/LAR to address updating/changing the outcome for the non-TXHML service of PCP to make them a person-centered outcome. This will be evidence by a revision of the PDP	MET
✓		**§9.583(h) Service Coordinator Assurances**	(2) coordinates the development and implementation of the individual's PDP;	For T5, the outcome associated with the CFC service of PAS/HAB was a service statement in the PDP dated 7/26/22.	T5 The SC will convene an SPT meeting with the individual/LAR to discuss updating/changing the outcome for the CFC service of PAS/HAB to make it a person centered outcome. This will be evidence by a revision of the PDP.	MET
✓		**§9.583(h) Service Coordinator Assurances**	(4) monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	For T2, there was no evidence of monitoring satisfaction for any services from the perspective of the person during the first 90-day reporting period for the IPC with a begin date of 6/28/22. For T2, there was no evidence of monitoring satisfaction with the non-TxHmL service of PCP, the TxHmL service of Dental and the CFC/CDS service of PAS/HAB from the perspective of the person during the second 90-day reporting period for the IPC with a begin date of 6/28/22.	T2 Future documentation will evidence monitoring satisfaction/dissatisfaction of the non-TXHML and TXHML services monthly or at least once every 90 days from the perspective of the individual. T2 Future documentation will evidence monitoring satisfaction/dissatisfaction of the non-TXHML service of PCP, and the TXHML service of Dental and CFC/CDS service of PAS HAB services monthly or at least every 90 days from the perspective of the individual.	MET MET
✓		**§9.583(h) Service Coordinator Assurances**	(4) monitors the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services;	For T5, there was no service coordinator contact for the months of August and September 2022. The service coordination plan in the PDP dated 7/26/22 stated contact frequency as monthly.	T5 Future documentation will evidence monitoring based of the frequency indicated in the PDP.	MET
✓		**§9.583(h) Service Coordinator Assurances**	(5) records each individual's progress;	For T2, there was no evidence of reporting progress/lack of progress towards the outcomes associated with the TxHmL services of Dental from the perspective of the person during the second 90-day reporting period for the IPC with a begin date of 6/28/22.	T2Future documentation will evidence monitoring progress/lack of progress of the TXHML service of Dental from the perspective of the individual.	MET

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EXHIBIT A-6

Executive Summary

PHARMACY OPERATIONS AND INVENTORY AUDIT (PHARM0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

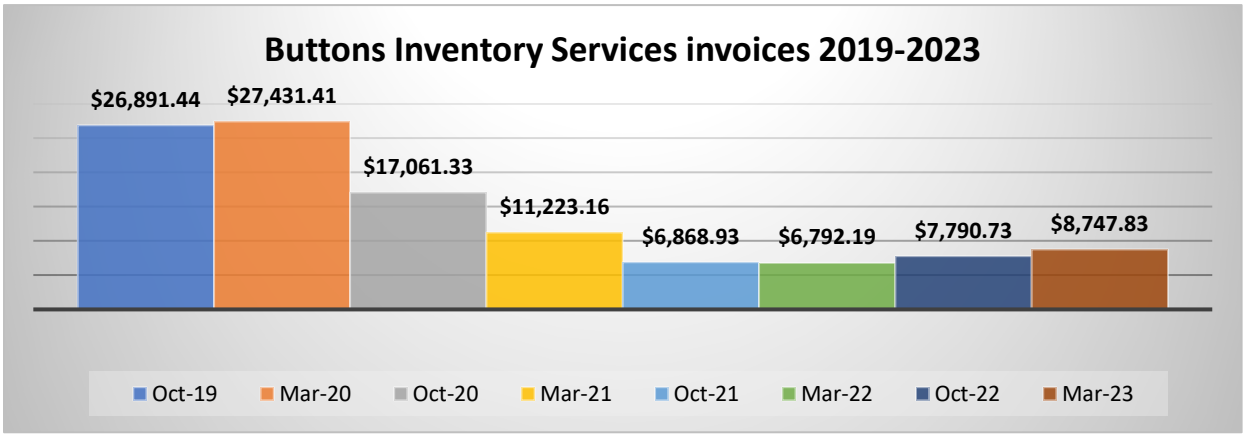
Observation #1 – Internal Audit found that all Pharmacy policies and procedures have been updated and are easily accessible by employees using the PolicyStat folders on The Harris Center's intranet site.

Management Response not required.

Observation #2 – Internal Audit noted the invoiced amounts from the Buttons Inventory Service have decreased sharply since the March 2020 invoice. The counts are performed in October and March, as was requested by the Board several years ago.

Per Angie Babin, the Senior Director of the Pharmacy Program, "the service charges of the Buttons Inventory Service audits are based on the value of the inventory being counted, so as the inventory values have dropped, so do the inventory audit service charges".

Exhibit I – Invoiced service charges for performing on-site inventory counts at Pharmacy locations



Source: Ross Financial System, account = "Buttons Inventory Service", listed vendor invoices from FY2019 through FY2023.

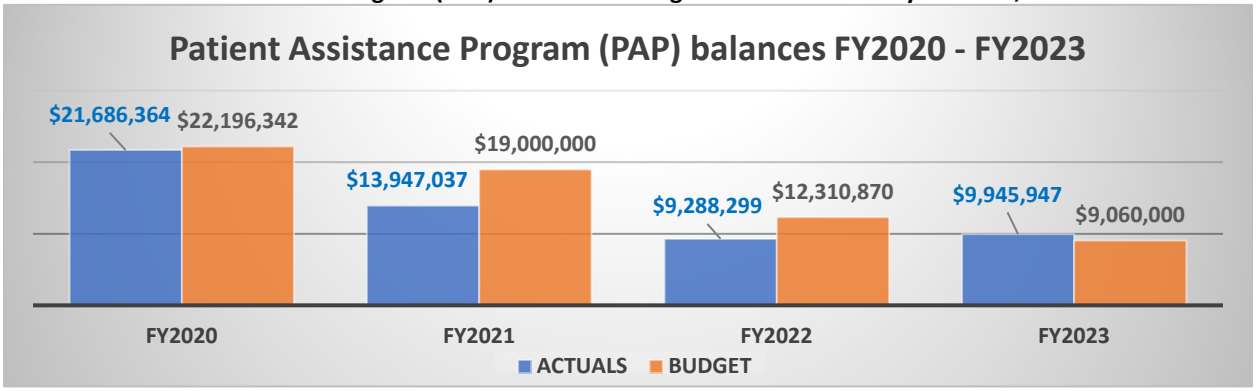
Management Response not required.

Observation #3 – Internal Audit noted the Patient Assistance Program FY2022 year-end Actuals per the 2021 and 2022 Annual Comprehensive Financial Reports (ACFRs) have decreased from $13.9 million to $9.3 million, representing a decrease of -$4.7 million, or about -33.4%.

The PAP FY2023 year-end valuations per the Trending Report shows Actuals increased to $9.9 million.

Per Angie Babin, the Senior Director of the Pharmacy Program, "the value of the PAP program continues to fall as medications evolve all the time and overall medication valuations have been falling."

Exhibit II – Patient Assistance Program (PAP) Actual and Budget balances at fiscal year-ends, FY2019-FY2022



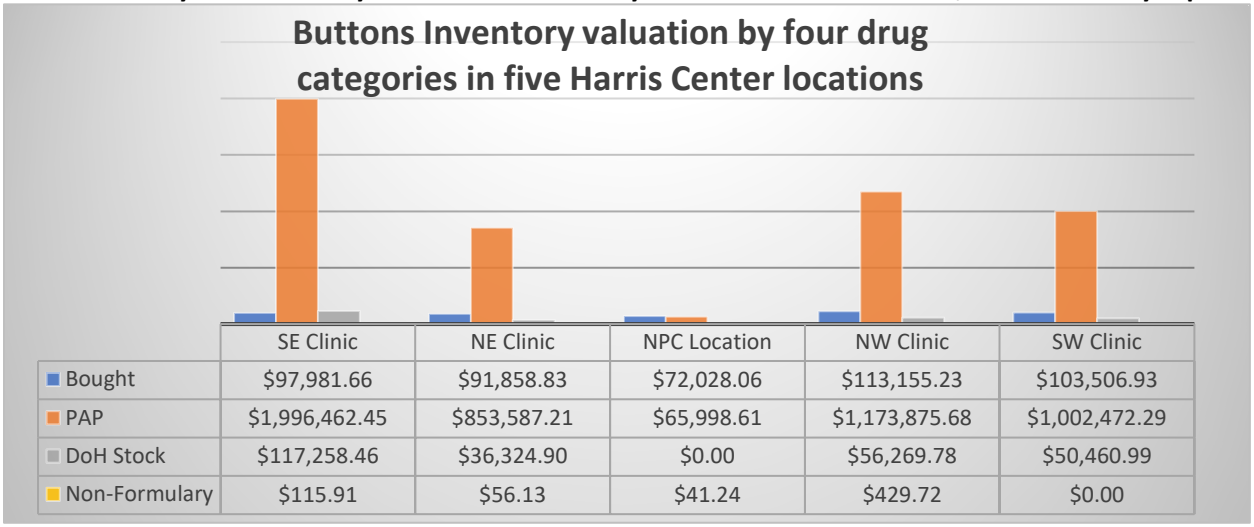
Source: Annual Comprehensive Financial Review, Budgetary Comparison Statement/Budget-to-GAAP Reconciliation-General Fund, page 30, For the Year Ended August 31, 2022 and August 31, 2021.

Management Response not required.

Observation #4 – Internal Audit noted the Patient Assistance Program (PAP) inventory items are the largest category of items compared with bought stock, Dispensary of Hope (DoH), and non-formularies. These values are based on the hand-count of items performed at pharmacy locations on March 1, 2023.

We noted that PAP item valuations generally represented 85% to 90% of the total inventory value in most of the locations, except for the Neuro Psychiatric Center (NPC), based on its own business model. Per Angie Babin, the Senior Director of the Pharmacy Program, "since patients enroll in the PAP program based on income eligibility, the process is time-consuming and not suited for delivering treatment for the NPC patients, who typically arrive there in severe crisis."

Exhibit III – Physical counts by the Buttons Inventory Service from the March 1, 2023 inventory report



	SE Clinic	NE Clinic	NPC Location	NW Clinic	SW Clinic
Bought	$97,981.66	$91,858.83	$72,028.06	$113,155.23	$103,506.93
PAP	$1,996,462.45	$853,587.21	$65,998.61	$1,173,875.68	$1,002,472.29
DoH Stock	$117,258.46	$36,324.90	$0.00	$56,269.78	$50,460.99
Non-Formulary	$115.91	$56.13	$41.24	$429.72	$0.00

Source: Buttons Inventory Service, bi-annual physical inventory report, valuations per March 1, 2023 inventory counts.

Management Response not required.

Pharmacy Operations & Inventory Audit

(PHARM0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Board of Directors approved an audit of the Pharmacy's operations and the drug inventories to test inventory counts and confirm compliance to inventory reporting. The Pharmacy Department expanded its services and its role at the Center over the past few years. A pharmacy inventory shall be performed as part of the bi-annual physical count as performed by the Buttons Inventory Company.

Internal Audit performed audits in FY2015, FY2018, and in FY2020. The FY2020 audit report focused on the contractor's inventory counts and reports to our management team. Pharmacy oversees controls over the Patient Assistance Program (PAP), which is a successful initiative for Harris Center consumers.

The Dispensary of Hope (DoH) is a non-profit 501 (c)(3) entity that specializes in distribution of pharmaceuticals that are donated by larger manufacturers, including AbbVie, Eli Lilly, Johnson and Johnson, Merck, and others. The Harris Center's ongoing PAP program has been beneficial in matching low-income patients with needed medications, and Pharmacy staff perform the administration and handling of the patient inventory items directly to eligible consumers. The Dispensary of Hope also sends inventory available for distribution to PAP consumers, and inventory is counted as DoH inventory.

The Pharmacy Department purchases additional pharmaceutical items for its clinical operations and uses, and the department has expanded services that serve more "external" clients and provide services to meet strategic objectives that work in tandem with other strategic objectives.

The Director of Pharmacy (DOP) provided procedures for two policy and procedures documents in 2019 which identified areas of concern: Controlled Substances and Security. The Pharmacy Department has issued updated policies in FY2023 covering more topics pertaining to Pharmacy fulfillment operations.

Operational Policies for the Pharmacy Department

From "Controlled Substances" – August, 2019

1. PROCEDURES:

A. No controlled substances will be dispensed by the Parata or Script-Pro robots.
B. A perpetual inventory will be kept on all controlled substances (II-V) regardless of the Board Requirement.
C. The perpetual inventory log shall document:
    a. The receipt of inventory
    b. The dispensing of inventory
    c. The transfer of inventory
    d. The destruction of inventory
D. After each entry is made into the perpetual inventory, a count on hand validation is required by the dispensing pharmacist. If a discrepancy is noted in the count, the pharmacist finding the discrepancy shall attempt to find the discrepancy prior to leaving the shift. If he/she cannot find the discrepancy, the Director of Pharmacy shall be notified immediately.
E. If after investigation, the Director cannot find a discrepancy, an incident report shall be written and if loss is significant, a DEA Form 106 shall be completed as required by DEA and Texas State Board of Pharmacy.
F. Monthly inventory of CII and CIII-V controlled substances, separating active and expired inventory in the documentation, shall be conducted with a witness and documented. This inventory shall include expired controlled substances. Document utilizing the controlled substance perpetual logs.
G. A separate annual CII and CIII-V controlled substance inventory shall be taken by the Pharmacist in Charge with a witness and Notarized as required by the Texas State Board of Pharmacy. This inventory shall be kept available for review for 2 years.

From "Security" – August, 2019

1. PROCEDURES:

A. General Pharmacy Security

a. The pharmacy will be secured with a security system with off-site monitoring if the pharmacy is not located in a building that has a 24/7 security guard. Any security breaches noted by the security system or a security guard will be reported to the Director of Pharmacy immediately. The Director of Pharmacy and the PIC will be responsible for dealing with any security breaches in accordance with the rules of the Texas State Board of Pharmacy.

b. All HARRIS CENTER pharmacies will be locked 24/7/365. The PIC will determine:

i. who routinely gains entrance into the pharmacy both during working hours and after hours,

ii. who will have access to the pharmacy and if the PIC allows access, a record (template attached to policy) of such will be kept by the PIC on site.

iii. who will be able to arm and disarm the security system and if the PIC allows such, a record of such persons will be maintained by the PIC on site.

c. Only with expressed written permission of the DOP will any pharmacy key be duplicated and such duplication will only be done by the Facilities Department at The HARRIS CENTER. At the NPC location, keys are property of Ben Taub General Hospital (BTGH). No duplicates are allowed at the NPC location. All keys are numbered and assigned to each employee.

d. If any employee of The HARRIS CENTER Pharmacy Department who has been issued a key leaves employment and does not return a pharmacy key issued, the DOP shall be alerted immediately and locks and/or entry code shall be changed. At NPC, the NPC-PIC will contact BTGH security and notify the DOP.

e. If it is known that the key or key code access has been compromised, the DOP shall be alerted immediately and locks and/or entry code shall be changed.

