CENTRAL HEALTH

Our Vision
Central Texas is a model healthy community.

Our Mission
By caring for those who need it most, Central Health improves the health of our community.

Our Values
Central Health will achieve excellence through:
Stewardship - We maintain public trust through fiscal discipline and open and transparent communication.
Innovation - We create solutions to improve healthcare access.
Right by All - By being open, anti-racist, equity-minded, and respectful in discourse, we honor those around us and do right by all people.
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EXECUTIVE COMMITTEE MEETING
Wednesday, September 9, 2026 4:00 p.m.

Videoconference meeting[1]

A quorum of the Committee and the presiding officer will be present at:

Central Health Administrative Offices
1111 E. Cesar Chavez St.
Austin, Texas 78702
Board Room

Links to livestream video are available at the URL below (copy and paste into your web browser):
https://www.youtube.com/@tchealthdistrict/streams

The Committee may meet via videoconference with a quorum present in person and will allow public participation via videoconference and telephone as allowed under the Open Meetings Act. All members of the public are free to observe the meeting through the YouTube link provided above and to participate in public comment, if desired, according to the instructions below.

A member of the public who wishes to make comments virtually during the Public Communication portion of the meeting must properly register with Central Health **no later than 2:30 p.m. on September 9, 2026**. Registration can be completed in one of three ways:

- Complete the virtual sign-in form at https://www.centralhealth.net/meeting-sign-up/;
- Call 512-978-9190. Please leave a voice message with your full name and your request to comment via telephone at the meeting; with the name of the meeting at which you wish to speak; or
- Sign-in at the front desk on the day of the meeting, prior to the start of the meeting.

Individuals who register to speak on the website or by telephone will receive a confirmation email and/or phone call by staff with instructions on how to join the meeting and participate in public communication.

PUBLIC COMMUNICATION

Public Communication rules for Central Health Board and Committee meetings include setting a fixed amount of time per person to speak and limiting Board and Committee responses to public inquiries, if any, to statements of specific factual information or existing policy. The Public Communication portion of the meeting will begin at approximately 4:00 p.m.

REGULAR AGENDA[2]

1. Approve the minutes of the Central Health Executive Committee June 10, 2026 meeting. (*Action Item*)

2. Receive and discuss a report from the Board Chair including:
   a. Board meeting mechanics and governance updates; and
   b. Tentative schedules. (*Informational Item*)

3. Discuss and take appropriate action on a Central Health System Artificial Intelligence Oversight and Governance Policy. (*Action Item*)

4. Discuss and take appropriate action on a Central Health System Immunization Policy. (*Action Item*)

5. Discuss and take appropriate action on the process for Central Health Appointments to the Integral Care Board of Directors. (*Action Item*)

6. Review, discuss, and take appropriate action on a presentation from the Central Health Chief Compliance Officer regarding the process and timing for Board review and approval of District policies. (*Action Item*)

7. Discuss and take appropriate action regarding a compliance update by the Chief Compliance Officer and receive a report from the Chief Compliance Officer regarding a pending investigation.[3,4] (*Action Item*)

8. Discuss and take appropriate action on the recommended Central Health Bylaws amendments.[3] (*Action Item*)

9. Review and take appropriate action on the policies necessary for the FY27 budget development process including:
   a. General Procurement, and
   b. Delegation of Purchasing Duties to Purchasing Authority and Certain Officers.[3] (*Action Item*)

10. Confirm the next regular Executive Committee meeting date, time, and location. (*Informational Item*)

Notes:

[1] This meeting may include one member of the Executive Committee participating by videoconference. It is the intent of the residing officer to be physically present and preside over the meeting at Central Health Administrative Offices, 1111 E. Cesar Chavez St., Austin, TX 78702, Board Room. This meeting location will be open to the public during the open portions of the meeting, and any member participating by videoconference shall be both visible and audible to the public whenever the member is speaking.

[2] The Executive Committee may take items in an order that differs from the posted order and may consider any item posted on the agenda in a closed session if the item involves issues that require consideration in a closed session and the Committee announces that the item will be considered during a closed session. A quorum of Central Health's Board of Managers may convene or participate via videoconference to discuss matters on the Committee agenda. However, Board members who are not Committee members will not vote on any Committee agenda items, nor will any full Board action be taken.

