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

Governance Committee Meeting
January 23, 2024
8:30 am

I. **DECLARATION OF QUORUM**

II. **PUBLIC COMMENTS**

III. **APPROVAL OF MINUTES**

A. Approve Minutes of the Board of Trustees Meeting Held on Tuesday, November 14, 2023
(EXHIBIT G-1)

IV. **REVIEW AND TAKE ACTION**

A. POLICY UPDATES/SUBSTANTIAL CHANGES

1. The Harris Center System Quality, Safety, and Experience Performance Improvement Plan FY2024
(EXHIBIT G-2)

B. NO/MINOR CHANGES

1. All Contracts
(EXHIBIT G-3)
2. Corporate Compliance Documentation and Claims Integrity Plan
(EXHIBIT G-4)
3. Financial Assessment
(EXHIBIT G-5)
4. Licensure Certification and Registration
(EXHIBIT G-6)
5. Mailing Services
(EXHIBIT G-7)
6. Medical Peer Review Policy
(EXHIBIT G-8)
7. Pharmaceutical Representatives Policy
(EXHIBIT G-9)
8. Pharmacy and Unit Medication/Drug Inventory
(EXHIBIT G-10)
9. Plan of Care
(EXHIBIT G-11)
10. Reporting Automobile Accidents
(EXHIBIT G-12)
11. Supervision of Peer Specialists
(EXHIBIT G-13)

V. **EXECUTIVE SESSION**

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

- **In accordance with §551.074 of the Texas Government Code, Discussion of Personnel Matters related to the Nomination of Individual Board members as Board Officers and Committee appointments. Mr. James Lykes, Chair of Governance Committee and Dr. R. Gearing, Chair of the Harris Center Board of Trustees**

VI. **RECONVENE INTO OPEN SESSION**

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

VIII. **ADJOURN**

Veronica Franco, Board Liaison
Jim Lykes, Chair, Governance Committee
The Harris Center for Mental Health and IDD

EXHIBIT G-1

BOARD OF TRUSTEES
THE HARRIS CENTER *for*
MENTAL HEALTH AND IDD
GOVERNANCE COMMITTEE MEETING
TUESDAY, NOVEMBER 14, 2023
MINUTES

CALL TO ORDER
Mr. Jim Lykes, Chairman called the meeting to order at 9:01 a.m. in Conference Room 109, 9401 Southwest Freeway, noting a quorum of the Committee was present.

RECORD OF ATTENDANCE

Committee Members in Attendance: Mr. J. Lykes, Mr. S. Zakaria, Dr. G. Santos, Mr. G. Womack, Mrs. N. Hurtado

Committee Member Absent: None

Other Board Member Present: Dr. R. Gearing, Dr. L. Moore, Mrs. B. Hellums, Dr. M. Miller, Jr

1. DESIGNATION OF BOARD MEMBERS AS VOTING COMMITTEE MEMBERS
Mr. Jim Lykes designated Dr. R. Gearing, Dr. L. Moore, Mrs. B. Hellums and Dr. Miller, Jr. as voting members of the committee.

2. DECLARATION OF QUORUM
The meeting was called to order at 9:01 a.m.

3. PUBLIC COMMENTS
There were no Public Comments.

4. APPROVAL OF MINUTES
Minutes of the Board of Trustees Governance Committee meeting held on Tuesday, October 24, 2023

MOTION: HELLUMS SECOND: MOORE
The Motion passed with unanimous affirmative votes

BE IT RESOLVED, Minutes of the Board of Trustees Governance Committee meeting held on Tuesday, October 24, 2023 EXHIBIT G-1 has been approved and recommended to the Full Board.

5. REVIEW AND TAKE ACTION

A. COMPLIANCE PLAN FY2024

MOTION: MOORE SECOND: HELLUMS
The Motion passed with unanimous affirmative votes

BE IT RESOLVED, Compliance Plan FY2024, EXHIBIT G-2 has been approved and recommended to the Full Board.

6. **EXECUTIVE SESSION –**Mr. Lykes announced the Board would convene into Executive Session at 9:04 a.m.

· **As authorized by § 551.074 of the Texas Government Code, performance evaluation of CEO. Mr. James Lykes, Chair of Governance Committee; S. Zakaria, Chair of the Harris Center Board of Trustees**

· **In accordance with §551.074 of the Texas Government Code, Discussion of Personnel Matters related to the Nomination of Individual Board members as Board Officers and the 2024 Slate of Officers. Mr. James Lykes, Chair of Governance Committee; S. Zakaria, Chair of the Harris Center Board of Trustees**

7. RECONVENED INTO OPEN SESSION AT 9:39AM

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

9. **ADJOURN**
MOTION: HURTADO SECOND: HELLUMS
The meeting was adjourned at 9:39 A.M.

Respectfully submitted,

Veronica Franco, Board Liaison
Jim Lykes, Chairman
Governance Committee
THE HARRIS CENTER for Mental Health and IDD
Board of Trustees

EXHIBIT G-2

Status **Pending** PolicyStat ID **14358146**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	1 year after approval

Owner	Luc Josaphat: Director of Quality Assurance
Area	General Administration
Document Type	Agency Plan

The Harris Center System Quality, Safety and Experience Performance Improvement Plan FY 2024

~~The Harris Center~~

The Harris Center System Quality, Safety and Experience Performance Improvement Plan

FY 2024

Introduction

~~The Quality, Safety, and Experience Plan (previously named The Harris Center's Annual PI Plan) is established in accordance with The Harris Center's mission to transform the lives of people with behavioral health and IDD needs. The center's vision is to empower people with behavioral health and IDD needs to improve their lives through an accessible, integrated, and comprehensive recovery-oriented system of care. Our values as a center include collaboration, compassion, excellence, integrity, leadership, quality, responsiveness, and safety. The Quality, Safety and Experience Plan has been established to embrace the principles of transparency of measures and outcomes, accurate measurement and data reporting, and personal and collective accountability for excellent outcomes.~~

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Vision

Our vision is to create a learning health system focused on a culture of continuous quality improvement and safety at The Harris Center to help people live their healthiest lives possible, and to become a national leader in quality and safety in the behavioral healthcare space as it influences dissemination of evidence-based practices.

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Mission

~~We aim to improve quality, efficiency, and access to care and associated behavioral health and IDD services by delivering education, providing technical support, generating, and disseminating evidence, and conducting evaluation of outcomes in support of operational and service excellence and process management across The Harris Center and with external partners.~~

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FY 2024 Goals

1. ~~Build a learning health system that focuses on continuous quality improvement, patient safety, improving processes and outcomes.~~
   ~~o Partner with Organizational Development to enhance educational offerings focused on quality and safety education with all new employee orientation (High Reliability, Just Culture, Advanced Quality Improvement methodology, etc.)~~
   ~~o Hardwire a process for continuous readiness activities that complies with all legislative regulations and accrediting agencies standards (e.g., CARF, CCBHC).~~
2. ~~Use transparent, simplified meaningful measures to champion the delivery of high-quality evidence-based care and service to our patients and their families and assure that it is safe, effective, timely, efficient, equitable, and patient centered care~~
   ~~o Define and implement a data management governance strategy to support a transparent environment to provide accessible, accurate, and credible data about the quality and equity of care delivered.~~

~~3. Develop, integrate, and align quality initiatives and cross-functional approaches throughout~~

~~The Harris Center organization, including all entities.~~

~~o Enhance current committee structure to cover broad quality and safety work through~~

1. Build a learning health system that focuses on continuous quality improvement, patient safety, improving processes and outcomes. Partner with Organizational Development to enhance educational offerings focused on quality and safety education with all new employee orientation (High Reliability, Just Culture, Advanced Quality Improvement methodology, etc.). Hardwire a process for continuous readiness activities that complies with all legislative regulations and accrediting agencies standards (e.g., CARF, CCBHC).

2. Use transparent, simplified meaningful measures to champion the delivery of high-quality evidence-based care and service to our patients and their families and assure that it is safe, effective, timely, efficient, equitable, and patient centered care. Define and implement a data management governance strategy to support a transparent environment to provide accessible, accurate, and credible data about the quality and equity of care delivered.

3. Develop, integrate, and align quality initiatives and cross-functional approaches throughout

The Harris Center organization, including all entities. Enhance current committee structure to cover broad quality and safety work through the System Quality, Safety and Experience Committee (formerly the Patient Safety Committee). Develop a decentralized Quality Forum that reaches frontline performance improvement (PI) and Health Analytics/Data staff to provide education and tools to lead PI initiatives at their local sites. Develop and strengthen internal learning collaborative process to align with the Harris Center strategic plan for care pathways. IDD Care Pathway.