B. Drug Security

a. The PIC shall provide effective controls to guard against the theft or diversion of drugs and/or records. Such controls shall include:

i. Maintaining a perpetual inventory of all controlled substances.

ii. All controlled substances will be stored in a locked storage area, which should remain locked, unless in use.

iii. Report any breaches, theft or diversion immediately to the DOP and document such via the agencies incident reporting system and follow Controlled Substances Operational Guideline.

b. The DOP or designee shall run a monthly report from the wholesaler which shall include purchases from all The HARRIS CENTER pharmacies. This report shall be reviewed monthly for potential issues related to theft or diversion.

c. All invoices for controlled substances and dangerous drugs shall be reviewed, initialed and dated by the pharmacist on duty and appropriately documented in the perpetual inventory. Monthly review of wholesaler report of controlled substances shall be reconciled with actual invoices and drug receipt to protect against diversion.

d. All expired drugs will be handled by a third party vendor/reverse distributor secured by the DOP.

e. Outside vendor will be utilized for inventory count twice per year. Test counts of specific high dollar drugs will be conducted during each inventory and audited against the outside vendor counts. The same test count drugs will be inventoried monthly by pharmacy staff with a witness in the months not completed with the outside vendor.

C. Security of Patient Information

a. In accordance with HIPAA, all patient sensitive information will be utilized on a need to know basis and done in conjunction with the performance of one's job duties at The HARRIS CENTER.

b. All discarded patient information will be placed in a shred bin provided by the agency, and that shred bin will be emptied by the HARRIS CENTER vendor hired to ensure appropriate destruction.

SCOPE AND OBJECTIVES

Audit Scope: The Pharmacy Operations & Inventory Audit was approved and has been included in Internal Audit's Fiscal Year 2023 Annual Audit Plan to assure that the department's operational and inventory controls are firmly in place.

Audit Objectives: This audit will review the operational and inventory controls used by the Pharmacy Department's staff and our audit objectives were designed to:

1. Assure that pharmacy staff can reconcile inventory items to invoiced items (from packing slips) and provide safeguards for proper storage and distribution of these pharmaceutical items.
2. Determine that pharmacy inventory items can be matched to the perpetual inventory counts, and returns are properly documented showing the returned items are placed in a sealed tote to the vendor and assure that expired medications are returned as needed to the distributor/vendor.
3. Affirm that Pharmacy Department staff lock up all controlled substances and provide safeguards to limit access to limited supplies of expensive medications.

AUDIT RISKS

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

1. Management does not acknowledge Pharmacy staff reports about inconsistent or weak controls over security or pharmacy inventory issues.
2. Management does not educate Pharmacy staff members as to identify process improvements or provide means to report potential process improvements.
3. Management pays excessively high service fees for operational or inventory reports but does not act on the vendor's recommendations as stated in their reports.

FIELD WORK

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

1. Review the Pingboard organization chart for names of current staff and management teams in the Pharmacy Department and note number of new hires in the Pharmacy Department.
2. Contact the Director of Pharmacy and request access to the latest bi-annual inventory report by the Buttons Inventory Company to see the results and any findings in the report. Next, compare and contrast results of this latest report with one (1) previous inventory report to affirm that the current evaluation is equally comprehensive and detailed as performed in the past.
3. Evaluate accrual reports tracking pharmacy and pharmaceutical item inventories, and tie activity to results in the recent inventory count report to show any discrepancies in the counts or identify other administrative issues that may occur.
4. Schedule a conference call with the Senior Director of Pharmacy to evaluate the department's challenges and accomplishments and types of support they seek from senior management.
5. Review the Notes published in the Annual Comprehensive Financial Review (ACFR) to show that the inventory has properly trended in the Financial Services reports since the prior year's report, to correlate this level of activity back to the most recent ACFR Notes, as published, January 2023.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

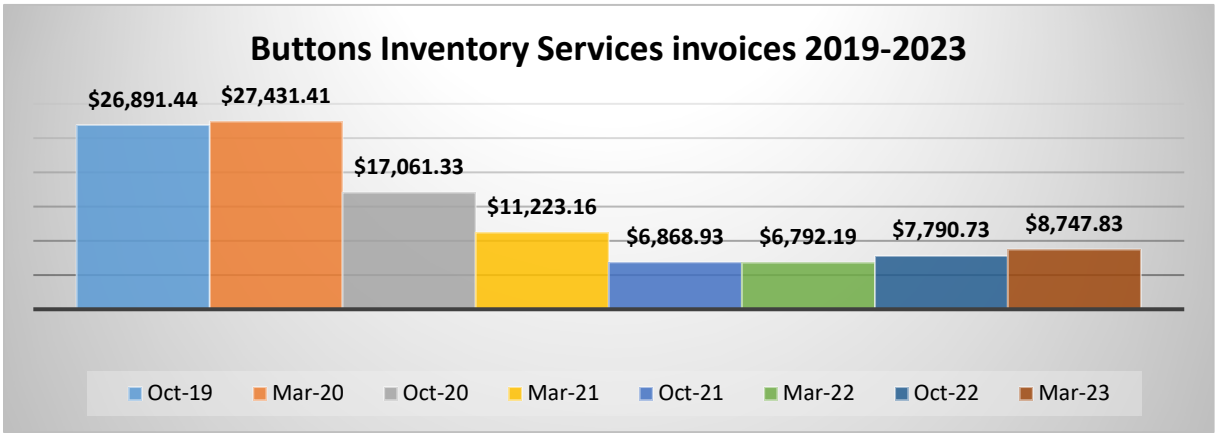
Observation #1 – Internal Audit found that Pharmacy policies and procedures have been updated, and are now easily accessible by employees using the PolicyStat folders on The Harris Center's intranet site.

Management Response not required.

Observation #2 – Internal Audit noted the invoiced amounts from the Buttons Inventory Service have decreased sharply since the March 2020 invoice. The counts are performed in October and March, as was requested by the Board several years ago.

Per Angie Babin, the Senior Director of the Pharmacy Program, "the service charges of the Buttons Inventory Service audits are based on the value of the inventory being counted, so as the inventory values have dropped, so do the inventory audit service charges."

Exhibit I – Invoiced service charges for performing on-site inventory counts at Pharmacy locations



Source: Ross Financial System, account = "Buttons Inventory Service", listed vendor invoices from FY2019 through FY2023.

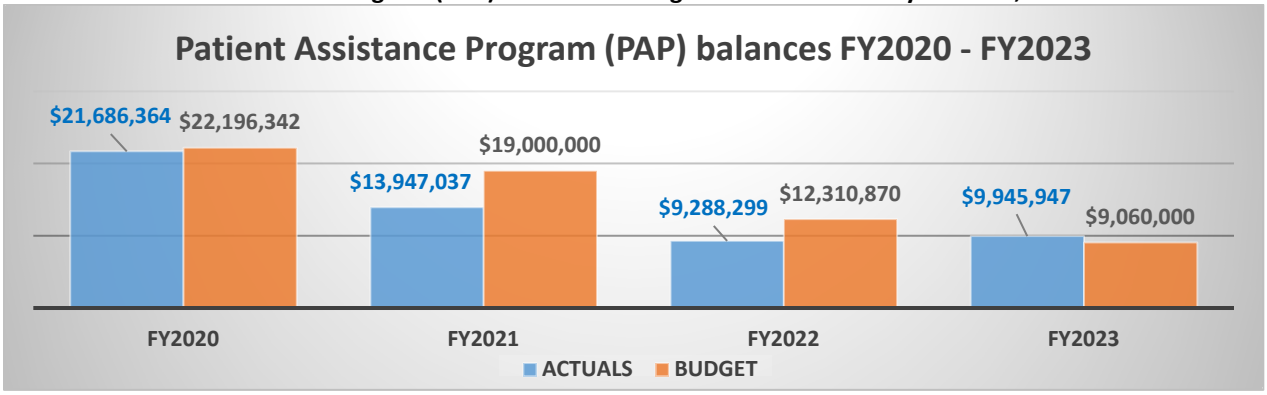
Management Response not required.

Observation #3 – Internal Audit noted the Patient Assistance Program FY2022 year-end Actuals per the 2021 and 2022 Annual Comprehensive Financial Reports (ACFRs) have decreased from $13.9 million to $9.3 million, representing a decrease of -$4.7 million, or about -33.4%.

The PAP FY2023 year-end valuations per the Trending Report shows Actuals increased to $9.9 million.

Per Angie Babin, the Senior Director of the Pharmacy Program, "the value of the PAP program continues to fall as medications evolve all the time and overall medication valuations have been falling."

Exhibit II – Patient Assistance Program (PAP) Actual and Budget balances at fiscal year-ends, FY2019-FY2022



Source: Annual Comprehensive Financial Review, Budgetary Comparison Statement/Budget-to-GAAP Reconciliation-General Fund, page 30, For the Year Ended August 31, 2022 and August 31, 2021.

Management Response not required.

Observation #4 – Internal Audit noted the Patient Assistance Program (PAP) inventory items are the largest category of items compared with bought stock, Dispensary of Hope (DoH), and non-formularies. These values are based on the hand-count of items performed at pharmacy locations on March 1, 2023.

We noted that PAP item valuations generally represented 85% to 90% of the total inventory value in most of the locations, except for the Neuro Psychiatric Center (NPC), based on its own business model. Per Angie Babin, the Senior Director of the Pharmacy Program, "since patients enroll in the PAP program based on income eligibility, the process is time-consuming and not suited for delivering treatment for the NPC patients, who typically arrive there in severe crisis."

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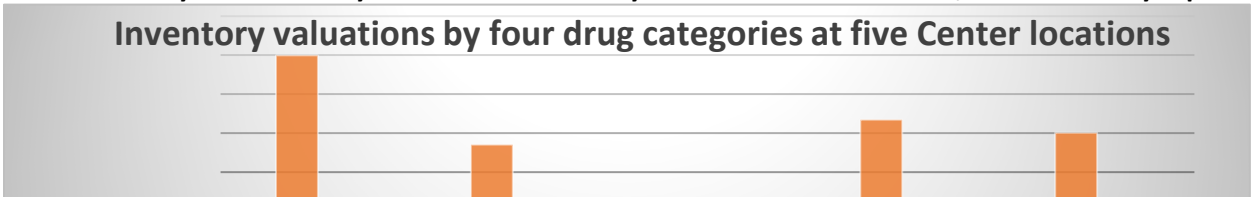

	SE Clinic	NE Clinic	NPC Location	NW Clinic	SW Clinic
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Non-Formulary	$115.91	$56.13	$41.24	$429.72	$0.00

Source: Buttons Inventory Service, bi-annual physical inventory report, valuations per March 1, 2023 inventory counts.

Management Response not required.

CONCLUSION

This audit reviewed how the Pharmacy Services performs their own internal pharmacy inventory audits, plus results of the biannual Buttons Inventory counts that provide unit-level inventory accountability.

Internal Audit spoke with the Senior Director of Pharmacy and she identified that the department's challenges include a nation-wide staffing shortage, and transitioning policies to the PolicyStat website, and education challenges throughout the agency. The department has met their FY2024 strategic plans goals for growth, and for improved billing and Medicaid programs. Among the challenges facing the Pharmacy Department, we heard about the staff shortage on several occasions in different locations.

The Director of Pharmacy attributes many improvements with the Dispensary of Hope, a 501(c)(3) based in Nashville, Tennessee. The Harris Center's PAP program was $9.3 million at the end of FY022 versus $13.9 million at the end of FY2021, according to the *Annual Comprehensive Financial Report* (ACFR), published at the year-end of FY2022. The Senior Director of Pharmacy described that the mix of items offered through Dispensary of Hope is moving to lower-cost generics, and this transition lowers the overall PAP valuation when compared with the prior year valuations.

During our site visits to the Southeast and Northeast Clinic locations, we noted strong demand for their services, with high volume dispensing activity performed in tight spaces. We spoke with pharmacists in charge (PIC) in those locations, who showed us how they control access to the operating location, and how they meticulously record their incoming inventory shipments, and reviewed the robotic dispensing process workflows. We talked about how they separated the PAP, DoH and bought inventories, and talked about the challenges they meet each day with helping patients with their medication needs.

This audit generated good conversations with the auditee. The Director of Pharmacy provided feedback, including: "Hi David, Wow you are both superstars! This is amazing. Thank you for taking so much pride in your review of pharmacy. It is very much appreciated." Internal Audit appreciates the recognition!

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 AUDIT REQUEST: TRAVEL REIMBURSEMENT AUDIT (SARTRAV0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit reviewed an ad-hoc travel report for January 2023, and we found that 8.04% of the paid travel reimbursements for the 1st trip of the day were from the employee's reported home address, going back to the employee's home address for lunch, and returning to the employee's home at the end of the day. We compared reported miles in other months: the ratio was 6.24% in October 2022, and 8.63% in April, 2023.

Internal Audit examined Travel Policy FM18A (effective 11/2022) which states: "mileage will be calculated based on distance from main place of employment to travel destination or client site." NOTE - If the employee's home address is identified as their main place of employment, the mileage incurred and reimbursed for the 1st trip of the day to a consumer or other travel destination is correctly calculated. The current online travel reporting system does not track commute miles which are not reimbursable per IRS regulations, however the policy calls for making such calculations.

Internal Audit also evaluated Section G in the FM18B Travel Reimbursements Policy (effective 05/2022) which described a methodology for calculating mileage from the employee's home to the 1st destination as "mileage to the 1st destination minus the mileage from home to their assigned HQ" as per IRS guidelines.

Internal Audit observed that the bulk of the reimbursed miles (90%+) are compliant with the current travel policies and procedures. Internal Audit recommends 1) that management revise the travel policies to use similar language in both policies and 2) provide additional training to assist employees in correctly reporting their monthly travel mileage.

Management Response not required.

Special Audit Request: Travel Reimbursements Audit

(SARTRAV0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Harris Center reimburses employees for travel in their personal vehicles for in-county travel to client locations to clients living in single family homes, apartment buildings or group homes. The Harris Center trains new employees on the travel reporting application from The Harris Center's locations, but several years ago, it appears that rules were relaxed to allow for travel reporting from the employee's home address because during that time, many staff may have been encouraged to consider their homes to be viable work locations.

The online in-county travel reporting application was developed years ago and upgraded in 2018 to improve compliance with IRS business travel regulations. The Harris Center's policies have followed IRS reimbursement guidelines and announced reimbursement rate changes over the years. The online mileage application is used daily to record Origins and Destinations (using addresses typed into the application's "drop-down" feature). The system uses address information from googlemaps.com databases to identify the actual distances from one address to the next address, and summarizes the monthly activity when sending report to the approver.

Internal Audit reviewed the FM18B Travel Reimbursement policy, which was last revised in May, 2022. The policy added a section to explain the Harris Center's position regarding the reimbursement of miles from an employee's home to a consumer's home location, as IRS rules prohibit reimbursement of "normal" mileage. This modification is the result of relaxing the origin of employees travel because many employees began to work from their home address location since the beginning of the pandemic in March, 2020.