[3] Possible closed session discussion under Texas Government Code §551.071 (Consultation with Attorney).

[4] Possible closed session discussion under Texas Health and Safety Code §161.032(b)(2) (Records and Proceedings Confidential).

Any individual with a disability who plans to attend this meeting and requires auxiliary aids or services should notify Central Health at least two days in advance, so that appropriate arrangements can be made. Notice should be given to the Board Governance Manager by telephone at (512) 978-8049.

Cualquier persona con una discapacidad que planee asistir o ver esta reunión y requiera ayudas o servicios auxiliares debe notificar a Central Health con la mayor anticipación posible de la reunión, pero no menos de dos días de anticipación, para que se puedan hacer los arreglos apropiados. Se debe notificar al Gerente de Gobierno de la Junta por teléfono al (512) 978-8049.

Consecutive interpretation services from Spanish to English are available during Public Communication or when public comment is invited. Please notify the Board Governance Manager by telephone at (512) 978-8049 if services are needed.

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Came to hand and posted on a Bulletin Board in the County Recording Office, Austin, Travis County, Texas on this the 02 day of September 2026

Dyana Limon-Mercado
County Clerk, Travis County, Texas

By Kayla Lopez Deputy

KAYLA LOPEZ

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 1

Approve the minutes of the Central Health Executive Committee June 10, 2026 meeting. (*Action Item*)

MINUTES OF MEETING – JUNE 10, 2026
CENTRAL HEALTH
EXECUTIVE COMMITTEE

On Wednesday, June 10, 2026, a meeting of the Central Health Executive Committee convened in open session at 5:09 p.m. remotely by toll-free videoconference and in person at the Central Health Administrative Offices. Clerk for the meeting was Briana Harris.

Committee members present in-person at Central Health: Chair Rodriguez, Vice Chair May, Treasurer Museitif, and Secretary Martin

Board members present via audio and video or in person: Manager Jefferson (online) and Manager Kitchen (online)

Absent: Motwani

COMMITTEE AGENDA

1. Approve the minutes of the Central Health Executive Committee May 13, 2026 meeting.

Clerk's Notes: Discussion on this item began at 5:09 p.m.

Manager May moved that the Committee approve the minutes of the Central Health Executive Committee May 13, 2026 meeting.

Manager Museitif seconded the motion.

Chairperson Geronimo Rodriguez	For
Vice Chairperson Eliza May	For
Treasurer Maram Museitif	For
Secretary Manuel Martin	For

2. Receive and discuss a report from the Board Chair including:
- **a. Board meeting mechanics and governance updates;**
- **b. Tentative schedules; and**
- **c. Texas Healthcare Trustees, Healthcare Governance Conference key takeaways.**

Clerk's Notes: Discussion on this item began at 5:10 p.m. Chairperson Rodriguez shared Board meeting mechanics and governance updates, the tentative schedules, and asked those who attended the Healthcare Governance Conference to share their key takeaways.

3. Receive and discuss a resolution approving an amendment to the Bylaws of Sendero Health Plans, Inc., regarding ex officio members of the Sendero Board of Directors.

Clerk's Notes: Discussion on this item began at 6:38 p.m. Chairperson Rodriguez presented a Resolution approving an amendment to the Bylaws of Sendero Health Plans, Inc.

4. Discuss Central Health owned or occupied real property and potential property for acquisition, lease, or development in Travis County, including next steps in the redevelopment of the Central Health Downtown Campus, administrative offices of Central Health Enterprise partners, and new developments in Eastern Travis County.

Clerk's Notes: Discussion on this item began at 6:41 p.m.

At 6:41 p.m. Chairperson Rodriguez announced that the Committee was convening in closed session to discuss agenda item 4 under Texas Government Code §551.072. Deliberation Regarding Real Property) and/or Texas Government Code §551.071 (Consultation with Attorney).

At 8:28 p.m. the Committee returned to open session.

5. Receive a briefing and take appropriate action on issues related to *Travis County Healthcare District d/b/a Central Health v. Ascension Texas f/k/a Seton Healthcare Family,* Cause No. D-1-GN-23-000398.

Clerk's Notes: Discussion on this item began at 6:41 p.m.

At 6:41p.m. Chairperson Rodriguez announced that the Committee was convening in closed session to discuss agenda item 5 under Texas Government Code §551.071 (Consultation with Attorney).