3-Year Long Term Goals (FY 2027)

- Zero preventable serious safety events
- Top quartiles for staff and provider engagement
- Top quartiles for patient satisfaction
- Increased access (numbers served)
- Improved outcomes
- Equitable care delivery
- Exemplar in Quality and Safety for Behavioral Health with national recognition
  Governance Structure

Governing Body

The Harris Center for Mental Health and IDD Board of Trustees is responsible for ensuring a planned, system-wide approach to designing quality goals and measures; collecting, aggregating, analyzing data; and improving quality and safety. The Board of Trustees shall have the final authority and responsibility to allocate adequate resources for assessing and improving the organization's clinical performance. The Board shall receive, consider, and act upon recommendations emanating from the quality improvement activities described in this Plan. The Board has established a standing committee, Quality Committee of

the Board of Trustees, to assess and promote patient safety and quality healthcare. The Committee provides oversight of all areas of clinical risk and clinical improvement to patients, employees, and medical staff.

Leadership

The Harris Center leadership is delegated the authority, via the Board of Trustees, and accountability for executing and managing the organization's quality improvement initiatives. Quality leadership provides the framework for planning, directing, coordinating, and delivering the improvement of healthcare services that are responsive to both community and patient needs that improve healthcare outcomes. The Harris Center leaders encourage involvement and participation from staff at all levels within all entities in quality initiatives and provide the stimulus, vision, and resources necessary to execute quality initiatives.

The Executive Session of the Quality Committee of the Board is the forum for presenting closed record case reviews, pharmacy dashboard report including medication errors, and the Professional Review Committee report.

Professional Review Committee (PRC)

The Chief Medical Officer (CMO) is delegated the oversight, via the Board of Trustees, to evaluate the quality of medical care and is accountable to the Board of Trustees for the ongoing evaluation and improvement of the quality of patient care at The Harris Center and of the professional practice of licensed providers. The PRC will act as the authorizing committee for professional peer review and system quality committees (Exhibit A). The committee will also ensure that licensing boards of professional health care staff are properly notified of any reportable conduct or finding when indicated. The Professional Review Committee has oversight of the following peer protected processes and committees:

- Medical Peer Review
- Pharmacy Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board
- System Quality, Safety and Experience Committee Membership:
    - Chief Executive Officer (Ex-Officio)
    - Chief Medical Officer (Chair)
    - Chief Operating Officer
    - Chief Nursing Officer
    - Chief Administrative Officer
    - Legal Counsel

- Divisional VPs and (CPEP, MH)
- VP, Clinical Transformation and Quality
- Director Risk Management/ERM
- Director of Pharmacy Programs

~~the~~ System Quality, Safety and Experience Committee ~~(formerly the Patient Safety Committee)~~

~~o Develop a decentralized Quality Forum that reaches frontline performance improvement (PI) and Health Analytics/Data staff to provide education and tools to lead PI initiatives at their local sites.~~

~~o Develop and strengthen internal learning collaborative process to align with the Harris Center strategic plan for care pathways.~~

~~▪ IDD Care Pathway~~

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Oversight:

- Medical Peer Review
- Pharmacy Peer Review
- Nursing Peer Review
- Licensed Professional Review
- Closed Record Review
- Internal Review Board
- System Quality, Safety and Experience Committee

Membership:

- Chief Executive Officer (Ex-Officio)
- Chief Medical Officer (Chair)
- Chief Operating Officer
- Chief Nursing Officer
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- Legal Counsel
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System Quality, Safety and Experience Committee
The Quality Committee of the Board of Trustees has established a standing committee, The System Quality, Safety and Experience Committee (previously the Patient Safety Committee) to evaluate, prioritize, provide general oversight and alignment, and remove any significant

barriers
for implementation for quality, safety, and experience initiatives across Harris Center programs.
The Committee is composed of Harris Center leadership, including operational and medical staff.
The Committee will approve annual system-wide quality and safety goals and review progress. The patient safety dashboard and all serious patient safety events are reviewed. Root Cause Analysis, Apparent Cause Analysis, Failure Modes and Effects Analysis, quality education projects, are formal processes used by the Committee to evaluate the quality and safety of mental
projects through The Harris Center's quality training program or other performance improvement
training programs are privileged and confidential as part of the Quality, Safety & Experience Committee efforts. The Committee also seeks to ensure that all The Harris Center entities achieve
standards set forth by the Commission on Accreditation and Rehabilitation Facilities (CARF) and
Certified Community Behavioral Health Clinic (CCBHC).
The System Quality, Safety and Experience Committee has oversight of the following committees
and/or processes: (Appendix A)
Oversight:

- Pharmacy and Therapeutics Committee
- Infection Prevention
- System Accreditation
- All PI Councils and internal learning collaboratives (e.g., Zero Suicide, Substance Use Disorders)
- Approval of Care Pathways
- Patient Experience / Satisfaction

Membership:

- Chief Executive Officer (Ex-Officio)
- VP, Clinical Transformation and Quality (Co-Chair)
- Chief Nursing Officer (Co-Chair)
- Chief Medical Officer
- Chief Operating Officer
- Legal Counsel
- Division Medical VPs and Medical Directors
- Chief Administrative Officer
- Director Risk Management / Audit
- Director of Compliance
- Chief Financial Officer
- Director Health Analytics

- ~~Director, Clinical Transformation, and Innovation~~
- ~~Director of Quality Assurance~~
- ~~Director of Pharmacy Programs~~
- ~~Director of Integrated Care~~
- ~~Nursing Directors~~
- ~~Infection Control Director~~
  ~~The criteria listed below provide a framework for the identification of improvements that affect health outcomes, patient safety, and quality of care, which move the organization to our mission~~
  ~~of providing the finest possible patient care. The criteria drive strategic planning and the establishment of short and long-term goals for quality initiatives and are utilized to prioritize quality improvement and safety initiatives.~~
- ~~High-risk, high-volume, or problem-prone practices, processes, or procedures~~
- ~~Identified risk to patient safety and medical/healthcare errors~~
- ~~Identified in The Harris Center Strategic Plan~~
- ~~Identified as Evidenced Based or "Best Practice"~~
- ~~Required by regulatory agency or contract requirements~~
  ~~Methodologies~~
- ~~The Model for Improvement (Appendix B) and other quality frameworks (e.g., Lean, Six Sigma) are used to guide quality improvement efforts and projects~~
- ~~A Root Cause Analysis (RCA) is conducted in response to serious or sentinel events~~
- ~~Failure Mode and Effects Analysis (FMEA) is a proactive tool performed for analysis of a~~

~~high-risk process/procedure performed on an as needed basis (at least annually)~~

~~Data Management Approach and Analysis~~

~~Data is used to guide quality improvement initiatives throughout the organization to improve, safety, treatment, and services for our patients. The initial phase of a project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking balancing measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project, examples include the medical record, patient satisfaction surveys, patient safety data, financial data. Benchmarking data supports the internal review and analysis to identify variation and improve performance.~~

~~Reports are generated and reviewed with the quality improvement team. Ongoing review of organization wide performance measures are reported to committees described in the Quality,~~

~~Safety and Experience governance structure.~~

The Quality Committee of the Board of Trustees has established a standing committee, The System Quality, Safety and Experience Committee (previously the Patient Safety Committee) to evaluate, prioritize, provide general oversight and alignment, and remove any significant barriers for implementation for quality, safety, and experience initiatives across Harris Center programs. The Committee is composed of Harris Center leadership, including operational and medical staff. The Committee will approve annual system-wide quality and safety goals and review progress. The patient safety dashboard and all serious patient safety events are reviewed. Root Cause Analysis, Apparent Cause Analysis, Failure Modes and Effects Analysis, quality education projects, are formal processes used by the Committee to evaluate the quality and safety of mental projects through The Harris Center's quality training program or other performance improvement training programs are privileged and confidential as part of the Quality, Safety & Experience Committee efforts. The Committee also seeks to ensure that all The Harris Center entities achieve standards set forth by the Commission on Accreditation and Rehabilitation Facilities (CARF) and Certified Community Behavioral Health Clinic (CCBHC).

The System Quality, Safety and Experience Committee has oversight of the following committees and/or processes: (Appendix A)

- Pharmacy and Therapeutics Committee
- Infection Prevention
- System Accreditation
- All PI Councils and internal learning collaboratives (e.g., Zero Suicide, Substance Use Disorders)
- Approval of Care Pathways
- Patient Experience / Satisfaction Membership:
    - Chief Executive Officer (Ex-Officio)
    - VP, Clinical Transformation and Quality (Co-Chair)
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    - Chief Administrative Officer
    - Director Risk Management / Audit
    - Director of Compliance
    - Chief Financial Officer
    - Director Health Analytics
    - Director, Clinical Transformation, and Innovation

- Director of Quality Assurance
- Director of Pharmacy Programs
- Director of Integrated Care
- Nursing Directors
- Infection Control Director

The criteria listed below provide a framework for the identification of improvements that affect health outcomes, patient safety, and quality of care, which move the organization to our mission of providing the finest possible patient care. The criteria drive strategic planning and the establishment of short and long-term goals for quality initiatives and are utilized to prioritize quality improvement and safety initiatives.