From Section "G" in FM18B Travel Reimbursement Policy (effective 05/22):

> G. When travel is required to a location in the field prior to the employee going to their assigned location, the employee will be able to claim mileage only in excess of the distance from their home to their assigned work location.
>
> Example: Home to assigned location is 10 miles
> Home to consumers home is 5 miles
> *Then no mileage reimbursement is allowed
>
> Home to assigned location is 10 miles
> Home to consumers home is 15 miles
> *Then mileage reimbursement is requested at 10 miles (roundtrip).
>
> The employee cannot claim mileage from their home to their primary work location.

There is an observed "contradiction" appearing in the Section H of the FM18B Travel Reimbursements Policy, which is worth noting when you can compare its logic and language with Section "G" language listed above.

From Section "H" in FM18B Travel Reimbursement Policy (effective 05/22):

> H. Employee's on-call beyond the person's normal shift shall be reimbursed point to point between the locations from which they were paged to the destination point of the page. It is expected that the on-call person should remain within a reasonable driving distance to the assigned location in order to respond to the on-call in a timely manner. Mileage reimbursement requested will be reviewed by the supervisor for appropriateness.

In summary, although Internal Audit reviewed one month of travel trips and we observed that on-call activity is very limited occurring less than 1% of the time, this Section H provision is only specifically useful for those rare occasions when point to point travel miles are used, and therefore not applicable to 99% of other travel. Since the majority of the in-county mileage reporting are travel trips to client locations during the day, the majority of our employees should follow the rules in Section G in the FM18B Travel Reimbursements Policy.

FM18B Travel Reimbursement Policy (effective 05/22) states: “When travel is required to a location in the field prior to the employee going to their assigned location, the employee will be able to claim mileage only in excess of the distance from their home to their assigned work location.”

FM18B Travel Reimbursement Policy (effective 05/22) states: “Employee’s on-call beyond the normal shift shall be reimbursed point to point between the locations from which they are paged to the destination point of the page. It is expected that the on-call person should remain within a reasonable driving distance to the assigned location in order to respond to the on-call in a timely manner. Mileage reimbursement requested will be reviewed by the supervisor for appropriateness.”

When the employee completes the travel report (for a monthly period) the report is routed to an approver. The approver reviews the submitted mileages and trips, to verify the accuracy of the submitted mileage claim. There is an option to override the mileage calculations from the googlemaps.com drop-down method, but it then requires populating a reason code, such as “construction”, or “road was closed.” These user overrides should not occur frequently but sometimes approvers also request reductions in submitted miles using the override features. Information Technology has published training for the In-County Mileage Report tool.

Today, the employees can record the “normal commute” miles using their own methods (based on Section G). Since the travel system does not automatically count the “normal commute” miles, then it is problematic for our employees to consistently calculate the miles per Section G in the FM18B Travel Reimbursements Policy.

In November, The Harris Center issued a new FM18A Travel Policy (effective 11/22), which included policies for all travel related topics, including “Mileage” that is not described similarly to the Section G language, and states: “Employees are reimbursed at the current standard mileage reimbursement rate determined by IRS. Mileage will be calculated based on distance from main place of employment to travel destination or client site.” This policy does not differentiate between “normal commute miles” from other “miles” and the policy language is quite different from that used in the FM18B Travel Reimbursement Policy (effective 05/22).

Internal Audit recommends that management standardize the “excess” mileage calculation determination by using the same wording in both the FM18A Travel Policy and FM18B Travel Reimbursement Policy documents. This will facilitate employees’ interpretation and compliance with policies and simplify them in training.

Also, another finding is FM18A Travel Policy use of a term “main place of employment” which has not been defined elsewhere in the policies; is the main place of employment strictly a Harris Center building location? Internal Audit believes this term is “debatable” when comparing the FM18A Travel Reimbursement Policy and FY18A Travel Policy documents.

SCOPE AND OBJECTIVES

Audit Scope: The Director of Internal Audit requested this Travel Reimbursements Audit to assess that employees are complying with the Harris Center's prevailing travel policies and procedures.

Audit Objectives: Internal Audit reviewed the travel policy and procedures to:

1. Assure that Financial Services processing of monthly mileage payments occurs on time.
2. Identify patterns of any significantly higher-than-average mileage reports in our review.
3. Affirm that employees are reimbursed in a timely manner after submitting travel reports.

This audit report is an expansion of review objectives in the Special Audit Request: Employee Mileage audit performed earlier this year. This audit views additional topics related to travel reimbursement.

AUDIT RISKS

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

1. Management does not understand the employee reimbursement process at The Harris Center well enough to address issues that may arise when approving mileage and other expense claims.
2. Management does not obtain seek to perform frequent reviews of employee mileage claims.
3. Management does not appear to evaluate methods to improve workload and productivity issues related to visiting our consumer clients in the various field locations.

FIELD WORK

1. Review an ad-hoc annualized report from the IT representative that contains all monthly mileage reports submitted by employees for reimbursement from September 1, 2021 through August 31, 2022. Note: Mileage calculations are generated from the data dropdowns supplied by googlemaps.com, which were broadly developed by the Harris Center's IT applications designs nearly 10 years ago.
2. Examine the mileage reports for high dollar outliers, high dollar calculations, or other anomalies such as overrides, explanations for routing changes, or other recurring employee comments.
3. Discuss employee compliance with mileage report approvers to understand any instances of significant use of mileage overrides that have modified the original googlemaps.com calculations.
4. Note any irregularities that appear in the discussion or in any documentation.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit reviewed an ad-hoc travel report for January 2023, and we found that 8.04% of the paid travel reimbursements for the 1st trip of the day were from the employee's reported home address, going back to the employee's home address for lunch, and returning to the employee's home at the end of the day. We compared reported miles in other months: the ratio was 6.24% in October 2022, and 8.63% in April, 2023.

Internal Audit examined Travel Policy FM18A (effective 11/2022) which states: "mileage will be calculated based on distance from main place of employment to travel destination or client site." NOTE - If the employee's home address is identified as their main place of employment, the mileage incurred and reimbursed for the 1st trip of the day to a consumer or other travel destination is correctly calculated. The current online travel reporting system does not track commute miles which are not reimbursable per IRS regulations, however the policy calls for making such calculations.

Internal Audit also evaluated Section G in the FM18B Travel Reimbursements Policy (effective 05/2022) which described a methodology for calculating mileage from the employee's home to the 1st destination as "mileage to the 1st destination minus the mileage from home to their assigned HQ" as per IRS guidelines.

Internal Audit observed that the bulk of the reimbursed miles (90%+) are compliant with the current travel policies and procedures. Internal Audit recommends 1) that management revise the travel policies to use similar language in both policies and 2) provide additional training to assist employees in correctly reporting their monthly travel mileage.

Management Response not required.

CONCLUSION

The Harris Center issued the **FM18A Travel Policy** (rev. 11/22) and the **FM18B Travel Reimbursement Policy** (rev. 5/22) to replace the older versions of the Harris Center's travel and travel reimbursement policies.

After a review of the policies, we observed statements in one policy that do not appear to be consistent with language in the other policy, which may lead to discrepancies in interpretation of the Center's policies.

The **FM18A Travel Policy** (11/22) clearly states that claims for travel for employees are reimbursed at the current standard mileage reimbursement rate determined by the IRS. The policy also states that the "mileage will be calculated based on distance from the main place of employment to travel destination or client site."

The issue is that there is no agreement about what a "main place of employment" is for The Harris Center's employees, nor knowledge if this business term has been defined to include the employee's home address.

The **FM18B Travel Reimbursement Policy** (5/22) policy discusses recognition of "normal commutation miles" versus computation of "excess" miles when a client location is longer than an employee's driving distances to the employee's main office location. Travel reports are submitted to Accounts Payable for miles may include "normal commute miles" activity which should not be reimbursed per IRS rules, but without a means of separating these miles, there is no method to report them separately which may represent a business risk.

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 ID

Executive Summary

SPECIAL AUDIT REQUEST: FLEET MANAGEMENT AUDIT (SARFM0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – In FY2022, the combined costs of operating agency-owned vehicles were $325,165.80. The Enterprise Fleet Management invoices totaled $422,628.45 through August 31, 2022. Therefore, the combined costs of agency-owned vehicles and leased vehicles totaled $747,794.25.

Observation #2 – In FY2023, the combined costs of operating agency-owned vehicles totaled $567,578.47, and included vehicle purchases of $250,589.00. The Enterprise Fleet Management invoices totaled $564,430.57. The combined costs of agency-owned vehicles and leased vehicles totaled $1,132,009.04.

Included in FY 2023 is the purchase of a Primary Care Van for $250,589.00.

Two-Year Cost Comparison for agency-owned vehicles and the Enterprise Fleet Management contract

	FY2022	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
	559000	VEHICLE REPAIR/MAINT.	$159,462.13		
	559001	GASOLINE PURCHASES	$156,174.80		
	559002	VEHICLE REPAIRS (ROUTINE)	$9,528.87		
Vehicle (Purch,Rent,Maint)	559091	TRANSPORTATION USE FEE			FY2022
	560000	VEHICLE PURCHASE			ENTERPRISE FM
	561000	VEHICLE RENT			Invoices thru 8/31/22
	FY2022	Total Vehicle (Purch,Rent,Maint)	$325,165.80	B	$422,628.45
			C	TOTAL:	$747,794.25

ACTUAL	FY2023	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
	559000	VEHICLE REPAIR/MAINT.	$167,719.61		
	559001	GASOLINE PURCHASES	$138,755.70		
	559002	VEHICLE REPAIRS (ROUTINE)	$10,514.16		
Vehicle (Purch,Rent,Maint)	560000	VEHICLE PURCHASE	$250,589.00		FY2023
	561000	VEHICLE RENT			ENTERPRISE FM
					Invoices thru 8/31/23
	FY2023	Total Vehicle (Purch,Rent,Maint)	$567,578.47	A	$564,430.57
			D	TOTAL:	$1,132,009.04

Source: Financial Services, online Trending Report and Purchase Order Review Report, at year-end August 31, 2023.

Management Response not required.

Special Audit Request: Fleet Management Audit

(SARFM0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Transportation Department currently manages maintenance issues for agency-owned vehicles. In 2022, the Board of Directors approved the Center's recommendation for a third-party fleet management vendor to provide transportation resources for employees at The Harris Center. In years past, the Center bought vehicles from local dealerships, and maintained them for reliable performance and had them inspected, provided towing as needed, and repairs as they occurred. The fleet management plan moves the burden of operations to a contracted service (Enterprise Leasing Management) for a predictable monthly fee. The fleet management operational plan has been in place since April, 2022.

Employees in Facilities Services used pick-up trucks, and in IDD units there was a need for the clients' transportation using large, multi-seat passenger vans, and counselors and professionals visit client locations at home and in group homes. There is enthusiasm about updating the fleet in one year's time. The fleet management plan from Enterprise Leasing has been slowly replacing agency-owned units with leased units. One of the complications is the shortage of replacement vehicles from Enterprise Leasing. The rate of supplying the vehicles has taken longer than originally anticipated but this slow replacement rate has not hobbled operations at The Harris Center, nor curtailed its ambitions to work harder, etc.

The last fleet management audit was performed by Internal Audit in late 2014, when all vehicles were agency-owned. The Transportation Department was responsible for assuring that the current fleets of agency-owned vehicles were maintained and that all inspections were passed and registrations were obtained timely. The Voyager company supplies a "credit card type" of service, and it can provide a one basic control by way of issuing detailed monthly billing summaries that shows activity of the vehicles. When fueling with the Voyager card, the employee is updating the vehicle's odometer mileage reading. This information helps the Transportation Department document the age and the utility of the vehicles, which was essential for planning the maintenance and other activities to keep the fleet operational.

There are currently 48 vehicles in inventory, according to the Corporate Radar fixed asset system. Over the past twelve months, the Transportation Department has successfully sold off 44 older vehicles in a process managed by Enterprise Leasing Management. Under the plan, the vehicles are identified by the business units, a list of disposals is created to document which titles are to be transferred, and once the titles are forwarded to Enterprise Leasing, who picks up vehicles from the Center's properties. There is a standard $495 fee per vehicle which includes all the administrative costs, plus towing charges.

The leased vehicles are believed to be more predictable in terms of service reliability and predictable in terms of scheduled expense charges. Enterprise Leasing performs all the routine maintenance and other operations to maintain the vehicles in terms of routine maintenance, registrations and inspections.

SCOPE AND OBJECTIVES

Audit Scope: The Special Audit Request: Fleet Management Audit has been included in Internal Audit's Fiscal Year 2023 Annual Audit Plan to assure that proper management controls are in place.

Audit Objectives: This audit will review the Transportation Department's staff procedures used to manage the fleet operation, and our audit objectives were designed to:

1. Assure that Transportation Department can reconcile all documentation for agency-owned and leased vehicles and they can provide safeguards for proper storage of keys and other collateral.
2. Determine that the Transportation Department records can be matched to the inventory records.
3. Affirm that Transportation Department can perform routine vehicle maintenance requirements while providing adequate vehicles and related services to the business units whenever required.

AUDIT RISKS

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

1. Management does not acknowledge Transportation Department reports about inconsistent or weak controls over inventory issues or leasing process issues.
2. Management does not ask Transportation Department staff to identify process improvements and the Department's staff does not negotiate process improvements with the leasing vendor.
3. Management may pay excessively high administrative service fees for inventory reports but not act on the inventory vendor's recommendations to change inventory as shown in the reports.

FIELD WORK

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

1. Contact the Director of Transportation and discuss the nature of the special management request and key business controls used in the vehicle consignment process that are problematic to enforce.
2. Contact the Transportation Specialist to gain an understanding of the daily work activity involved in the position, and to understand how the Specialist has performed her role with consignment of agency-owned vehicles that are being replaced by the Enterprise leased vehicles.
3. Review the current physical flow of financial documents that might be erroneously misdirected and recommend possible improved flows to improve transparency and user access to information.
4. Review the inventory of agency-owned vehicles sent to Enterprise Lease to verify these vehicles are being sold within reasonable timeframes (less than 90 days from the vehicle's title transfer date). Verify the typical methods being used to market the vehicles and assess the typical buyer type.
5. Read the procedures used to identify agency-owned vehicles to be sent to Enterprise Leasing, and show Center manager sign-offs that show approval of transfer to Enterprise Leasing's facilities.
6. Review Enterprise Leasing's database of leased vehicle inventory to show timeliness of key metrics and frequency of updates by comparing odometer readings on 3-4 vehicles to database metrics.
7. Examine the SafetyAlert sticker numbers to inventory of sticker numbers in departmental records to ensure that driver reports are tracked back to individual agency-owned and leased vehicles.
8. Obtain a small sample of Transportation Department notifications to inform drivers of reported unsafe driving activity or other complaints and assess that communication issues was resolved.
9. Verify that vehicle insurance carriers are alerted about use of agency-owned and leased vehicles.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – In FY2022, the combined costs of operating agency-owned vehicles were $325,165.80. The Enterprise Fleet Management invoices totaled $422,628.45 through August 31, 2022. Therefore, the combined costs of agency-owned vehicles and leased vehicles totaled $747,794.25.

Observation #2 – In FY2023, the combined costs of operating agency-owned vehicles totaled $567,578.47, and included vehicle purchases of $250,589.00. The Enterprise Fleet Management invoices totaled $564,430.57. The combined costs of agency-owned vehicles and leased vehicles totaled $1,132,009.04.