At 8:28 p.m. the Committee returned to open session.

6. Deliberation and possible action on the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of one or more Central Health employees.

Clerk's Notes: Discussion on this item began at 6:41p.m.

At 6:41 p.m. Chairperson Rodriguez announced that the Committee was convening in closed session to discuss agenda item 6 under Texas Government Code §551.071 (Consultation with Attorney) and Texas Government Code §551.074 (Personnel Matters).

At 8:28 p.m. the Committee returned to open session.

7. Confirm the next regular Executive Committee meeting date, time, and location.

Manager Museitif moved that the meeting adjourn.

Manager Valadez seconded the motion.

Chairperson Geronimo Rodriguez	For
Vice Chairperson Eliza May	For
Treasurer Maram Museitif	For
Secretary Manuel Martin	For

The meeting was adjourned at 8:29 p.m.

ATTESTED TO BY:

Geronimo Rodriguez, Chairperson
Central Health Executive Committee

Manuel Martin, Secretary
Central Health Board of Managers

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 2

Receive and discuss a report from the Board Chair including:
a. Board meeting mechanics and governance updates; and
b. Tentative schedules. (*Informational Item*)

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	September 9, 2026
Who will present the agenda item? (Name, Title)	Chair Rodriguez
General Item Description	Receive and discuss a report from the Board Chair including: ○ Board meeting mechanics and governance updates and ○ Tentative schedules
Is this an informational or action item?	Informational Item
Fiscal Impact	
Recommended Motion (if needed – action item)	

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Chair Rodriguez will give a verbal update.
2)
3)

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Verbal Update
Estimated time needed for presentation & questions?	10 minutes
Is closed session recommended? (Consult with attorneys.)	No
Form Prepared By/Date Submitted:	Valerie Guerra / September 2, 2026

Meeting	DATE	AGENDA ITEM	CONSENT/INFO/ ACTION
Community Event	9/12/2026	Vivir Con Ganas	
TCCC	9/15/2026	Travis County Commissioners Budget Vote	
Retreat	9/19/2026	Central Health Strategic Planning Retreat	Informational
Budget and Finance Committee	9/23/2026	Approve the minutes of the August 12 and 26, 2026 Budget and Finance Committee meeting.	Action
Budget and Finance Committee	9/23/2026	Receive August 2026 financial statements for Central Health.	Informational
Budget and Finance Committee	9/23/2026	Receive August 2026 financial statements for CommUnityCare Health Centers.	Informational
Board of Managers	9/23/2026	Approve the minutes of the Board of Managers September 9, 2026 meeting.	Consent
Board of Managers	9/23/2026	Receive and ratify Central Health investments for August 2026.	Consent
Board of Managers	9/23/2026	Receive the August 2026 financial statements for Central Health.	Consent
Board of Managers	9/23/2026	Discuss and take appropriate action on a Central Health System Artificial Intelligence Oversight and Governance Policy.	Consent
Board of Managers	9/23/2026	Discuss and take appropriate action on the recommended Central Health Bylaws amendments.	Consent
Board of Managers	9/23/2026	Review and take appropriate action on the policies necessary for the FY27 budget development process including: General Procurement, and Delegation of Purchasing Duties to Purchasing Authority and Certain Officers.	Consent
Board of Managers	9/23/2026	Discuss and take appropriate action on a Central Health System Immunization Policy.	Consent
Board of Managers	9/23/2026	Review, discuss, and take appropriate action on a presentation from the Central Health Chief Compliance Officer regarding the process and timing for Board review and approval of District policies.	Consent
Board of Managers	9/23/2026	Discuss and take appropriate action regarding a compliance update by the Chief Compliance Officer, and receive a report from the Chief Compliance Officer regarding a pending investigation.	Consent
Board of Managers	9/23/2026	Receive and discuss a report from the Board Chair including: a. Board meeting mechanics and governance updates b. Tentative schedules	Informational
Board of Managers	9/23/2026	Receive and discuss a report from the President & CEO including: a. Strategic Board Alignment; b. Clinical Excellence; c. Financial Sustainability; and d. People and Community.	Informational
Board of Managers	9/23/2026	Receive an update from The University of Texas at Austin Dell Medical School on current and future collaborations with Central Health, care and services provided consistent with Central Health's mission, and related reporting for the current fiscal year.	Informational
Board of Managers	9/23/2026	Approve 2027 meetings calendar	Action
Board of Managers	9/23/2026	Discuss and take appropriate action regarding an update on information related to Central Health Enterprise compensation philosophy.	Action