- High-risk, high-volume, or problem-prone practices, processes, or procedures
- Identified risk to patient safety and medical/healthcare errors
- Identified in The Harris Center Strategic Plan
- Identified as Evidenced Based or "Best Practice"
- Required by regulatory agency or contract requirements
  Methodologies
- The Model for Improvement (Appendix B) and other quality frameworks (e.g., Lean, Six Sigma) are used to guide quality improvement efforts and projects
- A Root Cause Analysis (RCA) is conducted in response to serious or sentinel events
- Failure Mode and Effects Analysis (FMEA) is a proactive tool performed for analysis of a high-risk process/procedure performed on an as needed basis (at least annually)
- Data Management Approach and Analysis

Data is used to guide quality improvement initiatives throughout the organization to improve, safety, treatment, and services for our patients. The initial phase of a project focuses on obtaining baseline data to develop the aim and scope of the project. Evidence-based measures are developed as a part of the quality improvement initiative when the evidence exists. Data is collected as frequently as necessary for various reasons, such as monitoring the process, tracking balancing measures, observing interventions, and evaluating the project. Data sources vary according to the aim of the quality improvement project, examples include the medical record, patient satisfaction surveys, patient safety data, financial data. Benchmarking data supports the internal review and analysis to identify variation and improve performance. Reports are generated and reviewed with the quality improvement team. Ongoing review of organization wide performance measures are reported to committees described in the Quality, Safety and Experience governance structure.

Reporting

Quality, Safety and Experience metrics are routinely reported to the Quality, Safety and Experience Committee. Quality, Safety and Experience Committee is notified if an issue is identified. Roll up reporting to the Quality Board of Trustees on a quarterly basis and more frequently as indicated.

~~Experience Committee. Quality, Safety and Experience Committee is notified if an issue is~~

~~identified. Roll up reporting to the Quality Board of Trustees on a quarterly basis and more frequently as indicated.~~

Evaluation and Review

At least annually, the Quality, Safety and Experience leadership shall evaluate the overall effectiveness of the Quality, Safety and Experience Plan and program. Components of the plan met, and this document is maintained to reflect an accurate description of the Quality, Safety and Experience program.

~~effectiveness of the Quality, Safety and Experience Plan and program. Components of the plan met, and this document is maintained to reflect an accurate description of the Quality, Safety and Experience program.~~

~~Committee Oversight~~

The Model for Improvement

Forming the Team:

Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.

~~effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.~~

Setting Aims:

Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

~~measurable; it should also define the specific population of patients that will be affected.~~

Establishing Measures:

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

~~leads to an improvement.~~

Selecting Changes

~~A~~All improvement requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

~~improvement. Organizations therefore must identify the changes that are most likely to result in improvement.~~

Testing Changes

~~The Plan-do-Study-Act (PDSA) cycle is shorthand for testing a change in~~

~~the real work setting – by planning it, trying it, observing the results, and~~

The Plan-do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for ~~actionoriented~~action oriented learning.

Implementing Changes ~~After testing a change on a small scale, learning~~:

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

~~team can implement the change on a broader scale — for example, for an~~

~~entire pilot population or on an entire unit.~~

Spreading Changes ~~After successful implementation of a change or~~:

After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

~~spread the changes to other parts of the organization or in other~~

~~organizations.~~

Sources:

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.

~~Approach to Enhancing Organizational Performance.~~

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-DoCheck-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]

~~with "Study." [See Deming WE. The New Economics for Industry, Government, and Education.~~

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Root Cause Analysis (RCA):

~~The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the~~

~~problem to the solution, and we try to solve a problem before comprehending its root cause. What we think~~

~~is the cause, however, is sometimes just another symptom.~~

~~One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents~~

~~itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again~~

~~and again until you reach the root cause.~~

The key to solving a problem is to first truly understand it. Often, our focus shifts too quickly from the problem to the solution, and we try to solve a problem before comprehending its root cause. What we think is the cause, however, is sometimes just another symptom. One way to identify the root cause of a problem is to ask "Why?" five times. When a problem presents itself, ask "Why did this happen?" Then, don't stop at the answer to this first question. Ask "Why?" again and again until you reach the root cause.

Failure Modes and Effects Analysis (FMEA):

~~FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur. In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent the system might fail. Then, team members with appropriate expertise work together to devise improvements to prevent those failures — especially failures that are likely to occur or would cause severe harm to patients or staff. The FMEA tool prompts teams to review, evaluate, and record the following:~~

~~•~~

~~•~~

~~•~~

~~•~~

FMEA is a tool for conducting a systematic, proactive analysis of a process in which harm may occur. In an FMEA, a team representing all areas of the process under review convenes to predict and record where, how, and to what extent the system might fail. Then, team members with appropriate expertise work together to devise improvements to prevent those failures — especially failures that are likely to occur or would cause severe harm to patients or staff. The FMEA tool prompts teams to review, evaluate, and record the following:

Steps in the process

Failure modes (What could go wrong?)

Failure causes (Why would the failure happen?)

Failure effects (What would be the consequences of each failure?)

~~Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes~~

Teams use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred. This emphasis

on prevention may reduce risk of harm to both patients and staff. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

~~may reduce risk of harm to both patients and staff. FMEA is particularly useful in evaluating a new process~~

~~prior to implementation and in assessing the impact of a proposed change to an existing process.~~

Attachments

Board Approved System Quality Safety and Experience Plan 2024.cleaned (1).pdf

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO	Wayne Young: Exec	12/2023
Legal	Kendra Thomas: Counsel	11/2023
Department Review 2	Luming Li: Chief Medical Ofcr (1101 1817)	11/2023
Department Review	Gertrude Leidich: Vice President Clinical Transformation and Quality	10/2023
Initial	Luc Josaphat: Director of Quality Assurance	10/2023

EXHIBIT G-3

Status **Pending** PolicyStat ID **14819517**

Origination	N/A	Owner	Kendra Thomas: Counsel
Last Approved	N/A	Area	General Administration
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	N/A		
Next Review	1 year after approval		

GA.A.6 All Contracts

1. PURPOSE:

The purpose of this policy is to protect the business interests of The Harris Center and ensure that any commitment of The Harris Center's financial resources and all contracts obligating The Harris Center are properly reviewed, prepared, approved and executed by authorized personnel.

2. POLICY:

It is the policy of The Harris Center for the Contract Services department under the supervision of the General Counsel to conduct the legal review and preparation of all contracts. All purchases of goods and services shall be made pursuant to a contract. Funds will only be disbursed through properly completed and approved contracts and amendments.

3. APPLICABILITY/SCOPE:

This policy applies to all contracts for goods and services awarded by The Harris Center and to which The Harris Center is a party, regardless of whether they have been drafted by The Harris Center or a third party. Contracts include, without limitation, all agreements, licenses, leases, purchase orders, promissory notes, assignments, powers of attorney, terms and conditions, memorandum of understanding, letters of intent, settlements, releases, waivers, renewals, amendments, or modifications to existing contracts, and other similar documents.

This policy applies to all employees of the Harris Center (including Trustees, officers, managers, directors and Executive Leaders). All employees shall comply with the policy and procedures for initiating, reviewing, and executing any contract to which The Harris Center is a party.

4. RELATED POLICIES/FORMS (for reference only):

Executive Contract Summary

5. PROCEDURE:

All Contracts

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Contracts Management for Local Authorities, 25 Tex. Admin. Code, Subchapter B
Uniform Grant and Contract Management Act, Tex. Government Code, Chapter 783
Texas Health & Safety Code, Chapter 250, §§533.007, 533.035, 534.052, 534.055, 534.061, 534.065, and 534.066.

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Legal Review	Kendra Thomas: Counsel	12/2023
Initial Assignment	Kendra Thomas: Counsel	12/2023

EXHIBIT G-4

Status **Pending** PolicyStat ID **14467682**

Origination	N/A
Last Approved	N/A
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Next Review	1 year after approval
Owner	Demetria Luckett
Area	Plans
Document Type	Agency Plan

EM.P.4 Corporate Compliance Documentation and Claims Integrity Plan

Corporate Compliance Documentation and Claims Integrity Plan

I. **PURPOSE:**

A. It is the practice of The Harris Center for Mental Health and IDD (The Harris Center) to obey the law and to follow ethical business and service practices, especially as it pertains to quantitative and qualitative documentation requirements of professional services and fee and claims billing. The Harris Center requires its employees, volunteers, and contract providers to be fully informed about and in compliance with all applicable laws, regulations, and regulatory requirements.

B. The Harris Center has developed a fraud and abuse compliance program that sets out the responsibilities and obligations of all employees, volunteers, and contract providers regarding submissions for reimbursement to Medicare, Medicaid, and other government payers for services rendered by The Harris Center and any of its employees, volunteers and contract providers, subsidiaries, divisions, and contractors. In addition, this Policy is intended to apply to all business arrangements with physicians, vendors, contract providers, and other persons who may be impacted by federal or state laws relating to claims of fraud and abuse.