Included in FY 2023 is the purchase of a Primary Care Van for $250,589.00.

Two-Year Cost Comparison for agency-owned vehicles and the Enterprise Fleet Management contract

	FY2022	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
	559000	VEHICLE REPAIR/MAINT.	$159,462.13		
	559001	GASOLINE PURCHASES	$156,174.80		
	559002	VEHICLE REPAIRS (ROUTINE)	$9,528.87		
Vehicle (Purch,Rent,Maint)	559091	TRANSPORTATION USE FEE			FY2022
	560000	VEHICLE PURCHASE			ENTERPRISE FM
	561000	VEHICLE RENT			Invoices thru 8/31/22
	FY2022	Total Vehicle (Purch,Rent,Maint)	$325,165.80	B	$422,628.45
			C	TOTAL:	$747,794.25

ACTUAL	FY2023	ACTUAL	ACTUAL		
		GL ACCOUNT	YTD		
	559000	VEHICLE REPAIR/MAINT.	$167,719.61		
	559001	GASOLINE PURCHASES	$138,755.70		
	559002	VEHICLE REPAIRS (ROUTINE)	$10,514.16		
Vehicle (Purch,Rent,Maint)	560000	VEHICLE PURCHASE	$250,589.00		FY2023
	561000	VEHICLE RENT			ENTERPRISE FM
					Invoices thru 8/31/23
	FY2023	Total Vehicle (Purch,Rent,Maint)	$567,578.47	A	$564,430.57
			D	TOTAL:	$1,132,009.04

Source: Financial Services online Trending Report and Purchase Order Report

Management Response not required.

CONCLUSION

Internal Audit performed the previous fleet management audit in late 2014, when all vehicles were agency-owned. The Transportation Department managed all the administrative duties in maintaining the agency-owned fleet and maintained additional controls through a contact with Voyager fuel service, which provides a credit card type of service with detailed monthly statements of vehicle activity.

Overall, Internal Audit believes the fleet management plan transition is going well, particularly because of the Transportation Specialist's strong organizational skills and competence in overseeing operations. Internal Audit's discussion with the Enterprise Fleet managers also addressed questions about how they have been able to provide ongoing strong support, and their commitment to service to the Center.

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.

The use of the Voyager fuel card serves as a control over typical fuel operating costs, and expanded use of the Voyager system coincides well with documenting leased vehicle mileage, which is tracked closely in the Enterprise database. As the leased vehicle mileages are regularly documented at the fuel pumps, mileages are recorded in the Enterprise database and viewable by the Transportation Specialist, who oversees Center-wide transportation activities.

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

STATUS REPORT: COVID-19 OSAR REIMBURSEMENT PROGRAM GRANT (SR0SARPG0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit staff reviewed reimbursements for PPE purchased between September 1, 2022 and August 31, 2023, which was the final grant phase. Internal Audit collaborated with the Harris Center's Director of Mental Health Projects as well as the Harris Center's Controller on a review process for payments to OSAR program grantees following eligibility rules from Texas Department of Health and Human Services (HHSC). Internal Audit established a working relationship with HHSC staff and the local OSAR provider called The Council on Recovery. The FY2023 grant provided $356k in awards to three (3) providers, including The Council on Recovery. In FY2022 and FY2023, the COVID-19 OSAR Reimbursement Program Grant paid $574,950.40 to OSAR providers who incurred increased costs during the COVID-19 pandemic period. The grant ended on August 31, 2023.

Exhibit I – List of OSAR COVID-19 reimbursements to HHSC Region 6 providers FY2022-FY2023

Claim#	Provider Name (FY2022 Program)	Rec'd Date	Payment Date	Amount
2022-01	Cenikor Foundation	2/1/2022	3/2/2022	$370.19
2022-02	The Montrose Center	2/2/2022	3/2/2022	$649.00
2022-03	Career and Recovery Resources, Inc.	2/3/2022	3/2/2022	$2,889.70
2022-04	Santa Maria Hostel	2/25/2022	3/23/2022	$65,733.88
2022-05	The Council on Recovery	5/23/2022	6/8/2022	$19,872.61
2022-06	The Center for Success Independence	5/23/2022	6/8/2022	$9,748.22
2022-07	The Council on Recovery	6/23/2022	7/6/2022	$9,775.82
2022-08	The Council on Recovery	6/23/2022	7/6/2022	$3,711.90
2022-09	The Council on Recovery	6/23/2022	7/6/2022	$161.45
2022-10	The Council on Recovery	6/23/2022	7/6/2022	$29,069.32
2022-11	The Women's Home	6/30/2022	7/13/2022	$3,933.84
2022-12	The Council on Recovery	8/10/2022	9/7/2022	$4,565.91
2022-13	The Council on Recovery	8/12/2022	9/7/2022	$68,400.00
	FY2022 Covid-19 Grant Program:		TOTAL:	$218,881.84
Claim#	Provider Name (FY2023 Program)	Rec'd Date	Payment Date	Amount
2023-01	Santa Maria Hostel	9/8/2022	9/14/2022	$65,859.00
2023-02	Santa Maria Hostel	9/22/2022	10/5/2022	$31,404.46
2023-03	Santa Maria Hostel	11/4/2022	11/16/2022	$15,692.38
2023-04	Santa Maria Hostel	12/15/2022	1/4/2023	$13,129.04
2023-05	Santa Maria Hostel	1/16/2023	2/1/2023	$9,365.11
2023-06	Santa Maria Hostel	2/13/2023	3/6/2023	$8,538.62
2023-07	The Council on Recovery	3/24/2023	4/5/2023	$7,634.70
2023-08	Santa Maria Hostel	4/6/2023	4/15/2023	$9,606.38
2023-09	Santa Maria Hostel	5/18/2023	6/9/2023	$12,635.26
2023-10	The Council on Recovery	5/22/2023	6/9/2023	$71,250.00
2023-11	Santa Maria Hostel	3/13/2023	6/7/2023	$9,292.27
2023-12	Santa Maria Hostel	6/13/2023	6/22/2023	$7,893.43
2023-13	Santa Maria Hostel	7/19/2023	7/26/2023	$7,979.71
2023-14	Cenikor Foundation	8/2/2023	8/8/2023	$245.82
2023-15	Santa Maria Hostel	8/7/2023	8/16/2023	$6,783.15
2023-16	Santa Maria Hostel	8/29/2023	9/6/2023	$36,856.03
2023-17	Santa Maria Hostel	8/29/2023	9/6/2023	$29,962.05
2023-17	Santa Maria Hostel	8/31/2023	9/6/2023	$11,941.65
	FY2023 Covid-19 Grant Program:		**TOTAL:**	**$356,068.56**
	TOTAL FY2022 and FY2023 Payments:			**$574,950.40**

Source: Internal Audit records, OSAR Program Administration (Internal Audit), from September 1, 2021 through August 31, 2023

Status Report: COVID-19 OSAR Reimbursement Program Grant (SROSARPG0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Harris Center for Mental Health and IDD co-operated a COVID-19 reimbursement program for the Texas Department of Health and Human Services (HHSC) organization's providers located in Region 6, which includes OSAR (Outreach, Screening, Assessment, and Referral) providers in Harris County, Texas. The Harris Center in this role will be serving Harris, Liberty, Montgomery, Walker, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Matagorda, Waller, and Wharton counties. The Gulf Coast Center, which is based in Texas City, has also provided like services in many of these same counties. [1]

It was recognized that during the COVID-19 pandemic that many OSAR program providers incurred additional incremental operating costs, such as purchases of additional personal protective equipment (PPE) for protecting staffs, purchase of cleaning supplies, hand sanitizers, thermometers and masks, client transportation costs, and Narcan purchases to name the typical reimbursement items.

The program was introduced at The Harris Center as a new grant in August, 2021, led by the Mental Health Division's Director of Special Mental Health Projects, and cooperative support from local provider The Council On Recovery, who provided expertise from the Senior Director of Program Operations. The Internal Audit staff received the incoming requests for reimbursements by seeking approval from two or more of the reviewers. Together we reviewed submitted requests on an excel reimbursement form and compared the requested amounts on the form against amounts listed on online sales documentation or on actual cash register tapes. The Staff Internal Auditor served as administrator and the main contact for the Region 6 providers, who had issued various email inquiries regarding reimbursement item eligibility.

The program initially sparked much interest but the COVID-19 reimbursement program rules are specific and in some cases require additional clarification. Our expanded our knowledge base by calling the two contacts at the Texas Department of Health and Human Services (HHSC) who provided expertise in the program, which helps make the correct call on approving submitted reimbursement items. Over time, the contacts and the OSAR review team members met by conference call to assure we were 'on track'. During the two year grant operation, the FY2023 COVID-19 OSAR reimbursement program was extended from April 13, 2023, to August 31, 2023.

[1] https://www.hhs.texas.gov/services/mental-health-substance-use/mental-health-substance-use-resources/outreach-screening-assessment-referral

SCOPE AND OBJECTIVES

Audit Scope: The Director of Internal Audit approved joining the team to review and approve requests from OSAR providers located in the Texas Department of Health and Human Services (HHSC) Region 6 area which includes OSAR providers based in Harris and the ten (10) surrounding counties in Texas.

Audit Objectives: The Director of Internal Audit agreed to participate in the COVID-19 OSAR grant in order to provide due diligence to the OSAR grant program originators. Our audit objectives were:

1. Obtain the list of providers in Region 6 and identify key contacts at each of the OSAR providers.
2. Communicate the role that the Center would provide in this specific COVID-19 grant program.
3. Identify the key requirements for reimbursement item eligibility.

AUDIT RISKS

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

1. The review team does not adequately identify reimbursement requests that are not eligible for the COVID-19 program, in accordance with the HHSC's COVID-19 grant documentation.
2. The review team does not adequately identify all grant-eligible provider reimbursement requests, in accordance with the HHSC's COVID-19 grant documentation.
3. The review team requests reimbursements to the Financial Services team for providers or items that were previously reimbursed from other sources or reimbursed from other grant programs.

FIELD WORK

1. Identify the provider list from the Texas Department of Health and Human Services (HHSC), and determine the primary contacts for each of these organizations.
2. Contact the Controller and explain that providers will submit reimbursement requests over time but not with any regularity, unless it is specified as such by the provider. Ensure that the Controller has provided the latest version of the W-9 form, and the Center's ACH authorization form.
3. Announce the availability of the OSAR grant reimbursement program and send these providers the basic documents to be used in the providers' submissions: the reimbursement form (excel format), program documentation from HHSC, and W-9 and the Center's ACH authorization form.
4. Review reimbursement requests daily and inform the submitting OSAR provider when materials are to be initially reviewed.
5. Perform reconciliation of Reimbursement Form to all submitted documentation sent as supports. Add Notes to the documentation to assist other team reviewers evaluate their inspection.
6. Request written approval from the team members and seek one or more acknowledged approvals before forwarding request to Controller's office for their review.
7. Verify on Aptean Ross Browser that payments were processed in a timely manner (within 10 days), otherwise send an inquiry to the Controller's office about the status of the reimbursement.
8. Verify that all payment requests were read at the Controller's email and payments fulfilled as documented on Ross Browser. (Note: A payment may be bundled with other payments to the OSAR provider, so total payment may be greater than the COVID-19 reimbursement payment.)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit staff reviewed reimbursements for PPE purchased between September 1, 2022 and August 31, 2023, which was the final grant phase. Internal Audit collaborated with the Harris Center's Director of Mental Health Projects as well as the Harris Center's Controller on a review process for payments to OSAR program grantees following eligibility rules from Texas Department of Health and Human Services (HHSC). Internal Audit established a working relationship with HHSC staff and the local OSAR provider called The Council on Recovery. The FY2023 grant provided $356,068.56 in awards to three (3) providers, including The Council on Recovery. In FY2022 and FY2023, the COVID-19 OSAR Reimbursement Program Grant paid $574,950.40 to OSAR providers who incurred increased costs during the COVID-19 pandemic period. The grant ended on August 31, 2023.

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	FY2022 Covid-19 Grant Program:		**TOTAL:**	**$218,881.84**
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2023-04	Santa Maria Hostel	12/15/2022	1/4/2023	**$13,129.04**
2023-05	Santa Maria Hostel	1/16/2023	2/1/2023	**$9,365.11**
2023-06	Santa Maria Hostel	2/13/2023	3/6/2023	**$8,538.62**
2023-07	The Council on Recovery	3/24/2023	4/5/2023	**$7,634.70**
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2023-09	Santa Maria Hostel	5/18/2023	6/9/2023	**$12,635.26**
2023-10	The Council on Recovery	5/22/2023	6/9/2023	**$71,250.00**
2023-11	Santa Maria Hostel	3/13/2023	6/7/2023	**$9,292.27**
2023-12	Santa Maria Hostel	6/13/2023	6/22/2023	**$7,893.43**
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2023-15	Santa Maria Hostel	8/7/2023	8/16/2023	**$6,783.15**
2023-16	Santa Maria Hostel	8/29/2023	9/6/2023	**$36,856.03**
2023-17	Santa Maria Hostel	8/29/2023	9/6/2023	**$29,962.05**
2023-17	Santa Maria Hostel	8/31/2023	9/6/2023	**$11,941.65**
	FY2023 Covid-19 Grant Program:		**TOTAL:**	**$356,068.56**
	TOTAL FY2022 and FY2023 Payments:			**$574,950.40**

Source: Internal Audit records, OSAR Program Administration (Internal Audit), from September 1, 2021 through August 31, 2023

Management Response not needed.

CONCLUSION

The Harris Center for Mental Health and IDD was designated as the administrator of the COVID-19 OSAR Reimbursement Program grant issued by the Texas Department of Health and Human Services (HHSC). The Harris Center and neighboring Gulf Coast Center in Texas City were responsible for supporting the Region 6 OSAR providers. We identified 24 OSAR providers designated as HHSC Region 6 (Harris County).

The COVID-19 OSAR reimbursement program was supported by the Director of Mental Health Projects, who introduced us to the key OSAR program contact (Council on Recovery). These managers plus the Internal Audit staff jointly reviewed Region 6 provider claims.

The COVID-19 grant was created to provide reimbursement funds to OSAR providers who had incurred incremental and usually unforeseen operating expenses such as for personal protective equipment (PPE) purchases, client transportation, and infection control measures to mitigate the spread of COVID-19 by adapting client housing, etc. These incremental expenses were incurred during the COVID-19 outbreaks.

The Internal Audit staffers, plus the Director of Special Mental Health Projects had coordinated a review process with the local OSAR provider's representative at The Council On Recovery. The team of four reviewers then reviewed the OSAR provider documentation and tested the reimbursement calculations.

Just as we saw in a prior grant, the HHSC administrators documented allowable reimbursement items and were readily available to call and clarify the eligibility for reimbursement of submitted requests. Internal Audit found no instances of unsubstantiated claims and hesitated in recommending payments when the documentation was not clear and additional verification was sought for the approval.

In the initial announcement, there was a FY2022 grant available through August, 31, 2022, and the FY2023 grant began September 1, which ultimately was extended through August 31, 2023.