Meeting	DATE	AGENDA ITEM	CONSENT/INFO/ ACTION
Board of Managers	9/23/2026	Foundation Board Formation	Action
Board of Managers	9/23/2026	Receive an update on organizational charts for both Central Health and the Central Health System.	Informational
Board of Managers	9/23/2026	Receive an update on the Central Health Chief Legal Officer.	Informational
Board of Managers	9/23/2026	Receive and discuss a briefing regarding Birch, et al. v. Travis County Healthcare District d/b/a Central Health and Dr. Patrick Lee, Cause No. D-1-GN-17-005824 in the 345th District Court of Travis County and services provided by faculty and residents of The University of Texas at Austin Dell Medical School in support of Central Health's mission.	Informational
Board of Managers	9/23/2026	Receive a briefing and take appropriate action on issues related to Travis County Healthcare District d/b/a Central Health v. Ascension Texas f/k/a Seton Healthcare Family, Cause No. D-1-GN-23-000398.	Informational
Board of Managers	9/23/2026	Deliberation and possible action on the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of one or more Central Health employees.	Informational

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 3

Discuss and take appropriate action on a Central Health System Artificial Intelligence Oversight and Governance Policy. (*Action Item*)

CENTRAL HEALTH

MEMORANDUM

To: Central Health Board of Managers
From: Jon Morgan, EVP & Chief Operating Officer
John Clark, SVP & Chief Information Officer
Date: September 3, 2026
Re: Artificial Intelligence Oversight and Governance Policy

Board of Managers,

Thank you for your feedback related to the draft AI Oversight and Governance Policy. This memorandum responds to guidance from the previous meeting and provides responses to questions from the Board outlining how the draft policy addresses those key issues.

Central Health System Approach

As AI becomes more common across clinical, coverage, operational, administrative, and workforce activities, it offers opportunities to improve access to information, reduce manual work, and support better decisions. However, AI must be guided by clear expectations for safety, privacy, accountability, and human oversight. To support this, leaders across Central Health, CommUnityCare, and Sendero are developing a system-wide approach to create a shared oversight framework, common policy foundation, and standard operating procedures for responsible AI adoption.

Central Health, CommUnityCare, and Sendero operate within a shared technology environment and infrastructure. Because AI technologies can impact systems, data, cybersecurity, privacy, and operations across entity boundaries, a coordinated approach to AI oversight is both practical and necessary. A system-wide approach allows the entities to leverage shared resources, avoid duplicative structures, and apply consistent standards for the responsible evaluation, adoption, and oversight of AI technologies.

Accordingly, the policy was intentionally developed as a shared framework that establishes common oversight, standards, risk assessment methodologies, escalation pathways, and oversight principles across all three entities. This approach promotes consistency while allowing each organization to pursue AI initiatives that align with its unique mission, operational objectives, and strategic priorities. While the policy was developed collaboratively, each entity will review and approve the policy through its own governance and approval processes.

CENTRAL HEALTH

Legal and Compliance Review and Requirements

This draft policy has been developed and reviewed by the leadership, legal and compliance teams at Central Health and CommUnityCare, as well as Sendero's leadership and compliance team.

As a governmental entity, healthcare provider and health plan, entities within our system operate within a variety of federal and state requirements governing privacy, security, transparency, nondiscrimination, and the use of AI-enabled technologies. Because we share many aspects of our technology infrastructure our system-wide policy must take each entity's unique requirements into consideration. These responsibilities are reflected throughout the policy through requirements for risk assessment, human oversight, regulatory review, escalation processes, vendor accountability, monitoring, and ongoing oversight.

Human Oversight

A core safeguard in the policy is that AI may support decisions, but it may not replace the people responsible for making them. AI technologies may help with analysis, recommendations, workflow efficiency, and access to information; however, they do not replace professional judgment or organizational responsibility.

Qualified team members remain responsible for decisions informed by AI, and appropriate human oversight is required throughout the AI lifecycle. This expectation protects patient safety, maintains accountability, and reinforces that AI is a tool to support human expertise rather than replace it.