C. In order to support this commitment, The Harris Center has established the following:

1. Designation of ~~a~~the Compliance Director as The Harris Center ~~official (Compliance Director)~~employee responsible for directing the effort to enhance compliance, including

implementation of the Policy.
~~Demetria Luckett~~
~~Email: Demetria.Luckett@TheHarrisCenter.org~~
~~Phone: 713-970-3432~~
~~Fax: 713-970-7694~~

2. Incorporation of standards and procedures that guide The Harris Center employees, volunteers, contract providers, and others involved with operational practices and administrative guidelines;
3. Identification of legal issues that may apply to business relationships;
4. Development of compliance initiatives/requirements at the unit level;
5. Coordinated training of clinical and administrative staff, volunteers, and contract providers concerning applicable compliance requirements and The Harris Center procedures;
6. A uniform mechanism for employees, volunteers, and contract providers, to raise questions and receive appropriate guidance concerning operational compliance issues;
7. Regular review and audit to assess compliance to identify issues requiring further education and to identify potential problems;
8. A process for employees, volunteers, and contract providers to report possible compliance issues and for such report to be fully and independently reviewed by the Corporate Compliance Director;
9. Enforcement of standards through well-publicized disciplinary guidelines.
10. Formulation of corrective action ~~Policies~~plans to address any compliance problems which are identified;
11. Regular review of the overall compliance effort to ensure that operational practices reflect current requirements that other adjustments are made to improve The Harris Center operations;
12. Coordination between The Harris Center departments and divisions and contract providers to ensure effective compliance in areas where activities might overlap.

II.SCOPE

A. This ~~Policy~~Plan applies to all The Harris Center staff, volunteers, contractors, and service activities and administrative actions governed by federal and state regulations related to health care providers.

B. It is the intent of The Harris Center that the scope of all documentation and claims compliance policies, and procedures should promote integrity, support objectivity and foster trust between providers and clients and payors.

III.Compliance Director

A. The primary responsibility for implementing and managing The Harris Center 's compliance Policy shall be assigned to The Harris Center Compliance Director. The Compliance Director will report documentation, ethical or compliance issues to the Chief Executive Officer (CEO), to the General Counsel, ---directly to the Board of Trustees. The Harris Center Board of Trustees endorses this activity and requires that all The Harris Center staff, volunteers, contract

providers and affiliates to comply with state and federal guidelines related to billing and claims as well as federal and state laws related to fraud, waste and abuse.

B. The Compliance Director will, with oversight of the CEO of The Harris Center and General Counsel ~~where appropriate~~, perform the following activities:

1. Review and amend as necessary, the Code of Conduct for all The Harris Center employees, volunteers and contract providers.
2. Assist in the review, revision, and formulation of appropriate guidelines for all activities and functions of The Harris Center, which involve issues of compliance.
3. Develop methods to ensure The Harris Center employees, volunteers and contract providers and vendors are aware of The Harris Center Code of Conduct and Corporate Compliance Policy and understand the importance of compliance.
4. Developing and delivering educational and training programs.
5. Coordinate compliance reviews and audits in accordance with The Harris Center procedures.
6. Receive and investigate instances of suspected compliance issues, as set forth in Sections IX, X and XI of this Policy.
7. Assist in the development of appropriate corrective actions as set forth in Section XI of this Policy.
8. Prepare Annual Compliance Review, as set forth in Section XII of this Policy.
9. Prepare Annual Corporate Compliance Work Policy, as set forth in Section XIII of this Policy
10. Prepare proposed revisions to the Compliance Policy, as set forth in Section XIV of this Policy.
11. Provide other assistance as directed by the Harris Center Board of Trustees, General Counsel, CEO and COO.

IV. STAFF TRAINING

A. All staff, volunteers and contract providers providing services or involved in the billing and claims process must participate in billing and claims compliance training. This training shall be documented and all staff must demonstrate competency before they are allowed to submit bills and claims of services rendered. Individual staff are responsible for maintaining compliance with The Harris Center billing and claims procedures and their managers are required to assure staff under their supervision is performing as required. The Harris Center has also adopted a Code of Conduct to guide all of its business activity.

B. All new hires receive Corporate Compliance training at new employee orientation. They demonstrate corporate competence and acknowledge the Code of Conduct as a condition of The Harris Center employment. All staff will take Corporate Compliance training (self-study), demonstrate corporate citizenship and acknowledge the Code of Conduct annually thereafter. Management staff may request additional Corporate Compliance training at any time. At a minimum the training shall include:

1. A review of The Harris Center 's Corporate Compliance program,

2. An overview of the fraud and abuse laws as they relate to the claim development and submission process;
3. An overview of the federal agencies that take the lead in combating fraud, waste and abuse;
4. An overview of the fraud, waste and abuse laws as they relate to prohibitions against payments for referrals, kickbacks and rebates and other illegal inducements;
5. The consequences to both individuals and The Harris Center of failing to comply with applicable laws.

C. **Documentation of Corporate Compliance Training.**

The Harris Center shall document the training provided (class or self- study) to each employee, volunteer and contract provider. The documentation shall include the name of the employees, volunteers and contract providers, the date and duration of the educational activity or program; and a brief description of the subject matter of the education.

All training materials and curriculum directed to address regulatory compliance issues will be reviewed and updated as needed by the Compliance Director.

V. PHYSICIAN CONTRACTS

A. It is the policy of The Harris Center that all Federal and state anti-kickback and physician self-referral laws, which prohibit the offer or payment of any compensation to any party for the referral of clients, be followed. All physician contracts as applicable shall be reviewed and approved by legal counsel prior to the execution to avoid violation of federal anti-kickback or self-referral laws.

B. To comply with applicable laws regarding client referrals, The Harris Center :

1. Shall comply with the polices governing gifts set forth in The Harris Center Employee Handbook;
2. Shall not submit nor cause to be submitted a bill or claim for reimbursement for services provided pursuant to a prohibited referral.

The Harris Center also shall ensure that any physician with whom an agreement is executed, and/or who serves as an attending physician in the facility, has current valid licenses as required by law and has not been excluded from participation in the Medicare and Medicaid programs.

VI. DOCUMENTATION AND CLAIMS AUDITS

A. Ongoing review and audit of all The Harris Center operations, including contracted services will occur and will be coordinated by The Harris Center Compliance Director. Such reviews and audits will be regular and ongoing, the results of which will be reported to The Harris Center 's CEO.

B. The Harris Center Compliance Director may, after consultation with the CEO and The Harris Center's legal counsel, engage external experts to perform focused reviews as needed. Monitoring shall occur at the provider level as well as with through third party review coordinated by the Compliance Director. Billing and claims issues identified through reviews shall be reported by T he Harris Center Compliance Director to the CEO and The Harris Center

's legal counsel and others as needed.

C. In order to assure compliance with Medicare/Medicaid and other government funded healthcare payment programs, The Harris Center has adopted a billing audit procedure to assist in its efforts to monitor the accuracy of claims. This procedure is adopted to ensure that representative claims from all The Harris Center 's individual and institutional providers are periodically reviewed in a manner which will enable The Harris Center to promptly identify deficiencies in the claim development and submission process, which could result in inaccurate claims.

D. **AUDIT PROCESS**
The Harris Center will conduct audits on a regular basis. The audits will be executed in accordance with the policies and procedures contained in the applicable auditing tool or protocol utilized by The Harris Center . The Harris Center will devote such resources as are reasonably necessary to ensure that the audits are initiated by persons with appropriate knowledge and experience to reflect changes in applicable laws and regulations.

E. **AUDIT POLICY**

1. **Chart Audits.** It is the policy of The Harris Center and the responsibility of each department manager to ensure that employees, volunteers and contract providers who have a direct impact on the claim development and submission to process are provided adequate and appropriate training. One mechanism for ensuring the accuracy of The Harris Center 's claims is to ensure that each new employee, volunteers and contract providers adequately understands the essential elements of his/her jobs functions. In furtherance of this objective, it is the policy of The Harris Center to review the work of employees, volunteers and contract providers in the manner set forth below:
2. **Billers and Coders.** Each employee, volunteer and contract provider whose principle function includes the billing or coding of claims to be submitted to the Medicare or Medicaid program shall have all of such employee's, volunteer's and contract provider's claim related work reviewed by the employee's, volunteer's and contract provider's supervisor for a period of not less than 15 days following the commencement date, or such later date as the manager is satisfied that the accuracy of the employees, volunteers and contract provider's claims justify cessations of the reviews.
    a. **Clinical Staff.** Patient care providers shall be provided written guidelines with respect to documentation services rendered by such providers at least one (1) time during the first 60 days of employment of client care personnel, the providers (manager, supervisor, or other appropriate persons) shall review all of the provider's documentation to ensure that the provider is accurately and completely documenting the services rendered by the provider. For the purpose of this policy, the term provider includes physicians, nurses, allied health professionals and other persons who may document the delivery of services in The Harris Center 's records (including medical records).
    b. **Periodic Audits.** The Harris Center will conduct periodic audits of claims submitted to the Medicare and Medicaid programs. At a minimum, The Harris Center's audit activities shall consist of: (1) individual provider

audits – the audit of not less than 100 claims annually of a sample randomly selected within an individual program site. Focus audits may also be conducted on individual staff.

c. **Complaint Audits/Focused Reviews.** Upon receipt of a credible allegation or complaint alleging improper or inaccurate billing practices at The Harris Center, The Harris Center shall undertake a review of the matter, including an extensive audit as dictated in The Harris Center Corporate Compliance Policy.