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

STATUS REPORT: NEW FRAUD HOTLINE REPORTING SERVICE

New Fraud Hotline Reporting Service:

- As of June 2023, Internal Audit has partnered with a new confidential external hotline fraud reporting service which replaces the prior reporting service. The new hotline service, called Fraud HotLine (www.fraudhl.com), allows users to self-report any fraud, waste, or abuse potential issues 24 hours a day, 365 days a year.
- The service is low-cost ($250 per year) and includes live operator support and an online portal to submit reports confidentially. Users can review report status on the Fraud HotLine website using assigned ReportID.
- The Fraud HotLine contact information will be circulated online on the Center's Harrisphere intranet, and promoted on Fraud Hotline posters that are prominently placed throughout The Harris Center's offices. The printed poster includes a QR code which employees can scan using any personal or agency cell telephone.
- The fraud awareness campaign will continue in observance of International Fraud Awareness Week, November 12 – 18, 2023.

Executive Summary

CHARITY CARE PROGRAM (CCP) AUDIT
(CCP0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found that since September 1, 2022, the Charity Care Program (CCP) has contributed a total of $45,148,865.38 through August 31, 2023, according to the online Trending Report.

Management Response not required.

Charity Care Program (CCP) Audit

(CCP0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Harris Center began its participation in the 1115 Waiver Transition process last year. In Year 1, the 1115 Waiver program covered uncompensated care, and the Medicaid shortfall. In Year 2, the Charity Care Program (CCP) transferred to reimbursing charges for charity care. [1]

On December 22, 2021, Texas Health and Human Services Commission (HHSC) received federal approval of the Public Health Providers – Charity Care Program (PHP-CCP) Protocol from the Center for Medicaid and Medicare Services (CMS). The approved protocol incorporated into a January 15, 2021 1115 Waiver.

The Texas Health and Human Services Commission (HHSC) developed the Public Health Provider – Charity Care Program (PHP-CCP) that is designed to allow qualified providers to receive reimbursement for the cost of delivering healthcare services, including behavioral health services, immunizations, and other preventative services, when those costs are not reimbursed by another source. The program is authorized under the 1115 waiver. [1]

In accordance with the Special Terms and Conditions of the 1115 waiver, to participate in the program, providers must be funded by a unit of government in order to be able to certify public expenditures. Publicly-owned and operated providers who are eligible to participate include:

- Community Mental Health Clinics (CMHCs)
- Community Centers
- Local Behavioral Health Authorities (LBHAs)
- Local Mental Health Authorities (LMHAs) [1]

From the HHSC website Training Report:

Cost Report Preparation & Certification. An eligible and participating provider will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred Medicaid and Uncompensated (uninsured) costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. Costs are only eligible to be reimbursed within 24 months after the date that the cost was incurred. The completed cost report will be transferred via a File Transfer Protocol (FTP) and subsequently an electronic mail will need to be sent to HHSC Provider Finance Department at PHPCCP@hhs.Texas.gov. [2]

Per TAC §355.8217, providers are required to have at least one financial contact attend the training annually. The cost report training is required annually by at least one financial contact to participate in the program.

Year 2 of the PHP-CCP Cost report will deploy the State of Texas Automated Information Reporting System (STAIRS) for the collection of cost reports to replace excel spreadsheets in Year 1.

HHSC will host cost report training webinars in preparation for Year 2 of the PHP-CCP on August 15, 2023, August 22, 2023, and September 15, 2023.

[1] *https://pfd.hhs.texas.gov/acute-care/public-health-provider-charity-care-program*

[2] *https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/2022/2022-phpccp-trng-presentation.pdf*

SCOPE AND OBJECTIVES

Audit Scope: To review the Charity Care Program (CCP) Year 2 implementation at The Harris Center.

Audit Objectives: The Charity Care Program requires providers to report semi-annually (April and October) on the following:

1. Implementation of activities foundational to quality improvement such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange. (Component 1 requirement).
2. Metrics that align with CCBHC measures and goals. (Component 2 requirement).
3. Evaluate the training and support of these initiatives throughout the Center's clinical offices.

AUDIT RISKS

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

1. The Center's management cannot perform minimal reporting activities semi-annually in order to comply with program requirements.
2. The Center's management does not properly account for funds received as program payments.
3. The Center's management does not formulate a process to account for the calculation of metrics in order to engage clinical operations to perform appropriate services.

FIELD WORK

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

1. Review the Harris Center's involvement in CCP documentation including program descriptions and diagrams, narratives and workflows that describe the metrics and performance calculations.
2. Evaluate methods currently used to track metric calculation and the presentation for payment, and methods being proposed to match performance in subsequent reporting periods.
3. Compare results of methodology for earning Component 1 and Component 2 payments with the online Financial Services reporting system reports.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found that since September 1, 2022, the Charity Care Program (CCP) has contributed a total of $45,148,865.38 through August 31, 2023, according to the online Trending Report.

Management Response not required.

CONCLUSION

The Texas Health and Human Services Commission (HHSC) developed the Public Health Provider – Charity Care Program (PHP-CCP) to allow behavioral healthcare providers to receive reimbursement for the cost of delivering a wide range of behavioral and primary healthcare services, including behavioral health services, immunizations, and other preventative services. The HHSC website noted that during this time of 1115 Waiver transition, it is important to cover costs not reimbursed by another source.

The Charity Care Program issued payments to the Center since September, 2022 and overall it appears to be a useful addition to the array of supporting our consumer constituencies in the community.

Respectfully submitted,

David W. Fojtik

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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

DIRECTED PAYMENT PROGRAM AUDIT
(DPP0123)

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found the Directed Payment Program (DPP) contributed $9,814,077.34 through August 31, 2023.

Management Response not required.

Directed Payment Program (DPP) Audit

(DPP0123)

INTERNAL AUDIT REPORT

October 17, 2023

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

Director, Internal Audit

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CURRENT PROCESS

The Harris Center received funding for the Delivery System Reform Incentive Payment (DSRIP) Program for years as part of the 1115 Waiver Program. The Directed Payment Program for Behavioral Health Services program is one of the four programs that has provided a transition from a legacy 1115 Waiver. The Centers for Medicaid and Medicare (CMS) approved a Directed Payment Program (DPP) for Behavioral Health Services (BHS) which began October 1, 2022 for the State Fiscal Year 2023 (SFY23).

According to the HHSC website, "DPP BHS is a DPP for community mental health centers (CMHCs) to promote and improve access to behavioral health services, care coordination, and successful care transitions for individuals enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs. It also incentivizes continuation of care for these individuals using the Certified Community Behavioral Health Clinic (CCBHC) model of care. The program is designed to promote and improve access to behavioral health services, care coordination, and successful care transitions for individuals enrolled in STAR, STAR+PLUS and STAR Kids programs." [1]

The Harris Center is a Certified Community Behavioral Health Center (CCBHC). As a condition of participation in DPP BHS, a provider must report program data semi-annually for all measures as a condition of program participations. Per Directed Payment Program rules, the funds are paid through two components of managed care capitation rates:

- Component 1 is equal to 65% of the total program value and provides a uniform dollar increase. As a condition of participation providers are required to report progress made toward certification or maintenance of CCBHC status and also required to report on implementation status of activities foundational to quality improvement such as telehealth services, collaborative care, integration of physical and behavioral health and improved data exchange. [1]
- Component 2 is equal to 35% of the total program value and provides a uniform rate increase applied to certain CCBHC services and paid at the time of claim adjudication. As a condition of participation, providers are required to report on metrics that align with CCBHC measures and goals. Providers that have CCBHC certification are eligible for a higher rate enhancement. [1]

Per the HHSC website, the Inter Governmental Transfer (IGT) prepaid is a lump sum which was initially allocated at the beginning of the State Fiscal Year SFY23 (Year 2), which began on October 1, 2022: [2]

Payment by Provider	Sum of Component 1 Total	Sum of Component 2 Total	Sum of Total
The Harris Center for Mental Health and IDD	**$11,429,381.63**	**$6,449,710.20**	**$17,879,091.82**
1346293156	$11,429,381.63	$6,449,710.20	$17,879,091.82
1144235748	$0.00	$0.00	$0.00
1174530109	$0.00	$0.00	$0.00
1265528798	$0.00	$0.00	$0.00
1417962010	$0.00	$0.00	$0.00

Texas Department of Health and Human Services: "Provider Finance: Directed Payment Program for Behavioral Health Services" *https://pfd.hhs.texas.gov/sites/rad/files/documents/acute-care/sfy2023-yr2-bhs-suggest-igt-amounts-per-provider.pdf*

There are reporting requirements in October and April, which is similar to reporting specified for DSRIP. The Harris Center obtained funding for SFY22 (Year 1) and for SFY23 (Year 2). We report in October, get paid in January, IGT paid in Jan; and we report in April to get paid in July, IGT paid in July.

[1] Directed Payment Program for Behavioral Health Services, https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-directed-payment-programs/directed-payment-program-behavioral-health-services-dpp-bhs

[2] https://pfd.hhs.texas.gov/acute-care/directed-payment-program-behavioral-health-services

SCOPE AND OBJECTIVES

Audit Scope: To review the Directed Payments Program (DPP) as implemented at The Harris Center.

Audit Objectives: The Directed Payments Program requires providers to report semi-annually on:

1. Implementation of activities foundational to quality improvement, such as telehealth services, collaborative care, integration of physical and behavioral health, and improved data exchange. (Component 1 requirement).
2. Metrics that align with CCBHC measures and goals. (Component 2 requirement).
3. Evaluate the training and support of these initiatives throughout the Center's clinical offices.

AUDIT RISKS

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

1. The Center's management chooses not to perform minimal reporting activities semi-annually in order to comply with program requirements.
2. The Center's management record funds received as Directed Payment Program payments or account for their allocation.
3. The Center's management does not streamline the reporting or calculation of key metrics for clinical operations in order for them to improve the performance of behavioral health services.

FIELD WORK

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

1. Review the documentation of the Directed Payment Program (DDP) from the Texas Department of Health and Human Services (HHSC) website for specific rules for the Directed Payment Program.
2. Review the Center's prior work in DDP documentation including program descriptions and any other diagrams, narratives and workflows that describe the metrics and performance calculations.
3. Evaluate methods currently used to track metric calculation for reporting purposes.
4. Evaluate the presentation for metric fulfillment, payments received, and any methods developed to match performance to incentive dollars.
5. Compare results of earning Component 1 and Component 2 payments with the Financial Services online reports and evaluate discrepancies found with the Financial Services management teams.

OBSERVATIONS, RECOMMENDATIONS & MANAGEMENT RESPONSES

Observation #1 – Internal Audit found the Directed Payment Program (DPP) contributed $9,814,077.34 through August 31, 2023.

Management Response not required.

CONCLUSION

The Directed Payment Program (DPP) succeeds the Delivery System Reform Incentive Payment (DSRIP) as a part of the 1115 Waiver Program Transition process.

The Directed Payments Program contains programs that replace existing hospital payment programs, incentives for Physicians and other providers, but also includes a program called Behavioral Health (BH). The DPP requires semi-annual reporting of the Center's clinical performance against CCBHC standards.

The use of Component 1 standards drives innovation and improvement of operations and infrastructure and represents 65% of the service value paid monthly as inter-governmental transfer payments (IGT). The revenues of the program include primarily IGT payments then supplemented with reimbursements from the managed care companies involved with Star+Plus program associated with the DDP program.

In addition, the program's Component 2 metrics are paid at adjudication which occur months later after an initial treatment is performed.

Internal Audit believes the Directed Payment Program has strong potential for growth for the Center, and it contribution provides new opportunities for expanding our services.

Respectfully submitted,

David W. Fojtik

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The HARRIS CENTER for Mental Health and IDD

ANNUAL REPORT ON FISCAL YEAR 2023 INTERNAL AUDIT ACTIVITIES INCLUDING

APPENDIX 1 – FY 2023 ISSUE TRACKING MATRIX
APPENDIX 2 – FY 2024 AUDIT PLAN

David W. Fojtik, CPA, CIA, CFE
Internal Audit Director

Kirk D. Hickey, CFE
Staff Auditor

October 17, 2023

9401 Southwest Freeway
Houston, Texas 77074

Annual Report on Fiscal Year 2023

Purpose of the Annual Report: To provide information on the benefits and effectiveness of the internal audit function.

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I. Message from the Director of Internal Audit

I am pleased to submit the Internal Audit Annual Report for the fiscal year ended August 31, 2023. This report itemizes the services provided and other activities performed by the Harris Center Office of Internal Audit and fulfills the Texas Internal Auditing Act (the Act) requirements set out in Texas Government Code, Section 2102.009.

Included in this report are Internal Audit's Key Wins and Accomplishments for Fiscal Year 2023, the results of seven (7) Board approved audit plan, explanations for any deviations from the audit plan, and results of five (5) Special Management Requests and two (2) Follow-up Audits completed during the year. The results of these reports have been communicated to the Board of Trustees through the Audit Committee.

I believe the work of the Office of Internal Audit contributed to making the Harris Center's operations more efficient and effective by providing positive contributions to risk management efforts, control systems, and governance processes.

The Harris Center's Internal Department in FY2023 incorporated myriad creative solutions in orchestrating new efficiencies — as well as new methods — in evidence gathering. We have experienced and benefitted from the Center's willingness to build cloud-based platforms that are designed to not only facilitate remote collaboration but automate workflows and we were successful in streamlining and facilitating the actions of multiple stakeholders to reach common, intersecting goals.

Internal Audit always strives to uphold the goal that the Board and management can rely on the collective competencies of the audit staff to think critically and to address high priority risks. We will continue to utilize data analytics in routine audits which are quick and discrete wins typically found in core business processes, such as accounts payable, travel, payroll, general ledger, and in IT.

At this time, we are pleased to present the following recap of audit activities in Fiscal Year 2023. We thank you for your continued support of the Internal Audit Department.

David W. Fojtik

September 27, 2023

II. The Internal Audit Department's Mission and Responsibilities

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Mission Statement

Internal Auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

— The Institute of Internal Auditors (IIA) Standards for the Professional Practice of Internal Audit

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Internal Audit's goals are to assist the Center accomplish its objectives by bringing a systematic, disciplined approach in evaluating and improving the effectiveness of risk assessment and risk management models. Internal Audit works to ensure that The Harris Center's business risks are being mitigated or accepted, or in other cases can be easily transferred or managed within an acceptable degree.

The Internal Audit Department's charge is derived by The Harris Center's Board of Trustees' ("the Board") need to perform various independent reviews of key business processes and auditable entities at the Center. The Director of Internal Audit is appointed to provide the unique consultative role that can truly provide an objective functional responsibility to the Board and the Audit Committee members, and at the same time he can maintain the administrative responsibility to the Chief Executive Officer.

The Internal Audit Department's primary responsibilities include:

1) Establishing an annual risk assessment of the Center's business units (auditable entities).
2) Performing reviews of auditable entities to evaluate their internal controls and management's compliance to such controls.
3) Recommending best practices, where possible, and soliciting meaningful corrective action plans.