These principles are embedded throughout the policy and are specifically reflected in the General Principles section (Section VII.A.1) and the Prohibited AI Uses section (Section VII.C.3), which state that AI systems shall not replace human judgment in clinical decision-making and must include appropriate human oversight.

Prohibited Use (Shadow IT)

The policy also establishes clear guardrails around prohibited uses of AI, including autonomous clinical judgment without appropriate healthcare provider review, autonomous coverage denials without human oversight, generation of false or misleading information, use of public AI tools with PHI or PII, bias amplification or discrimination, and circumvention of security or privacy controls. Section VII.C.3 outlines these prohibited AI uses in detail. These requirements are important because they help educate staff, reduce the risk of unapproved or unsafe AI use, and protect patients, members, the workforce, and the organization.

AI Risk Management

Section VII.C.4, AI Risk Management, establishes a risk-tiered approach to AI oversight. In practical terms, this means AI tools are not all treated the same; they are reviewed based on how much risk they may create and how significantly they could affect patients, members, staff, operations, privacy, security, or decision-making. AI systems that require heightened scrutiny must complete a documented risk assessment before deployment and whenever material changes occur.

The section also describes the controls needed to manage AI-related risks throughout the AI lifecycle. These controls include security and privacy reviews, protections for sensitive information, review of third-party vendors, validation of AI-generated outputs, human oversight, ongoing monitoring, auditability, and transparency. Together, these requirements help ensure AI systems are deployed responsibly, remain secure and reliable, protect patient and member information, and continue to align with organizational, regulatory, and ethical expectations.

Please see attachment for additional information regarding identified risk categories and risk mitigation approaches outlined within the policy.

Training Requirements

The Texas Department of Information Resources requires covered entities to complete annual AI training, and Central Health must meet this requirement. The training also serves a practical purpose: it helps ensure staff understand the expectations, risks, and responsibilities associated with AI before using these tools in the Central Health System environment. In addition to annual training, vendor-specific training will be provided when AI-enabled tools are selected so end users understand how the tool works, what limitations or risks to watch for, and how to escalate concerns when needed.

AI Use Cases

During the Board discussion, two examples were identified: AI capabilities related to HR recruitment and benefits, and AI-enabled software that could support Board meeting transcription, notes, or summaries. These examples illustrate the broad range of ways AI may be used across the organization. Rather than addressing individual technologies or use cases, the policy establishes a consistent framework for evaluating, approving, and overseeing AI use regardless of where it is deployed. This approach allows the organization to apply common standards for risk management, privacy, security, accountability, and human oversight across existing and future AI-enabled capabilities.

Executive Sponsors and Business Owners remain key drivers of responsible AI adoption. Their role is to ensure that AI use cases align with organizational and entity-level strategic priorities, are appropriately integrated into workflows, deliver measurable value, and remain subject to ongoing oversight within their areas of responsibility. This helps ensure AI is used in ways that support patient, member, workforce, and community needs rather than creating barriers to accessing care, coverage, or services.

AI capabilities are already present in parts of the current environment, including call center technologies, the electronic medical record, Microsoft 365, and Copilot-enabled tools that support administrative work. The framework is intended to bring both existing and future use cases under a consistent review process so each tool is evaluated based on its risk level, data use, privacy and security requirements, need for human oversight, operational impact, and alignment with organizational priorities.

Closing

The AI policy creates a consistent foundation for evaluating, adopting, overseeing, and continuously improving AI capabilities across our system. It supports responsible innovation while reinforcing accountability, transparency, quality, equity, privacy, security, and public trust. Through this system-wide approach, Central Health, CommUnityCare, and Sendero Health Plans are positioned to use AI in a coordinated and responsible way that remains grounded in mission and focused on meaningful value for the communities we serve.