VII. COST REPORT SUBMISSIONS

A. The Harris Center is required to submit various cost reports to federal and state governments in connection with its operation and to receive payment. Such reports will be prepared as accurately as possible and in conformity with applicable laws and regulations. If errors are discovered, billing personnel shall contact an immediate supervisor promptly for advice concerning how to correct the error(s) and notify the appropriate payor. In some instances, errors shall also be reported to The Harris Center Compliance Director if it is suspected that the error has affected The Harris Center-wide billing process or jeopardized The Harris Center's on-going participation in federally funded programs.

B. In the preparation of cost reports for Medicare or Medicaid or any other state or federal cost reporting documents, all employees, volunteers, and contract providers involved in the preparation shall ensure that:

1. Information provided for or used in the cost report is adequately supported by documentation.
2. Non-allowable costs are properly identified and removed;
3. Statistics are based on reliable information;
4. Related parties are identified and their services treated in accordance with program rules; and
5. Costs claimed in non-conformity with program rules, as interpreted by the Medicare or Medicaid program or the fiscal intermediary, either are disclosed in a letter accompanying the cost report or are in protested amounts.

VIII. REPORTING COMPLIANCE ISSUES

A. Billing and claims shall be made only for services provided to clients, directly or under contract, pursuant to all terms and conditions specified by the government or third-party payor and consistent with industry practice. The Harris Center and its employees, volunteers, and contract providers shall not make or submit any false or misleading entries on any bills or claim forms, and no employees, volunteers, or contract providers shall engage in any arrangement or participate in such an arrangement at the direction of another employees, volunteers and contract providers (including any supervisor), that results in such prohibited acts. Any false statements on any bill or claim form shall subject the employees, volunteers, and contract providers to disciplinary action by The Harris Center, including possible termination of employment.

B. False claims and billing fraud may take a variety of different forms, including but not limited to false statements supporting claims for payment, misrepresentation of material facts,

concealment of material facts, or theft of benefits or payments from the part entitled to receive them. The Harris Center and employees, volunteers, and contract providers shall specifically refrain from engaging in the following billing practices:

1. Making claims for items or services not rendered or not provided as claimed;
2. Submitting claims to any payor, including Medicare and Medicaid, for services or supplies that are not medically necessary;
3. Submitting claims for items or services that are not provided as claimed;
4. Submitting claims to any payor, including Medicare and Medicaid, for individual items or services when such items or services either are included in The Harris Center's per diem rate or are of the type that may be billed only as a unit and not unbundled;
5. Double billings (billing for the same item or service more than once);
6. Paying or receiving anything of financial benefit in exchange for Medicare or Medicaid referrals (such as receiving non-covered medical products at no charge in exchange for ordering Medicare-reimbursed products); or
7. Billing clients for services or supplies that are included in the per diem payment from Medicare, Medicaid, a managed care Policy or other payor.
8. Submitting a false statement, false information, misrepresentation, or omitting pertinent facts to obtain greater compensation than the provider is legally entitled to.
9. Submitting false statements, false information, or misrepresentation, or omitting pertinent facts on any application or any document requested as a prerequisite for payment.

C. If an employee, volunteer or contract provider has any reason to believe that anyone (including themselves) is engaging in false billing practices, that employee, volunteer, or contract provider shall immediately report the practice to The Harris Center's Compliance Director ~~at 713-970-3432~~or at www.fraudhl.com; 1-855-372-8345 (1-855-FRAUD-HL). All reports to The Harris Center ~~Compliance Director~~shall remain confidential.

D. Failure to act when an employee, volunteer or contract provider has knowledge that someone is engaged in false billing practices shall be considered a breach of that employee's, volunteer's or contract provider's responsibilities and shall subject him/her to disciplinary action by The Harris Center, including possible termination of employment and prosecution.

E. Questions about operational issues should be directed to the person(s) having supervisory responsibility for a specific clinical provider, program or unit. Training materials will instruct The Harris Center employees, volunteers and contract providers that they need to report to The Harris Center's Compliance Director any activity that they believe to be inconsistent with The Harris Center's policies and or legal requirements. The materials will explain how the Compliance Director can be contacted.

F. Employees, volunteers and contract providers must immediately report all known or suspected instances of documentation and claims fraud to the Compliance Director. Employees, volunteers and contract providers who become aware of potential violations of professional licensing and certification requirements are to report them immediately to their immediate supervisor and to the Compliance Director.

G. The Qui Tam Act- Whistleblowers Protection Act protects all employees, volunteers and contract providers who report in good faith of known or suspected compliance issues. No employees, volunteers or contract providers shall be subjected to retaliation or harassment of any kind. Concerns about possible retaliation or harassment should be reported to the Compliance Director, who will immediately report to the CEO.

H. The Harris Center Compliance Director will maintain a log of compliance concerns that are reported to the Compliance Office. All reports will be undertaken with a preliminary investigation, which will determine if a full investigation is warranted. In instances where a full inquiry is not warranted, the log should explain why no investigation was undertaken. This log will record the issue, the clinical providers, units, departments and/or organizations affected, the result of the any investigation and whether the issue has been addressed. The log reports should note any issues, which remain open. This log is to be treated as a confidential document and access will be limited to the Corporate Compliance Director and to the CEO.

IX. COMPLIANCE HOTLINE

The Harris Center has established a telephone "FRAUD Hotline" to permit compliance issues to be reported on a confidential basis. The Hotline ~~1-800-737-6789~~1-855-FRAUD-HL (1-855-372-8345) available 24 hours a day, seven days a week. Use the Company ID "Harris" to submit a report.

X. INVESTIGATING COMPLIANCE ISSUES

A. Whenever conduct is inconsistent with The Harris Center's Corporate Compliance operating procedures and is reported, The Harris Center's Compliance Director should determine whether there is reasonable cause to believe that a material compliance issue may exist. If a preliminary review indicates a problem may exist, an inquiry into the matter will be undertaken. Responsibility for conducting the review will be decided on a case–by–case basis. The results of the inquiry will be made available to the General Counsel, CEO and COO.

B. The Harris Center employees, volunteers, and contract providers will be expected to cooperate fully with inquiries undertaken pursuant to this Policy. To the extent practical and appropriate, efforts should be made to maintain the confidentiality of such inquiries and the information gathered.

C. Investigation of all calls and reports of potential fraud shall occur according to the following guidelines:

1. **Purpose of the Investigation.** The purpose of the investigation shall be to identify those situations in which the laws, rules, and standards of the Medicare and Medicaid programs may not have been followed; and to identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violated Medicare or Medicaid laws, rules or standards; to identify individuals who may have knowingly or inadvertently violated the Codes of Conduct; to identify individuals who may have knowingly or inadvertently violated The Harris Center policies or procedures; to facilitate the correction of any practices not in compliance with the Medicare or Medicaid laws, rules and standards; to implement those procedures necessary to insure future compliance; to protect The Harris Center in the event of civil or criminal enforcement actions, and to preserve and protect The Harris Center 's assets.

2. **Control of Investigations.** All reports received, whether by a manager of The Harris Center's

program component or directly through an internal audit shall be forwarded to the Compliance Director. The Compliance Director will be responsible for directing the investigation of the alleged problem or incident or recommending that legal counsel conduct the investigation. Under the direction of the CEO, in undertaking this investigation, the Compliance Director may solicit the support and assistance of legal counsel and internal or external auditors, and internal or external resources with knowledge of the applicable laws and regulations and required policies, procedures or standards that relate to the specific problem in question.

3. **Investigative Process.** Upon receipt of an employee's, volunteer's, or contract provider's complaint, report, or other information (including audit results), that suggests that the existence of a serious pattern of conduct in violation of the compliance policies, or applicable laws or regulations, an investigation under the direction and control of the Compliance Director shall be commenced. Steps to be followed in undertaking the investigation shall include at a minimum:
    a. The Compliance Director will notify the CEO, General Counsel and the COO of the nature of the ~~compliant~~complaint and the Compliance Director will conduct a preliminary investigation into the allegation to determine the level of investigation necessary based on the seriousness of the allegation. After the CEO, General Counsel and COO review the preliminary investigation, they will determine and advise the Compliance Director whether to proceed with a full formal investigation. In some instances, a complaint may be resolved with a simple phone call, while others will require a formal investigation. If the Compliance Director has reasonable cause to believe that a risk issue exists, the Compliance Director will report the issue to the CEO, General Counsel and COO, who will make a case-by-case decision as to whether an employee, volunteer, or contract provider should be removed from his/her work area during the investigation.
    b. The investigation shall be commenced as soon as possible but in no more than five (5) business days following the receipt of the complaint or report. A full investigation will not exceed more than 30 business days. In instances where additional time is needed, a request by the Compliance Director with an explanation as to why may be sent to and approval may be granted by the CEO. The investigations shall include, as applicable, but need not be limited to:
        1. An interview of the complainant, the person who is the focus of the complaint, and other persons who may have knowledge of the alleged problem or process and a review of the applicable laws and regulations which might be relevant to or provide guidance with respect to the appropriateness or inappropriateness of the activity in question, to determine whether or not a problem actually exists.
            a. If the preliminary review results in conclusions or findings that are permitted under applicable laws, regulations or policy or that the complained of act did not occur as alleged or that it does not otherwise appear to be a problem, the investigation shall be closed. The CEO, COO, and the person who is the focus of the investigation will be notified that the case has been closed.
            b. If the preliminary investigation concludes that there is the existence of a serious pattern of conduct in violation of the

compliance Policy, improper billing occurring, that practices are occurring which are contrary to applicable law, inaccurate claims are being submitted, or that additional evidence is necessary, the investigation shall proceed to the next step—a full formal investigation. If a full formal investigation is required, the CEO, General Counsel, COO and the appropriate Executive Management Team member shall be notified a formal investigation will be required.