4) Monitoring the Center's operations for observations of waste, abuse, and fraud in Center offices.
5) Challenging the Center's business units' management teams to integrate process improvements into their workflow whenever and wherever feasible.
6) Dialoguing issues with members of the Center's senior management and Chief Executive Officer, and as needed, additionally with the members of the Board of Trustees.
7) Presenting the results of Board-approved audit reports to the Audit Committee during the year.
8) Educating the Center's management and staff on changes in federal, state, and local regulations.
9) Promoting management's training of their employees for performing their job duties efficiently, and to strive for employee compliance in their job functions.
10) Maintaining the anonymous hotline for employee and consumer reports of waste and fraud with an external fraud hotline service called FraudHotLine (www.fraudhl.com), which allows employees to self-report any fraud, waste, or abuse, and relay their own ideas for process improvement.

The Internal Audit Department mission is to enhance and protect THC's organizational value and its reputation by providing risk-based business process assessments (BPAs) that identify new opportunities for growth as well as provide various objective assurance services, auditing skills, and investigative services. Internal Audit has worked with external auditor firms, business consultants, industrial psychologists, and other healthcare professionals to evaluate complex healthcare business issues.

III. Internal Audit Department Services

The Internal Audit Department is responsible for continuously assessing the Center's tolerance for risk by developing audit objectives, priorities and procedures that balance risk with effective internal controls. While management is solely responsible to adhere to internal controls, the Internal Audit Department is (within the audit scope) solely responsible for evaluating the adequacy and effectiveness of these controls. Internal control comprises methods and procedures are adapted to:

* Safeguard physical and digital assets and promote operational efficiency.
* Check accuracy and reliability of financial and other operational data.
* Encourage adherence to prescribed Center's established policies and procedures.
* Discourage waste, abuse, and misuse of the Center's resources by soliciting employee hotline tips.
* Review clinical and business office operations to ascertain consistency with the Center's goals.

It is the responsibility of the Internal Auditor to give an opinion, at least once annually, on the adequacy and effectiveness of financial and other internal controls used in the key business processes at the Center. This opinion is based on the adequacy of controls noted from a selection of risk-based system audits and other advice work on control systems. such as the results of investigative inquiries, fieldwork of performing internal process reviews, and the evaluation of audit reports produced by external sources that can enhance the Internal Auditor's opinion of the particular findings during internal audit.

Internal Audit worked to support The Harris Center's achievement of its mission by strengthening internal controls, applying proven scientific management principles, aligning Agency and departmental resources, and through ongoing fraud deterrence and prevention. Internal Audit continued to refine the audit approach and methodologies in order to build stronger levels of proficiency and increase the understanding of the Harris Center's culture and build long-term and trusting relationships with the Center's Board of Directors and specifically the Board's Audit Committee, management, and other relevant stakeholders.

The Internal Audit Department's mission provided an unbiased and independent assurance of business processes and consulting services that add value by improving the organization's business operations. Internal Audit helped the units accomplish its goals by using a systematic, disciplined fraud risk assessment approach to improve the effectiveness of risk management, control, using three primary objectives:

* Mitigating or even avoiding potential losses.
* Increasing process efficiency and effectiveness; and
* Ensuring resources are applied toward accomplishing the Center's vision, mission, and goals.

Internal Audit performed five types of audit and consultative services throughout the year:

Traditional Audits: Internal Audit reviewed management, financial, and operating controls to appraise the soundness and adequacy of the controls and advise management whether the internal control systems provide reasonable assurance regarding the achievement of objectives; that established plans, policies, and procedures are complied with; and assure that The Harris Center's assets are properly accounted for and are being safeguarded from loss. Internal audits regularly result in recommendations to improve operating efficiency and internal controls.

Advisory Services: Internal Audit undertook management requested reviews of current and proposed operating practices and prevailing policies and procedures and identified changes in the system of internal controls occurring with system development and implementation, financial and operational processes, or process improvement.

Fraud Assessments and Investigations: Internal Audit investigated allegations of fraud, waste, conflicts of interest, or improper governmental activities which determined if the conditions were to be confirmed as material in magnitude or have great likelihood to pose future business risks to the Center or substantiated for a future review.

External Audit Coordination: Internal Audit has been the external auditors' liaison to The Harris Center. Internal audit coordinated projects and contracts, performed key communications and data exchange roles during the performance of business process and operational audits, reviews, and provide a singular contact for future investigations between the Center and external audit agencies including public accounting firms.

Data Analytic Services: Internal Audit has usually performed a variety of traditional audits and maintains its responsibilities over audit project performance, advisory services, fraud assessments and investigations. However, the audit professional training seminars widely support integration of more data analysis and other online tools in order to review complete sets of business data versus traditional sampling tools. This provides management with greater assurance of complete review and includes evaluation of anomalies in the data workflow that can strongly evidence fraudulent activity.

We will continue to use IDEA CaseWare, a data analytical software package that has desk-top auditing tools to view large volumes of business data, and it can be enhanced to provide continuous monitoring of business data, such as payroll or billing, to show anomalies that suggest operational failure or possible fraudulent activity.

Internal Audit is currently working to implement continuous monitoring on key business data as a means of assuring adequate and comprehensive review of these data in order to test for duplicates, such as duplicate invoices or other data, which may indicate fraudulent activity or at least dubious integrity on the part of a vendor's accounting department, etc. Continuous monitoring is superior to sampling because it is capable of reviewing complete data sets.

IV. Departmental Statement of Goals and Goal Assessment Results

Goal #1: Conducted scheduled and unscheduled audits to provide management with appraisals of the Center's compliance with policies and procedures as well as local, state, and federal laws, and regulations.

Assessment for Goal #1: Developed an annual audit plan that was approved by Center's Audit Committee. Performed active testing and reviews of the projects approved by the Audit committee. Identified key controls designed to ensure compliance, identified internal control weaknesses, and made constructive recommendations to the Management.

Goal #2: Insured compliance with those requirements mandated by government standards as defined by the Institute of Internal Auditors (IIA), the Governmental Accounting Standards Board (GASB), and the Association of Certified Fraud Examiners (ACFE).

Assessment for Goal #2: Scheduled and unscheduled audits were performed in compliance with applicable governmental auditing standards as outlined in the 2014 published guidelines by the Comptroller General of the United States.

The Internal Audit staff also completed annual trainings, maintained professional memberships and certifications to remain on the forefront of new governmental auditing standards and emerging trends and issues such as ransomware and business email compromise.

V. FY2023 Key Activities and Accomplishments

FY2023 Key Activities

- Internal Audit completed a risk assessment of The Harris Center's key auditable entities in preparing the collection of projects listed on the Fiscal Year 2023 Audit Plan.
- Internal Audit completed seven (7) Board-approved internal audit projects largely in the order shown in Table I. Note that audit projects with higher calculated risk ratings were prioritized for their review earlier in the annual Audit Plan schedule than for other projects on the list of Board-approved projects.
- Completed five (5) special audit requests (SARs) and priority special management requests to report on special issues, and performed two (2) follow-up audits on the prior year's special audit requests for New Hire Drug and TB Testing, and for resolving Human Resources discovered payment issues with several vendor organizations that are critical to the Center's onboarding and new hire selection workflows.
- Discussed the Incident Report and Safety Alert reports with Risk Management and Human Resources to determine if any behaviors may harm consumers or damage The Harris Center's reputation for funding. In June, Internal Audit entered into an agreement with FraudHotline (www.fraudhl.com) to replace the Safety Alert organization, who announced they are leaving the audit hotline reporting business.

FY2023[1] Key (Wins) Accomplishments

✓ Employee License Update – Internal Audit continued our review of monthly employee license renewals by reviewing the Human Resources Department's monthly report showing renewal activity. Last year and in prior years, there seemed to be dozens of employees with licenses that appeared to be expired; in actuality they may have not had the ability to effectively report their renewal activity. However, the efforts provided by Internal Audit and the renewed interest in assistance from Human Resources seems to have reduced the number of expired licenses down to zero. We worked with Information Technology and Revenue Management

on the evaluating Cactus Software, a firm which specializes in credentialing systems, which are absolutely critical for creating higher quality billing to payers and to the community.

- ✓ Employee Mileage Update – Internal Audit evaluated the composition of employee trip reporting and found about 12% of trips from home to client residential addresses may also include normal commute mileage, which is not reimbursable according to IRS travel guidelines. Additional we found a like number of trip mileage was from client addresses to home which may include normal commute mileage. Our examination of origins and destinations found that employees reported multiple trips to the client locations and some additional trips to home during the day, which technically are also not reimbursable. The Harris Center has two separate travel policies: 18A Travel Policy and 18B Travel Reimbursements, which we recommend should reference each other and share a common reimbursement methodology. Otherwise, we believe that nearly 90% of recorded mileage complies with the policies, and despite the employees' efforts to curb or reduce their mileage claims, the overall volume of reimbursements grows.
- ✓ Strategic Objectives Audit – We reviewed the Center's confirmed Strategic Objectives for FY2023, and we reached out to clinical and administrative subject matter experts who could help us finalize the goals outlined in the Objectives, which included:
  - Review of the progress on quarterly basis (Quarters 1 thru 4) using EPIC data.
  - Review of the quarterly billings to ensure appropriate billing timeframes are met.
- ✓ OSAR Provider Reimbursement Grant for COVID-19 for the FY2023 program – Internal Audit staff reviewed reimbursements for PPE purchased between September 1, 2022 and August 31, 2023, which was a final grant phase. Internal Audit collaborated with the Harris Center's Director of Mental Health Projects as well as the Harris Center's Controller on a review process for payments to OSAR program grantees following eligibility rules from Texas Department of Health and Human Services (HHSC). Internal audit established a working relationship with the HHSC staff and the local OSAR provider called The Council on Recovery. The OSAR program deals with treating patients with substance abuse. The FY2023 grant provided $254k in awards to two (2) providers,

including The Council on Recovery. The grant will end on August 31, 2023, according to HHSC's documentation and website information.

- ✓ Follow-Up: Outstanding HR Contracts Review – Last year, Internal Audit learned of Human Resources had issued repeated requests to obtain additional budget dollars to fund contracts related to recruitment. Internal Audit contacted the HR generalist responsible for the processing of these invoices, and we have found significant improvement in the process. The budgets for these recruitment contracts are well-funded and the onboarding process has been reorganized. We found that the process days for these contracts has dropped significantly starting in 4Q 2022, which we attribute to the Human Resources reorganization that began at the same time.
- ✓ Follow-Up: New Hire Drug and TB Testing Process Review – Last year, Internal Audit discovered that a newly hired employee reported that she had not undertaken a drug test on her first day at the Center. Additionally, we found that some employees were tested and those with a Positive score were not hired, and four were found to be Negative-Dilute; it was discussed with the Human Resources onboarding team. This year, we found the Center's onboarding team has a new supervisor who is more knowledgeable of the specific onboarding candidate quality verification, and she had made several process improvements to ensure that the process controls were sturdy and remained in place over several months in review.

VI. Audit Projects Completed by the Internal Audit Department in Fiscal Year 2023

Most audit project work begins with an assessment of risk followed by review of systems and identification of known weaknesses, such as inadequate separation of duties, or failure to follow established procedures. Testing of compliance by a sampling of transactions confirms that controls do perform during an operation. If necessary, a larger substantive sample is tested to evaluate the extent of any error or loss.

The Harris Center's departmental management teams are responsible for establishing and maintaining a system of internal controls to comply with Center-approved policies and procedures. The objectives of an internal control system are to provide management with reasonable, but not absolute, assurance that agency assets are safeguarded against loss from unauthorized use or theft, or that transactions are executed in accordance with management's authorization and recorded properly. Policy and procedure add

specific requirements to controls and elevate the awareness of possible weaknesses that they should be aware of.

Due to inherent limitations in any system of internal accounting controls, data errors or other irregularities may occur and may not be detected in a timely manner by management or by audit reviews. The projection of system evaluations in future periods is subject to the risk that the procedures may become inadequate because of changes in conditions, or because the degree of compliance with procedures may deteriorate over time.

The scope of work completed for Internal Audit's Fiscal Year 2023 Audit Plan did not claim to constitute an exhaustive evaluation of all the overall internal control structure of all business units within the Center. These examinations were designed to test management's compliance with approved policy and procedures. During the Fiscal Year 2023 performance timeframe, it was determined that departmental compliance with established or drafted criteria to govern activities are "adequate" overall.

Internal Audit tracked all findings and observations throughout the year in a follow-up matrix, which shows the noted specific weaknesses were discussed with management. Internal Audit also pursued a timeframe to address the weaknesses. By the end of the year, Internal Audit had obtained satisfactory management responses to the report findings or had a follow-up discussion about the corrective action plan details. The finalized issue resolution to the observed weaknesses was discussed with the Audit Committee members.

Table 1 below lists the Board-approved audits completed in Fiscal Year 2023 in the order of completion. Please note that projects began in report sequence but may have been delayed for adding more of the audit client's procedures or policies, or a system upgrade or other significant factor that can affect performance.

Table 1

Audit Title:	Report Sequence #	FY2023 Audit Number	Completed Audit Report Date
Fixed Assets/Inventory Control Audit	1	FAINV0123	01/19/2023
Employer Retirement Plan Contributions Audit	2	RETIRE0123	05/23/2023
Contracts with Service Agencies	3	SERVICES0123	05/23/2023
Charity Care Program (CCP)	4	CCP0123	10/17/2023
Accounts Receivable and Fee Collections Audit	5	ARFC0123	10/17/2023
Directed Payment Program (DPP)	6	DPP0123	10/17/2023
Pharmacy Operations/Inventory Audit	7	PHARM0123	10/17/2023

Source: Internal Audit Department, October 2023

The Board-approved audits were performed as they were sanctioned for the Fiscal Year 2023 Audit Plan. Internal Audit performed a risk assessment ranking process of the above business units (auditable entities) and determined the greatest operational and financial levels of risk at The Harris Center.

Table 2 lists five (5) Special Audit Requests that were requested by management and completed in Fiscal Year 2023 to assure compliance with their respective department's basic controls, and compliance with contract performance requirements.

Table 2

Audit Title:	Report Sequence #	FY2023 Audit Number	Completed Audit Report Date
Special Audit Request: Employee License Report	1	SAREMPLIC0123	1/17/2023
Special Audit Request: Employee Mileage Report	2	SAREMPMR0123	1/17/2023
Special Management Request: Agency Vehicle Auction Sales	3	SMRAVA0123	07/18/2023
Special Audit Request: Travel Reimbursements Audit	4	SARTRAV0123	10/17/2023
Special Management Request: Fleet Management Audit	5	SARFLEET0123	10/17/2023

Source: Internal Audit Department, October 2023

Table 3 lists two (2) Follow-Up audits that were undertaken to review previously issued audit reports that included findings.

Table 3

Audit Title:	Report Sequence #	FY2023 Audit Number	Completed Audit Report Date
Follow-Up: HR Outstanding Invoices Review (SAR in FY2022)	1	FUHRINV0123	05/23/2023
Follow-Up: New Hire Drug & TB Testing Audit (SAR in FY2022)	2	FUNEWHIRE0123	07/18/2023

Source: Internal Audit Department, October 2023

VII. Analysis of Findings and Observations

Internal Audit performs audits by examining business processes and procedures, compliance to policy and procedures, and observations of the workflows. In the event that we observe non-compliant outcomes, we identify the outcome as a "Finding," which may be enhanced with a Recommendation statement to add clarity about the nature of the non-compliance or avoid a missed beneficial outcome. The Recommendation clarifies the nature of a corrective action and may suggest how management may proceed to correct it.