2. The identification and review of representative bills or claims submitted to the Medicare/Medicaid programs to determine the nature of the problem, the scope of the problem, the frequency of the problem, the duration of the problem, and the potential financial magnitude of the problem.
3. Identifying witnesses, taking written statements, and interviews of the person or persons in the departments and institutions who appeared to play a role in the process in which the problems exists. The purpose of the interview will be to determine the facts related to the complained of activity, and may include, but shall not be limited to:
    a. Individual understanding of the Medicare and Medicaid laws, rules and regulations.
    b. Collecting documentary and demonstrative evidence such as medical records, financial records, Human Resource files and records, copies of contracts or agreements with employees, agents, vendors an external contractors which describe business relationships;
    c. The identification of persons with supervisory or managerial responsibility in the process;
    d. The adequacy of the training of the individuals performing the functions within the process;
    e. The extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the Medicare or Medicaid laws, rules or regulations;
    f. The nature and extent of potential civil or criminal liability of individuals or The Harris Center ; and
    g. Drawing conclusions and reporting investigative findings and preparation of a summary report which (1) defines the nature of the problem (2) summarizes the investigation process, (3) identifies any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the Medicare/Medicaid laws, rules and policies, (4) if possible, estimates the nature and extent of the resulting overpayment by the government, if any.
    h. When an investigation is concluded, and a case has been confirmed, the Compliance Director will notify the CEO, General

Counsel, COO and the appropriate ~~EMT member~~VP of the findings. The Federal False Claims Act requires that persons holding management positions be held responsible for awareness and practices of their staff. Persons in management positions may be held accountable for the foreseeable failure of staff to adhere to standards, policies, regulations and laws whether there is actual knowledge, deliberate ignorance or reckless disregard on the part of the management staff.

i. When an investigation is concluded and a case has been found to be unconfirmed, inconclusive or unfounded, the Compliance Director will notify the CEO, General Counsel, COO, and the appropriate ~~EMT member~~VP of the findings. The person who is the focus of the investigation will be notified that the case has been closed.

j. Investigation reports will have one of the four findings:

i. Confirmed—An allegation that is supported by evidence collected during an investigation.

ii. Unconfirmed—Evidence collected during the investigation proved that the allegation did not occur.

iii. Inconclusive—Evidence collected during the investigation led to no conclusion or definite result due to a lack of witnesses or other relevant evidence.

iv. Unfounded—Allegation is determined not to be true prior to any investigation.

D. ORGANIZATIONAL RESPONSE

1. **Criminal Activity.** In the event The Harris Center uncovers what appears to be criminal activity on the part of any employees, volunteers, and contract providers or program component, it shall undertake the following steps.
    a. Immediately stop all billing related to the problem in the unit(s) where the problem exists until such time as the offending practices are corrected.
    b. Initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent, or with reckless disregard for the Medicare and Medicaid laws. Appropriate disciplinary action shall include, at a minimum, the removal of the person from any position with oversight for or impact upon the claims submission or billing process and may include, in addition, suspension, demotion, and discharge.
    c. Make reports to governmental authorities and law enforcement officials as appropriate.

2. **Non-Criminal Activity.** In the event the investigation reveals billing or other problems, that do not appear to be the result of conduct, that is intentional, willfully indifferent, or with reckless disregard for the Medicare and Medicaid laws, The Harris Center shall nevertheless undertake the following steps.
    a. **Improper Payments:** In the event the problem results in duplicate payments by Medicare or Medicaid, or payments for services not rendered or provided other than

as claimed, it shall:

1. Correct the defective practice or procedure as quickly as possible;
2. Calculate and repay to the appropriate governmental entity duplicate payments for improper payments resulting from the act or omission;
3. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.
4. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

b. **No improper Payment:** In the event the problem has or does not result in an overpayment by the Medicare or Medicaid program, The Harris Center :

1. Correct the defective practice or procedure as quickly as possible.
2. Initiate such disciplinary action, if any, as appropriate given the facts and circumstances. Appropriate disciplinary action may include but is not limited to, reprimand, demotion, suspension, and discharge.
3. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

E. STAFF DISCIPLINE

Employees, volunteers and contract providers may be subject to adverse personnel action for failing to participate in organizational compliance efforts, including but not limited to:

1. The failure of an employee, volunteer or contract provider to comply with The Harris Center policy and procedure and/or perform any obligation required of the employees, volunteers or contract providers relating to compliance with the program or applicable laws or regulations.
2. The failure to report suspected violations of compliance programs laws or applicable laws or regulations to an appropriate person; and
3. The failure on the part of a supervisory or managerial employee, volunteer, and contract provider to implement and maintain policies and procedures reasonably necessary to ensure compliance with the terms of the program or applicable laws and regulations.

~~Adverse personnel action~~Disciplinary actions will follow The ~~Harris Center 's existing employee, volunteer and contract provider's~~ Human Resources policies and procedures.

XI. CORRECTIVE ACTION POLICY

A. Whenever a compliance issue has been identified, the Compliance Director has the responsibility and authority to take or direct appropriate action to address the issue. The corrective action will be set forth in writing. In developing the ~~corrective action~~Corrective Action Policy, the Compliance Director should obtain advice and guidance from others as necessary, such as the CEO and COO and The Harris Center's legal counsel if needed. Information about corrective action ~~policies~~plans shall be provided to the CEO and General Counsel.

B. Corrective Action shall be pre-approved by, at a minimum, the CEO and General Counsel.

Corrective action should be designed to ensure not only that the specific issue at hand is addressed but also systems are placed in operation, which would prohibit the repeat of similar problems. Corrective actions may require certain functions to be reassigned, training to take place, restrictions on personnel, reassignment of duties, terminating contractual relationships, that repayment be made, or that the matter be disclosed externally. Corrective action may include recommendations that a sanction or disciplinary action be imposed. Moreover, if the Compliance Director believes that any non-compliance has been willful, that belief and the basis for it shall be reported to the CEO and ~~COO~~General Counsel. The Harris Center employees, volunteers, and contract providers who have engaged in willful billing and claims misconduct will be subject to disciplinary action up to and including termination and criminal prosecution.

XII. ANNUAL COMPLIANCE REVIEW

A. On or before the end of each fiscal year, the Compliance Director will arrange for a review of The Harris Center's current compliance and regulatory operations. The purpose of the review is to ascertain whether the compliance operations of The Harris Center are within standards.

XIII. ANNUAL REPORT (Memorandum of Record)

A. On or before September 1, the Compliance Director shall prepare and distribute to the General Counsel and CEO a report describing the compliance efforts during the preceding fiscal year. The report shall include the following elements:

1. A summary of the general compliance activities undertaken during the preceding fiscal year, including any changes made to the Compliance Policy;
2. A summary of the Hotline log for the preceding fiscal year;
3. A summary of the preceding fiscal year's Compliance Review;
4. A description of actions taken to ensure the effectiveness of the training and education efforts;
5. A summary of actions to ensure compliance with The Harris Center 's policy on dealing with excluded persons;
6. Recommendations and result of recommendations for changes in the policy that might improve the effectiveness of The Harris Center 's compliance effort; and
7. Any other information specifically requested by the General Counsel, CEO and the Board of Trustees.

XIV. REVISIONS TO THE INTEGRITY POLICY

A. This Compliance Policy is intended to be flexible and readily adaptable to changes in regulatory requirements and in the health care system as a whole. The Policy shall be regularly reviewed to assess whether it is working and effective. The Harris Center 's CEO shall have the authority to amend the Policy at any time.

XV. EXCLUDED PERSONS

A. The Harris Center complies with 42 U.S.C. 1320a-7a(a)(6), which imposes penalties for "arranging (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program for the provision

of items or services for which payment may be made under such a program". Accordingly, prior to employing or contracting with any provider for whom The Harris Center intends to submit bills to a Federal health program and on a monthly basis, The Harris Center confirms the provider has not been excluded from participation in federally funded programs. Those steps will include checking the provider's name against the HHS/OIG Cumulative Sanctions list and the GSA Debarred Bidders List. The Harris Center's Compliance Director will ensure that The Harris Center staff responsible for credentialing has addressed this with each new hire. The Harris Center will neither use nor hire a provider who is barred from participation in a federally funded program. If The Harris Center learns that any of its current providers (either as employees, volunteers or contract providers) has been proposed for exclusion or excluded, it will remove such persons from any involvement in or responsibility for Federal health insurance programs until such time that The Harris Center has confirmed the matter has been resolved.

XVI. REFERENCES:

A. The Deficit Reduction Act-2005
B. The Federal Anti-Kickback Statute
C. The Stark Law
D. The Texas Illegal Remuneration Statute
E. Civil Money Penalties Statute
F. The Federal False Claims Act
G. The Medicaid Fraud Prevention Act
H. Center for Medicare and Medicaid Services
I. Office of the Attorney General
J. U.S. Department of Justice / Federal Bureau of Investigation

XVII. ATTACHMENTS

Code of Conduct

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO	Wayne Young: Exec	12/2023
Legal	Kendra Thomas: Counsel	11/2023
Director Review	Demetria Luckett	09/2023

Initial	Christopher Webb: Audit	09/2023
Initial	Demetria Luckett	09/2023

EXHIBIT G-5

Status **Pending** PolicyStat ID **14496191**

Origination	09/2020	Owner	Keena Pace: Exec
Last Approved	N/A	Area	Assessment, Care & Continuity
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

ACC.A.11 Financial Assessment

1. PURPOSE:

The purpose of this policy is to complete a financial assessment at intake and yearly thereafter to ensure compliance to the state rules and laws by establishing a uniform evaluation of ~~a~~ patient's financial status and residency that determines the patient's ability to pay by using a sliding fee scale.

2. POLICY:

It is the policy of the Harris Center to conduct and document a financial assessment for each patient within the first thirty (30) days of services. The Harris Center shall update the financial assessment for patients at least on a yearly basis and whenever the consumer reports any significant change in income, insurance, family size, or extraordinary expenses~~,~~ in which case the financial will be updated before the yearly anniversary of the previous financial.

3. PROCEDURES:

Financial Assessment

4. APPLICABILITY/SCOPE:

This policy applies to all Harris Center staff, contractors, visitors, and people served.

5. ~~RELATED POLICIES/FORMS (for reference only):~~RELATED POLICIES/FORMS:

- Fee Schedule/Standard Charge
- ~~Charity Care Policy~~FM25A Charity Care Policy

~~6. PROCEDURES:~~

~~Financial Assessment~~

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- Community Centers-Fees for Services, Tex. Health & Safety Code §534.017
- Local Mental Health Authorities Responsibilities, Charges for Community Services, 25 Tex. Admin. Code, Chapter 412, Subchapter C

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Departmental Review	Keena Pace: Exec	10/2023
Initial Assignment	Keena Pace: Exec	10/2023

EXHIBIT G-6

Status **Pending** PolicyStat ID **14133023**

Origination	N/A	Owner	Toby Hicks
Last Approved	N/A	Area	Human Resources
Effective	Upon Approval		
Last Revised	N/A		
Next Review	1 year after approval		

HR.A.14 Licensure, Certification and Registration

1. PURPOSE:

The purpose of this policy is to establish a method for ensuring current licensure, certification, or registration for The Harris Center for Mental Health and IDD (The Harris Center) employees is consistent with Federal and State laws, regulations and organizational standards.

2. POLICY:

Employees who hold job classifications that require professional and occupational licensure, certification, or registration must maintain those credentials in an active and current status as a condition of employment.

Employees who hold such job classifications will have their licensure, certification, or registration verified through the issuing agency prior to providing services and at the time of renewal.

Violations of this policy or associated procedures may result in appropriate disciplinary actions in accordance with The Harris Center Code of Conduct/Ethics, Standards of Behavior, Employee Handbook and other applicable Harris Center policies, or as outlined in any procedure document related to this policy.

3. APPLICABILITY/SCOPE:

All The Harris Center employees, volunteers and contractors that hold job classifications that require licensure, certification and/or registration.

4. PROCEDURES:

~~HR15B - Licensure, Certification and Registration Procedure~~Licensure, Certification and Registration Procedure

5. RELATED POLICIES/FORMS (for reference only)::

~~HR2A - Credentialing and Privileging~~Credentialing and Privileging

~~HR10A - Employment Eligibility Verification~~ Employment Eligibility Verification

~~HR15B - Licensure, Certification and Registration~~

Employee Handbook

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Competency and Credentialing, 36 Tex. Admin. Code &§301.331

~~Violations of this policy or associated procedures may result in appropriate disciplinary actions in accordance with The Harris Center Code of Conduct/Ethics, Standards of Behavior, Employee Handbook and other applicable Harris Center policies, or as outlined in any procedure document related to this policy.~~

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Legal Review	Kendra Thomas: Counsel	12/2023
Department Review	Joseph Gorczyca	11/2023
Initial Assignment	Toby Hicks	10/2023

EXHIBIT G-7

Status **Pending** PolicyStat ID **14593116**

Origination	09/2020	Owner	Kendra Thomas: Counsel
Last Approved	N/A	Area	General Administration
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	11/2022		
Next Review	1 year after approval		

GA.A.4 - Mailing Services

1. PURPOSE:

The purpose of this policy is to establish clear expectations on utilization of the mailing services provided by The Harris Center for Mental Health and IDD.

2. POLICY:

The Harris Center will maintain a mailing permit by paying an annual fee to a third party vendor for the use of a mail metering service. The funding of said service is for the benefit of all recognized units of The Harris Center that have an assigned Unit Number issued by the Accounting Department. All business-related mail must be routed through the Mail Room for appropriate postage and shipping. Rates for shipping mail will be charged back to the Unit number that appears on the mailing medium e.g. envelope, box, etc.

Timely delivery, quality service and a worry free experience are what we value for our internal customers. We expect Units to assist in meeting these goals by ensuring outgoing mail items bear the approved Agency logo along with the Unit Number of the mailing department and a return address that includes an office number.

3. APPLICABILITY/SCOPE

All recognized Agency departments with a unit number assigned by the Accounting Department.

4. RELATED POLICIES/FORMS (for reference only):

None

5. PROCEDURES:

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

None

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Legal Review	Kendra Thomas: Counsel	11/2023
Initial Assignment	Kendra Thomas: Counsel	11/2023

EXHIBIT G-8

Status **Pending** PolicyStat ID **14831277**

Origination	04/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	02/2023
Next Review	1 year after approval
Owner	Luming Li: Chief Medical Ofcr (1101 1817)
Area	Medical Services
Document Type	Agency Policy

MED.A.3 - Medical Peer Review Policy

1. PURPOSE:

The purpose of this policy is to ensure a process whereby the quality of care provided by physicians and physician assistants at The Harris Center for Mental Health & IDD (The Harris Center) is physician-peer-driven and meets professionally recognized standards of health care via ongoing objective, non-judgmental, consistent and fair evaluation by the medical staff.

2. POLICY:

It is the policy of The Harris Center to consistently assess, monitor, and evaluate physician-patient care activity to ensure the highest quality of care for all patients of The Harris Center. Triggers for physicians and physician assistants may include findings from routine patient record reviews, incident reports, patient or staff complaints, sentinel events or critical incident reviews. The deliberations of the medical peer review are held in accordance with all rules, statutes, and laws pertaining to peer review and any protections allowed under these regulations in regard to confidentiality and privileged nature of medical peer review deliberations and proceedings. The Medical Peer Review Committee is a subcommittee of the Professional Review Committee (PRC).

3. APPLICABILITY/SCOPE:

This policy applies to any employed and contracted licensed physicians and physician assistants for the evaluation of clinical practice under the supervision of a licensed physician.

4. PROCEDURES:

Medical Peer Review Procedure

5. RELATED POLICIES/FORMS (for reference only):

Professional Review Committee

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Health Care Quality Improvement Act of 1986,42 U.S.C. §§11101, et seq.

Report and Confidentiality Requirements, Tex. Occupations Code, Subchapter A. §§160.001, et. seq.

Physician Assistants- Duty to Report; Medical Peer Review, Texas Occupations Code Subchapter A. §204.208

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Final Legal Review	Kendra Thomas: Counsel	12/2023
Department Review	Luming Li: Chief Medical Ofcr (1101 1817) [AP]	12/2023
Initial Assignment	Luming Li: Chief Medical Ofcr (1101 1817) [AP]	12/2023

EXHIBIT G-9

Status **Pending** PolicyStat ID **14433297**

Origination	02/2016
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2023
Next Review	1 year after approval
Owner	Gertrude Leidich: Vice President Clinical Transformation and Quality
Area	Medical Services
Document Type	Agency Policy

MED.PHA.A.3 - Pharmaceutical Representatives Policy

1. PURPOSE:

To provide guidelines for the activities of pharmaceutical representatives as they relate to The Harris Center associated matters.

2. POLICY:

It is the policy of The Harris Center to ensure positive, constructive, and objective relationship activities between The Harris Center and Pharmaceutical Company representatives. Pharmaceutical Representative's access to clinical sites and The Harris Center personnel shall occur on a scheduled basis as approved by the Harris Center Chief Medical Officer or Divisional VPs of Medical Services. These activities include, but are not limited to, the review of product information, sponsorship of medical education, coordination of studies for new and existing drugs and products, and responses to requests for procurement or recall of specific products.