An audit report finding needs to be resolved in a timely manner by seeking a response from the auditee or management. The Finding is normally addressed with a Management Response, to allow the auditee or management to indicate their specific actions to correct the issue. Internal Audit expects management to voice plans for the correction action but not assume it is addressed unless it verified by both Internal Audit and Management as a valid Finding. Internal Audit expects most audit report Findings to be resolved in a timely manner.

An audit report Observation is similar to a Finding, but it does not indicate that its discovery requires action to correct an incorrect process outcome. A Recommendation may be added to enhance the clarity of the Observation, but it is not required. While a Management Response may be listed on the written report, Internal Audit will not consider it necessary for the auditee or management to fulfill the correction or issue, but Internal Audit recommends that an auditee resolve the issue to its desired process, policy, or procedure.

Table 4 summarizes the findings and observations reported in projects completed during Fiscal Year 2023.

Table 4

	Number of Audit Recommendations
Findings/Observations	**36**
Total Observations by Internal Audit	**20**
Total Findings by Internal Audit	**16**
Total Findings Addressed by Management	**16**

Source: Internal Audit Department, August 2023

VIII. Standard Allocation of Effort by all Positions and Staff Productivity

Internal Audit recommendations provide insight into the effectiveness of the Center's performance to its business plan and business policy and procedures. Internal Audit provides reviews to deliver improvements in performance, fairness, objectivity, consistency, and management decision making.

There are also critical long-term benefits of a strong measurement review system which can simply justify the recommended requests, create enduring focus, and justify reallocation of funds or resources.
Most importantly, performance measures are a leading indicator of long-term compliance conditions and, consequently, represent a long-term planning asset when conducting internal reviews such as:

- Learn from best-practice measurement systems,
- Forecast the costs and benefits of measurement systems,
- Identify measures important to the head of the unit,
- Categorize types of measures, weigh tangible and intangible measures,
- Align measures throughout the organization that is audited,
- Link measures to strategic Center goals,
- Identify roadblocks to measure development,

- Gain employees' buy-in to the measurement system recommendations,
- Automate processes and procedures,
- Measure effectiveness of shared service and cross-functional processes,
- Monitor and manage using key measures and ensure the consistency and integrity of measures,
- Prepare for changes in strategy or operations,
- Translate measured results into further action,
- Compare output to outcome and determine the frequency of gathering data and reporting.

Internal Audit tries to accomplish the tasks through the use of a 'budgeted hours' approach, in other words, any activity undertaken is measured in hours and effort by position. For Fiscal Year 2023, Internal Audit delivered 54 total hours above budgeted (2,744 actual vs. 2,690 budgeted) accomplished through off-hours. Based upon the prior fiscal year when we were 85 net hours over budget, in FY 2023 we endeavored to work smarter and faster using such tools as data analytic audit programs which allows us to be as lean, nimble, and less intrusive as possible to our audit clients.

Table 5 shows standard allocation of effort by two Internal Audit positions for Fiscal Year 2023 audits.

Table 5

Standard Allocation of Effort by all Positions in Internal Audit for Fiscal Year 2023

	Priority Budgeted Hours	Actual Hours Utilized	Over <Under> Total Budgeted Hours
Regular Hours Available	4,160	4,214	54
PTO	(150)	200	50
Training	(80)	64	-16
Travel	(40)	20	-20
Administration	(150)	220	70
Approved Audits	(1,680)	1,500	(180)
Follow Up / Special Audit Requests	(430)	600	170
Participation with Outside Auditors	(40)	40	0
Consulting Activity Projects	(120)	100	(20)
Hours Required:	**(2,690)**	**2,744**	**54 ***

**** Accomplished through off-hours***

Net Hours Over <under> Budget ***54***

IX. Internal Audit Professional Development

The Department's leadership is committed to achieving an outstanding level of professional competency which is enumerated through professional certification, improved with continuing education, sustained by supporting local audit organizations and demonstrated through the Department's audit product.

Internal Audit staff has completed annual training requirements as Certified Professional Education units (CPE) and Certified Education Units (CEU) and maintained memberships and credentials. All the courses listed were on-line and the majority of the hours were completed after business hours.

David W. Fojtik, CPA - Annual Training	**Hours**
➢ Audit Conclusions and Reporting	18
➢ Auditing Developments	16
➢ Institute of Internal Auditors Annual Conference	8
➢ Ethics Training for Texas CPAs	4
	46

Kirk D. Hickey, CFE – Annual Training	**Hours**
➢ Institute of Internal Auditors Annual Conference	8
➢ Healthcare Fraud and Abuse Annual Review	1
➢ Confessions of a Fraudster	1
➢ Synthetic Account Fraud – What is it?	1
➢ Fraud prevention from an Individual	1
➢ Houston ACFE Data Analytics Review	1
➢ How to Navigate Current Cybersecurity Risks	1
➢ Overview of NIST 2.0 guidelines	2
➢ Elements of Successful Hotline/Forensic Accounting	1
➢ Ten Common Health Care Fraud Schemes	2
➢ The Roles of Forensic Social Work in Caring for …	1
	20

In addition, Internal Audit's personnel have completed the following courses:

- Bloodborne Pathogens
- Consumer Rights
- Cyber Security Basics
- Defensive Driving Skills
- Equality and Diversity
- Ethics and the Code of Conduct
- HIPAA Compliance in the Workplace
- Principles of Crisis Intervention
- The Importance of Safety
- Valuing Diversity in the Workplace

X. Internal Audit Staff Professional Certifications and Memberships

Professional Memberships*

David W. Fojtik

- Texas Society of Certified Public Accountants, Houston (TSCPA)
- Houston Chapter, The Institute of Internal Auditors (IIA)
- Association of Healthcare Internal Auditors (AHIA)
- Association of Certified Fraud Examiners (ACFE)

Kirk D. Hickey

- Association of Certified Fraud Examiners (ACFE)

Professional Certifications*

David W. Fojtik

- Certified Public Accountant – CPA
- Certified Internal Auditor – CIA
- Certified Fraud Examiner – CFE

Kirk D. Hickey

- Certified Fraud Examiner – CFE

**All national and local membership dues and certification fees are paid by the Internal Audit staff.*

The maintenance of each certification requires a minimum of 20 to 40 hours of formal continuing education hours each year, which is obtained by attending conferences, viewing webinars, and other self-study events.

Membership in these organizations provide excellent opportunities in learning new auditing and fraud detection techniques and afford valuable networking opportunities with other healthcare professionals.

The Internal Audit staff are also expected to continuously stay abreast of professional publications on a variety of risk and healthcare topics.

XI. Appendix 1 – FY 2023 Issue Tracking Matrix

Audit Report Topic	*Findings or Observations // Management Response*
1. Fixed Assets and Inventory Control Audit FAINVC0123 Report Date: 01-17-23 **COMPLETED**	**Finding #1 –** Internal Audit generated the Fixed Assets for Managers report, and we found 42 items in with fixed assets associated with 10 employees who have terminated recently from The Harris Center. The Employee Name is used to provide a custodial contact for the listed Asset Number as a control, therefore, Fixed Asset Designees (FAD-A through FAD-J) should update their records according to policy and procedures MF7A Asset Tracking and Depreciation, revised August 23, 2022. **Management Response #1 – (Senior Director – Strategic Finance):** Fixed Asset Examiner sent the departmental Fixed Asset Designees (FADS) an email, sharing the Internal Audit Findings with proposed corrective action timelines for FADs. The Fixed Asset Examiner proposes to send the FADs the monthly Termed Employee List with a reminder/instruction to submit paperwork to update the Employee information and give them a deadline. **Finding #2 –** Internal Audit generated the Fixed Assets with Cost for TCRMF online report, and we found that 13 fixed asset records lacked both a logical Location Code and/or completed Address field (blank). This finding includes all seven (7) fixed asset units found in prior report pulled May 9, 2022, plus three (3) new ThinkCentre M90Q units on a new report dated November 14, 2022. **Management Response #2 – (Senior Director – Strategic Finance):** The report pulls the data from the "Current Agency Owned" assets and thus the missing addresses are for locations that are not Agency Owned Facilities. The Fixed Asset Examiner has reached out to IT to discuss the possibility of integrating the Non-Agency Owned Facilities into the PowerBI report.
2. Special Audit Request: Employee Licenses Report SAREMPLIC0123 Report Date: 01-17-23 **COMPLETED**	**Finding #1 –** Internal Audit found four (4) employees in November 2022 had licenses that expired within 60 days of the review. Considering The Harris Center's staff size, and count of licenses nearing 1,000 in total, it does illustrate the failure to capture license renewals on an automatic or even passive basis as there is significant and potential liability in failing to update licenses. Many of the renewals require time and resources to follow-up with the license holders to produce the documentation, which usually are stored as email attachments from the regulatory agencies. **Management Response #1 (Vice President - Human Resources):** Management agrees with Finding #1 and will expediate resolution of the issues. ***Update:*** *Internal Audit discussed this process and learned that the email notification process has recently changed in format and appearance, but continues to be issued 90, 60 and 30 days prior to renewal date. Human Resources reported that the number of license follow-up requests for renewal completion from their staff has dropped sharply to a much smaller number in recent weeks.* **Finding #2 –** Internal Audit found twelve (12) employees in the monthly license report in which the listed license number could not be matched perfectly with information stored at the regulatory agency's license verification database. Some of the same issues were identified in Internal Audit's audit reports in the past. We observed that the annual renewal process does not automatically correct the mismatches nor does it create a work queue to resolve the problem. **Management Response #2 (Vice President - Human Resources):** Management agrees with Finding #2 and will expediate resolution of the issues.

3. Employer Retirement Plan Contribution Review
RETPLAN0123
Report Date: ~~04-18-23~~
Report Date: 05-23-23

COMPLETED

Finding #1 – Internal Audit confirmed the employer contributions for two retirement accounts for one employee matched exactly on the employee's Lincoln Financial retirement report dated 12/31/22, and the contributions shown on the employee's pay stubs, dated December 2, and December 16, 2022.
The 12C pay stub with a December 30, 2022 check date shows the employee's deduction for 403b plan, and a company paid contribution in the 403b/401a Plan account. The contributions were included in the Lincoln Financial's January 2023 retirement plan statement, after contribution payments were received. The contribution payments were applied to the employee's account on a trade date of January 11, 2023.

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

4. Directed Payment Program (DPP) Audit
DPP0123
Report Date: ~~04-18-23~~
Report Date: ~~07-18-23~~
Report Date: 10-17-23

COMPLETED

Observation #1 – Internal Audit found the Directed Payment Program (DPP) contributed $9,814,077.34 through August 31, 2023.
Management Response not required.

5. Charity Care Program (CCP) Audit
CPP0123
Report Date: ~~04-18-23~~
Report Date: ~~07-18-23~~
Report Date: 10-17-23

COMPLETED

Observation #1 – Internal Audit found that since September 1, 2022, the Charity Care Program (CCP) has contributed a total of $45,148,865.38 through August 31, 2023, according to the online Trending Report.
Management Response not required.

6. Contracts with Service Agencies Audit
SERVICES0123
Report Date: ~~04-18-23~~
Report Date: 05-23-23

COMPLETED

Observation #1 – Internal Audit reviewed the Ultra Medical Cleaning account and we found a January 25, 2023 electronic funds transfer (EFT) paid for invoices, dated July 1, 2022 and July 19, 2022, which would normally be processed in the FY2022 budget period; the invoiced charges totaled $64,105.65. The Contract Term for CT142639 is listed as November 1, 2022 thru August 31, 2024.

Exhibit I - Vendor invoices presented for initial payment during FY2023 fiscal year period

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

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

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

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

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

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

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

Vendor Payee	Vendor Inv.	Inv. #	Inv. Date	Paymt Date	Payment	Proces Days	Inv. Amt
AlliedUniversal	13494434	715558	5/05/2022	11/16/22	CHECK511590	195	$16,114.15
AlliedUniversal	13494442	715559	8/18/2022	11/16/22	CHECK511590	90	$16,012.78

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

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

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

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

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

Unit	Account	Unit Description	August	Septembe r	October	Novembe r	Dece mber
			2022	2023	2023	2023	2023
1827	576002	1827 7011 SOUTHWEST FREEWAY	$33,765.90	$32,233.44	$12.17	$28,409.61	$0.00

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

Management Response #3 (Director of Facility Services): This would be a function of the finance department which Facilities has no control or insight into we submit utility bills for payment, account payables do the rest.

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

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

Management Response #4 (Controller): Agree.

7. Follow-up: Outstanding HR Invoices Review FUHRINV0123
Report Date: ~~04-18-23~~
Report Date: 05-23-23

COMPLETED

Finding #1 – Internal Audit reviewed the CT142318 P-Recruitmen pool contract invoices and noted that the large number of invoices created in July and August 2022 were processed after 90 or more days. The P-Recruitmen pool contract includes four (4) payees, including Elite Personnel and Burnett Specialty, whose invoices in July and August 2022, reflecting labor requirements in FY2022. The P-Recruitmen contract was approved for $324k, effective Sept. 1, 2022 thru August 31, 2023.

The current contract shows invoices created in July and August 2022 totaled $55,589.07 (about 17.1%) and paid of the $324k NTE amount. The P-Recruitmen contract shows $36k remaining. For invoices created in September and October, the majority of invoices were finalized within 60 days, and in November and December, the majority of these invoices were finalized within 45 days. There is a marked reduction in A/P process days beginning in the early November, 2022 time period.

Management Response #1 (VP-Human Resources): Ninfa Escobar has responsibility for the invoicing process related to our Talent Acquisition vendors. Good improvement has been made. We are assigning this work to our new OC Coordinator. Once completed, we expect that all invoices will be handled within 30 days.
Management Response #1 (Chief Administrative Officer): The HR Department has restructured accountability of the vendor payment process within the leadership team. We have observed a marked improvement in invoice processing since these changes within the department.
We will continue to monitor the performance of these processes to ensure sustainability of these improvements.

8. Follow-up: New Hire Drug and TB Testing FUNEWHIRE0123
Report Date: ~~04-18-23~~
Report Date: 07-18-23

COMPLETED

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 & Organizational Development): "Thank you for your patience – in meeting with my team, below are the dispositions. It appears we did in fact have one employee that we cannot locate drug screen for (#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 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.