The Harris Center personnel are strictly prohibited from accepting any form of gifts, courtesies, meals, or remuneration in any amount from pharmaceutical company representatives. The Harris Center personnel are required to immediately report any form of employment with pharmaceutical companies, including payments for speaking fees, travel, or food, on behalf of pharmaceutical companies, to their immediate supervisor and complete the Outside Practice Questionnaire for Licensed or Non-Licensed Staff.

3. APPLICABILITY/SCOPE:

All Harris Center employees, contractors, interns, volunteers, and programs.

4. RELATED POLICIES/FORMS (for reference only):

Outside Practice for Employees of the Harris Center form
Outside Practice for Non-licensed Personnel of the Harris Center form

5. PROCEDURES:

Pharmaceutical Representatives Procedure

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

CARF Section 2E

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Final Legal Review	Kendra Thomas: Counsel	10/2023
Department Review	Luming Li: Chief Medical Ofcr (1101 1817)	10/2023
Initial Assignment	Gertrude Leidich: Vice President Clinical Transformation and Quality	10/2023

EXHIBIT G-10

Status **Pending** PolicyStat ID **14490077**

Origination	07/2008
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/2023
Next Review	1 year after approval

Owner	Tanya White: Mgr
Area	Medical Services
Document Type	Agency Policy

MED.PHA.A.4 - Pharmacy and Unit Medication/Drug Inventory

1. PURPOSE:

To establish a uniform policy to control and account for all medications received, dispensed, and destroyed by the pharmacy.

2. POLICY:

It is the policy of The Harris Center to account for stock supplies of prescription drugs and at a minimum, conduct inventory twice per year. The Harris Center pharmacies shall maintain records of all pharmacy transactions in accordance with legal requirements. In order to control and account for all medication, these records shall include documentation of the receipt and delivery of prescription drugs as well as those dispensed.

The Harris Center units may maintain stock supplies of medications for consumer use as deemed appropriate by The Pharmacy and Therapeutics Committee. Any medication stocked by a unit will be the responsibility of the Unit's Lead Psychiatrist.

3. APPLICABILITY/SCOPE:

All Harris Center ~~Mental Health~~mental health and IDD service sites, clinics, treatment programs, residential care programs~~,~~ and pharmacies.

4. PROCEDURES

A. Clinic Pharmacies Inventory (AMH)

B. Clinic Nurses' Station Inventory (AMH) C. IDD Residential Units' Inventory

5. RELATED POLICIES/FORMS ~~(for reference only)~~:

MED.PHA.A.2 Medication Storage, Preparation, and Administration Areas

~~6. PROCEDURES:~~

~~A. Clinic Pharmacies Inventory (AMH)~~

~~B. Clinic Nurses' Station Inventory (AMH)~~

~~C. IDD Residential Units' Inventory~~

7. REFERENCES~~:~~ /RULES/REGULATIONS/ STANDARDS:

- Controlled Substances Act, 21 U.S.C. §§827, 842, 958(d)
- Tex. Controlled Substances Act, Tex. Health & Safety Code §481.067
- Pharmacies-All Classes of Pharmacies-Inventory Requirements, 22 Tex. Admin. Code §291.~~14~~17
- The Harris Center's Policy and Procedure Handbook CARF Section 2E

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Final Legal Review	Kendra Thomas: Counsel	11/2023
Department Review	Luming Li: Chief Medical Ofcr (1101 1817)	10/2023
Initial Assignment	Tanya White: Mgr	10/2023

EXHIBIT G-11

Status **Pending** PolicyStat ID **14496189**

Origination	09/2018	Owner	Keena Pace: Exec
Last Approved	N/A	Area	Assessment, Care & Continuity
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

ACC.A.2 Plan of Care

1. PURPOSE:

To ensure the development of a comprehensive person-centered plan based on client, family/legal guardian input, assessments, and narrative summaries.

2. POLICY:

It is the policy of The Harris Center for Mental Health and IDD (The Harris Center) to ensure every client served will be an active participant in the development of his or her Person-Centered Plan in conjunction with his/her assigned interdisciplinary treatment team.

3. PROCEDURES:

Plan of Care

4. APPLICABILITY/SCOPE:

This applies to all of The Harris Center Programs/Units that provide services.

5. RELATED POLICIES/FORMS (for reference only):

- Person and Family Centered Recovery Plan
- Individual Plan of Care
- Safety Plan

- Person Directed Plan
- Progress Notes

~~6. PROCEDURES:~~

~~Plan of Care~~

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- IDD-BH Contractor Administrative Functions, Mental Health Community Services Standards-Standards of Care, 26 Tex. Admin. Code Ch. 301, Subchapter G
- Behavioral Health Delivery System, Standards for Services to Individuals with Co-Occuring Psychiatric and Substance Use Disorders-Screening, Assessment, & Treatment Planning, 26 Tex. Admin. Code, Chapter 306, Subchapter A
- Behavioral Health Delivery System, Mental Health Rehabilitative Services, 26 Tex. Admin. Code Ch. 306, Subchapter F
- Roles and Responsibilities of a Local Authority, 40 Tex. Admin. Code Ch. 2, Subchapter G
- Home Community-Based Services (HCS) and Community First Choice (CFC), 40 Tex. Admin. Code, Part 1, Chapter 9, Subchapter D
- Texas Home Living Program and Community First Choice Program (CFC), 40 Tex. Admin. Code, Part I Chapter 9, Subchapter N.

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Legal Review	Kendra Thomas: Counsel	11/2023
Departmental Review	Keena Pace: Exec	10/2023
Initial Assignment	Keena Pace: Exec	10/2023

EXHIBIT G-12

Status **Pending** PolicyStat ID **14627509**

Origination	11/2012
Last Approved	N/A
Effective	Upon Approval
Last Revised	01/2023
Next Review	1 year after approval
Owner	Kendra Thomas: Counsel
Area	Environmental Management
Document Type	Agency Policy

EM.A.5 Reporting Automobile Accidents

1. PURPOSE:

Ensure all motor vehicular accidents are documented and reported.

2. POLICY:

It is the policy of The Harris Center for Mental Health and IDD (Harris Center) that any accident involving a Harris Center vehicle, or personal vehicle used in the course and scope of Harris Center business shall be reported immediately upon discovery to the appropriate Harris Center personnel, the police and other law enforcement officials having jurisdiction.

3. APPLICABILITY/SCOPE:

This policy applies to all Harris Center Staff, contractors, volunteers, and interns.

4. RELATED POLICIES/FORMS (for reference only):

- Employee On-The-Job Inquiries and Illnesses
- Supervisor's Accident Report
- Incident Reporting

5. PROCEDURES:

6. REFERENCES: RULES/REGULATIONS/ STANDARDS:

- The Harris Center Policy and Procedure Handbook

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	12/2023
Legal Review	Kendra Thomas: Counsel	11/2023
Initial Assignment	Kendra Thomas: Counsel	11/2023

EXHIBIT G-13

Status **Pending** PolicyStat ID **14496192**

Origination	05/2020	Owner	Shiela Oquin: ExecAsst
Last Approved	N/A	Area	Assessment, Care & Continuity
Effective	Upon Approval	Document Type	Agency Policy
Last Revised	10/2023		
Next Review	1 year after approval		

ACC.A.15 - Supervision of Peer Specialists

1. PURPOSE:

To ensure effective supervision of Peer Specialists across all divisions and programs at The Harris Center.

2. POLICY:

It is the policy of The Harris Center to provide supervision to all Peer Specialists consistent with state rules and laws. Peer Specialist supervision must focus on peer specialists' provision of services, including review of cases and activities, skill building, problem resolution, and professional growth. Supervision may also include aspects specific to ~~The~~the Harris Center, such as following organizational policy or other administrative matters.

3. PROCEDURES:

Supervision of Peer Specialists

4. APPLICABILITY/SCOPE:

This policy will apply to all Peer Specialists across all divisions and programs at The Harris Center.

5. ~~RELATED POLICIES/FORMS (for reference only):~~RELATED POLICIES/FORMS:

- Supervision Verification Form

- Direct Hours Tracking/Supervised Work Experience Form
- ACC18B Supervision of Peer Specialists Procedure

~~6. PROCEDURES:~~

~~Supervision of Peer Specialists~~

7. REFERENCES: RULES/REGULATIONS/ STANDARDS:

Peer Specialists, Texas Government Code §531.0999
Medical Assistance Program, Texas Human Resources Code §32.024(kk)
Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter N

Approval Signatures

Step Description	Approver	Date
Management of Board Approval	Christopher Webb: Audit	Pending
CEO Approval	Wayne Young: Exec	10/2023
Legal Review	Kendra Thomas: Counsel	10/2023
Departmental Review	Keena Pace: Exec	10/2023
Initial Assignment	Shiela Oquin: ExecAsst	10/2023