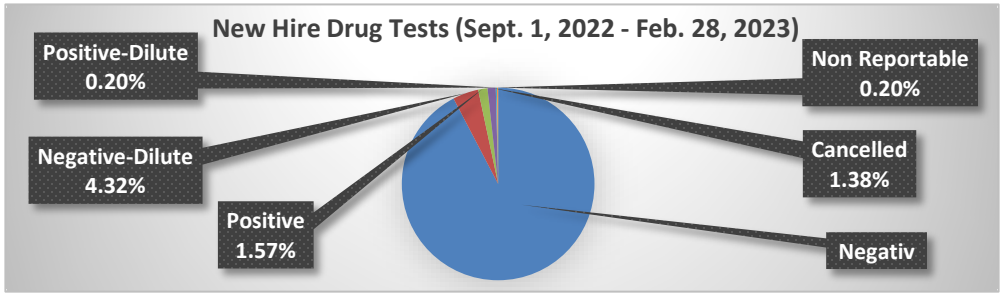


Exhibit I – Breakdown of new hire drug test results, by report result, September 1, 2022 to February 28, 2023

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)" fr. NovaHealth/DISA report, April 4, 2023

9. Special Audit Request: Agency Vehicle Auction Sales Process Review **SMRAVA0123** **Report Date: 07-18-23** **COMPLETED**	**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 those found on the Carfax.com website's trade-in calculators in June of 2023. **Management Response not required.** **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. The Auction Price as Reported in 2022 column totaled $9,820, Internal Audit's research on Carfax.com showed total vehicle trade-in values in 2023 as $17,680, and thus the sales results were $7,860 lower than the expected values found on the Carfax.com website's trade-in June of 2023. **Management Response not required.** **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. **Management Response not required.**
10. Travel Reimbursement Audit **TRAVREIM0123** **Report Date: ~~04-18-23~~** **Report Date: ~~07-18-23~~** **Report Date: 10-17-23** **COMPLETED**	**Observation #1 –** Internal Audit reviewed an ad-hoc travel report for January 2023, and we found that 8.04% of the paid travel reimbursements for the 1st trip of the day were from the employee's reported home address, going back to the employee's home address for lunch, and returning to the employee's home at the end of the day. We compared reported miles in other months: the ratio was 6.24% in October 2022, and 8.63% in April, 2023. Internal Audit examined Travel Policy FM18A (effective 11/2022) which states: "mileage will be calculated based on distance from main place of employment to travel destination or client site." NOTE - If the employee's home address is identified as their main place of employment, the mileage incurred and reimbursed for the 1st trip of the day to a consumer or other travel destination is correctly calculated. The current online travel reporting system does not track commute miles which are not reimbursable per IRS regulations, however the policy calls for making such calculations. Internal Audit also evaluated Section G in the FM18B Travel Reimbursements Policy (effective 05/2022) which described a methodology for calculating mileage from the employee's home to the 1st destination as "mileage to the 1st destination minus the mileage from home to their assigned HQ" as per IRS guidelines. Internal Audit observed that the bulk of the reimbursed miles (90%+) <u>are</u> compliant with the current travel policies and procedures. Internal Audit recommends 1) that management revise the travel policies to use similar language in both policies and 2) provide additional training to assist employees in correctly reporting their monthly travel mileage.

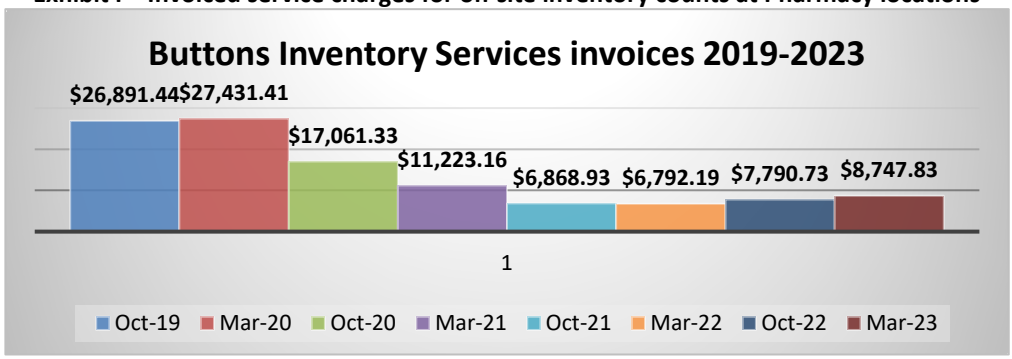
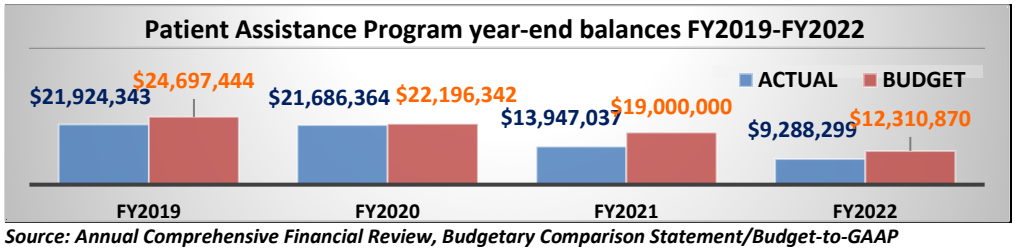
11. Pharmacy Operations and Inventory Audit PHARM0123 Report Date: 10-17-23 **COMPLETED**	**Observation #1 –** Internal Audit found that all Pharmacy policies and procedures have been updated and easily accessible by employees using the PolicyStat folders on The Harris Center's intranet site. **Management Response not required.** **Observation #2 –** Internal Audit noted the invoiced amounts from the Buttons Inventory Service have decreased sharply since the March 2020 invoice. The counts are performed in October and March, as was requested by the Board several years ago. Per Angie Babin, the Senior Director of the Pharmacy Program, "the service charges of the Buttons Inventory Service audits are based on the value of the inventory being counted, so as the inventory values have dropped, so do the inventory audit service charges". **Exhibit I – Invoiced service charges for on-site inventory counts at Pharmacy locations**  ***Source: Ross Financial System, account = "Buttons Inventory Service", FY2019 thru FY2023.*** **Management Response not required.** **Observation #3 –** Internal Audit noted the Patient Assistance Program FY2022 year-end Actuals per the 2021 and 2022 Annual Comprehensive Financial Reports (ACFRs) have decreased from $13.9 million to $9.3 million, representing a decrease of -$4.7 million, or about -33.4%. Per Angie Babin, the Senior Director of the Pharmacy Program, "the value of the PAP program continues to fall as medications evolve all the time and overall medication valuations have been falling." **Exhibit II – Patient Assistance Program (PAP) Actual and Budget balances, FY2019-FY2022**  ***Source: Annual Comprehensive Financial Review, Budgetary Comparison Statement/Budget-to-GAAP Reconciliation-General Fund, page 30, For the Year Ended August 31, 2022 and August 31, 2021.*** **Management Response not required.** **Observation #4 –** Internal Audit noted the Patient Assistance Program (PAP) inventory items are the largest category of items compared with bought stock, Dispensary of Hope (DoH), and non-formularies. These values are based on the hand-count of items performed at pharmacy locations on March 1, 2023. We noted that PAP item valuations generally represented 85% to 90% of the total inventory value in most of the locations, except for the Neuro Psychiatric Center (NPC), based on its own business model. Per Angie Babin, the Senior Director of the Pharmacy Program, "since patients enroll in the PAP program based on income eligibility, the process is time-consuming and not suited for delivering treatment for the NPC patients, who typically arrive there in severe crisis."

Exhibit III – Physical counts in Buttons Inventory Service March 1, 2023 inventory report

Buttons Inventory valuation by 4 drug categories

	SE Clinic	NE Clinic	NPC Location	NW Clinic	SW Clinic
Bought	$97,981.66	$91,858.83	$72,028.06	$113,155.23	$103,506.93
PAP	$1,996,462.45	$853,587.21	$65,998.61	$1,173,875.68	$1,002,472.29
DoH Stock	$117,258.46	$36,324.90	$0.00	$56,269.78	$50,460.99
Non-Formulary	$115.91	$56.13	$41.24	$429.72	$0.00

Source: Buttons Inventory Service, bi-annual physical inventory report, valued in March 1, 2023 inventory counts.

Management Response not required.

12. Status Report: COVID-19 OSAR Reimbursement Program Grant Audit SRORPG0123 Report Date: 10-17-23

COMPLETED

Observation #1 – Internal Audit collaborated with the Harris Center's Director of Mental Health Projects and Harris Center's Controller on a review process for reviewing reimbursement payments to local OSAR providers. We used COVID-19 program grant eligibility rules from Texas Department of Health and Human Services (HHSC) program documentation and established a working relationship with the HHSC staff and the local OSAR provider called The Council on Recovery. Providers were required to show sales receipts of eligible purchases, and in several instances the review team disallowed reimbursement claims for Amazon shipping or other overnight fees.

In FY2022 and FY2023, the COVID-19 OSAR Reimbursement Program Grant paid out $574,950.40 to OSAR providers in HHSC Region 6 who incurred increased incremental costs in the COVID-19 pandemic period. The grant ended on August 31, 2023.

Exhibit I – Summary OSAR reimbursements to HHSC Region 6 providers, FY2022-FY2023

Claim#	Provider Name (FY2022 Program)	Rec'd Date	Payment Date	Amount
2022-01	Cenikor Foundation	2/1/2022	3/2/2022	**$370.19**
2022-02	The Montrose Center	2/2/2022	3/2/2022	**$649.00**
2022-03	Career and Recovery Resources, Inc.	2/3/2022	3/2/2022	**$2,889.70**
2022-04	Santa Maria Hostel	2/25/2022	3/23/2022	**$65,733.88**
2022-05	The Council on Recovery	5/23/2022	6/8/2022	**$19,872.61**
2022-06	The Center for Success Independence	5/23/2022	6/8/2022	**$9,748.22**
2022-07	The Council on Recovery	6/23/2022	7/6/2022	**$9,775.82**
2022-08	The Council on Recovery	6/23/2022	7/6/2022	**$3,711.90**
2022-09	The Council on Recovery	6/23/2022	7/6/2022	**$161.45**
2022-10	The Council on Recovery	6/23/2022	7/6/2022	**$29,069.32**
2022-11	The Women's Home	6/30/2022	7/13/2022	**$3,933.84**
2022-12	The Council on Recovery	8/10/2022	9/7/2022	**$4,565.91**
2022-13	The Council on Recovery	8/12/2022	9/7/2022	**$68,400.00**
	FY2022 Covid-19 Grant Program:		**TOTAL:**	**$218,881.84**
Claim#	**Provider Name (FY2023 Program)**	**Rec'd Date**	**Payment Date**	**Amount**
2023-01	Santa Maria Hostel	9/8/2022	9/14/2022	**$65,859.00**
2023-02	Santa Maria Hostel	9/22/2022	10/5/2022	**$31,404.46**
2023-03	Santa Maria Hostel	11/4/2022	11/16/2022	**$15,692.38**
2023-04	Santa Maria Hostel	12/15/2022	1/4/2023	**$13,129.04**
2023-05	Santa Maria Hostel	1/16/2023	2/1/2023	**$9,365.11**
2023-06	Santa Maria Hostel	2/13/2023	3/6/2023	**$8,538.62**
2023-07	The Council on Recovery	3/24/2023	4/5/2023	**$7,634.70**
2023-08	Santa Maria Hostel	4/6/2023	4/15/2023	**$9,606.38**
2023-09	Santa Maria Hostel	5/18/2023	6/9/2023	**$12,635.26**
2023-10	The Council on Recovery	5/22/2023	6/9/2023	**$71,250.00**
2023-11	Santa Maria Hostel	3/13/2023	6/7/2023	**$9,292.27**
2023-12	Santa Maria Hostel	6/13/2023	6/22/2023	**$7,893.43**
2023-13	Santa Maria Hostel	7/19/2023	7/26/2023	**$7,979.71**
2023-14	Cenikor Foundation	8/2/2023	8/8/2023	**$245.82**
2023-15	Santa Maria Hostel	8/7/2023	8/10/2023	**$6,783.15**
2023-16	Santa Maria Hostel	8/29/2023	9/6/2023	**$36,856.03**
2023-17	Santa Maria Hostel	8/29/2023	9/6/2023	**$29,962.05**
2023-18	Santa Maria Hostel	8/31/2023	9/6/2023	**$11,941.65**
	FY2023 Covid-19 Grant Program:		**TOTAL:**	**$356,068.56**
	TOTAL FY2022 and FY2023 Payments:			**$574,950.40**

Source: Internal Audit records, OSAR Program Administration (Internal Audit), Sept. 1, 2021 - August 31, 2023

13. Special Audit Request: Fleet Management Audit SMRFM0123 Report Date: 10-17-23

COMPLETED

Observation #1 – In FY2022, the combined costs of operating agency-owned vehicles were $325,165.80. The Enterprise Fleet Management invoices totaled $422,628.45 through August 31, 2022. Therefore, the combined costs of agency-owned vehicles and leased vehicles totaled $747,794.25.

Observation #2 – In FY2023, the combined costs of agency-owned vehicles totaled $567,578.47, and included vehicle purchases of $250,589.00. The Enterprise Fleet Management invoices totaled $564,430.57. The combined costs of agency-owned and leased vehicles totaled $1,132,009.04.

Included in FY 2023 is the purchase of a Primary Care Van for $250,589.00.

	FY2022	ACTUAL	ACTUAL	
		GL ACCOUNT	YTD	
Vehicle (Purch,Rent,Maint)	559000	VEHICLE REPAIR/MAINT.	$159,462.13	
	559001	GASOLINE PURCHASES	$156,174.80	
	559002	VEHICLE REPAIRS (ROUTINE)	$9,528.87	
	559091	TRANSPORTATION USE FEE		
	560000	VEHICLE PURCHASE		
	561000	VEHICLE RENT		
	FY2022	Total Vehicle (Purch,Rent,Maint)	$325,165.80	B
			C	TOTAL:

ACTUAL	FY2023	ACTUAL	ACTUAL	
		GL ACCOUNT	YTD	
Vehicle (Purch,Rent,Maint)	559000	VEHICLE REPAIR/MAINT.	$167,719.61	
	559001	GASOLINE PURCHASES	$138,755.70	
	559002	VEHICLE REPAIRS (ROUTINE)	$10,514.16	
	560000	VEHICLE PURCHASE	$250,589.00	
	561000	VEHICLE RENT		
	FY2023	Total Vehicle (Purch,Rent,Maint)	$567,578.47	A
			D	TOTAL:

Compiled October 4, 2023
K. Hickey, Staff Internal Auditor, D. Fojtik, Director, Internal Audit

XII. Appendix 2 – FY 2024 Audit Plan

Approval is requested for the listed project areas to be audited in Fiscal Year 2024. At any time, however, a special request/project may warrant adjustments in the schedule. The list below does not represent any order because the sequence of the audits depends primarily upon availability of the Center's schedules for internal or external staff contacts.

1) **Check/EFT/ACH Signature Levels Review** – (120 Hours Scheduled)
2) **Bank/Treasury/Investment Controls –** (120 Hours Scheduled)
3) **New Vendor Setups and Changes in Chase App** – (40 Hours Scheduled)
4) **Third-Party Billings and Refunds Audit –** (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.)	*630 Hours*

There are 1,440 audit hours scheduled for Fiscal Year 2024, with an emphasis on DSRIP revenue replacement streams, financial operations, and special audit reviews. As strategic objectives and risk of new business entities increase, Internal Audit will continue to provide continued value by co-sourcing arrangements with external audit and other experts who can enable Internal Audit to assess threats, prepare and execute audit plans, and acquire skills through knowledge transfer.

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 seven (7) audits identified by our risk assessment and with solicited input from the Board and Senior Management. These proposed projects are subject to the Board of Trustees' review and approval. In addition, we expect at least three (3) Special Audit Requests to be called during the year, and we will assist the external auditors as they review the agency's variety of business operations when preparing The Harris Center's *Annual Comprehensive Financial Report (ACFR)*.