CENTRAL HEALTH
TRAVIS COUNTY HOSPITAL DISTRICT

Risk Category	Risk Description	Key Guardrails in the Policy
Bias & Health Equity	AI produces disparate outcomes across demographic, socioeconomic, or vulnerable populations.	AI impact Assessment; Health Equity impact evaluation; AI Risk Management; fairness, equity and bias mitigation; Protected Groups; periodic reviews. [Sections III, IV, VII (A), VII (C) (4), VII (B) (5)]
Autonomous Decisions	AI agents perform actions or make consequential decisions without sufficient oversight.	Prohibited AI Uses; Technical and administrative Controls; Human-in-the-loop requirements; approval process; defined authority limits; escalation pathway; Heightened Scrutiny AI System. [Sections III, VII (C) (3), VII (C) (4)]
AI Incident Management & Reporting	Failure to identify, investigate, document, escalate, and report AI-related incidents, model failures, safety events, privacy breaches, or vendor incidents.	Incident reporting; escalation procedures; Vendor requirements for AI. [Sections III, VII (C) (4), VII (C) (4) (F)]
Clinical Safety	AI recommendations influence diagnosis, treatment, care management, or patient prioritization incorrectly.	Human clinicians remain final decisionmaker; validation before deployment; clinical oversight requirements. [Sections IV, VII (A) (1), VII (C) (3), VII (C) (4) (E)]
Shadow AI & Workforce Training	Employees use unsanctioned AI applications or misuse approved tools.	AI training; AI acceptable use guidelines; Risk Mitigation for AI Ecosystem. [Sections IV, VII (A) (9), VII (C) (4)]
Regulatory & Legal Compliance	Non-compliance with HIPAA, SaMD, 1 TAC 219, Texas AI regulations, or healthcare standards.	General Principles; Regulatory and compliance monitoring; legal review; documentation and approvals; policy accountability. [Sections VII (A), VII (C) (2), VII (C) (4) (B) (ii), VII (C) (5)]

Risk Category	Risk Description	Key Guardrails in the Policy
Privacy, PII & PHI Exposure	Unauthorized disclosure of PHI, PII, employee, or confidential organizational information through AI systems.	Prohibited AI Uses; Risk Mitigation for AI Ecosystem; DLP controls; sensitive data filtering; Privacy and Data Protection; audit logging; BAAs. [Sections VII (C) (3), VII (C) (4)]
Cybersecurity Threats	AI-related vulnerabilities such as prompt injections, unauthorized access, or data exfiltration.	DLP Controls, System's Privacy Policies, Data Use Standards; Security and Resilience; AI performance monitoring; access controls; vendor security, privacy, legal and procurement review & assessments. [Sections VII (A) (9), VII (C) (4) (D), VII (C) (4) (F)]
Model Drift & Performance Decay	AI accuracy declines as conditions, data, workflows, or populations change.	Continuous monitoring AI performance; Detection and Response; vendor requirements; Audit Rights governance and oversight. [Sections VII (A) (8), VII (C) (4) (B) (iii), VII (C) (4) (F)) (iii), VII (C) (4) (e), VII (C) (5)]
Governance & Accountability	AI initiatives lack ownership, oversight, or documentation.	System AI Council; Risk-tiering; Risk mitigation documentation and escalation pathway; Infrastructure Standards; Information Security Policies; Data protection Processes; Cyber Security controls and acceptable use guidelines; business-owner accountability; oversight process. [Sections VII (A), VII (B), VII (A), VII (A) (9), VII (B) (3)]
Transparency & Explainability	Users cannot understand how AI recommendations were produced.	Model documentation; Explainable outputs; Versioning and Reproducibility. [Sections VII (C) (2), VII (C) (3) (c), VII (C) (4) (e), VII (C) (4) (f)]
Adversarial Manipulation & Unsafe Model Behavior	Risks from jailbreaks, malicious inputs, unsafe tool execution, unintended agent actions, and manipulation of AI behavior.	Zero-trust approach; input validation; output filtering; human authorization for high-risk actions; anomaly detection; adversarial testing; least-privilege access; monitoring of tool use and intermediate actions.

Risk Category	Risk Description	Key Guardrails in the Policy
		[Sections VII (C) (4) (C) (iii) (d), VII (C) (4) (c) (i), VII (C) (4) (B) (iii), VII (C) (4) (C) (iii)]
Operational Value Realization & Efficiency Risk	AI systems fail to deliver expected outcomes, ROI, efficiency gains, scalability, or business value relative to cost and operational burden.	Defined ROI metrics; AI Impact Assessment for benefit realization; periodic business reviews; performance tracking; decommissioning criteria; executive sponsor accountability. [Sections III, VII (B) (3), VII (C) (5) (b) (i)]
Resilience, Disaster Recovery & Business Continuity	AI system failures, outages, dependencies, or disruptions that impact operations or patient/member services.	Disaster recovery plans; business continuity; adversarial testing; Model versioning and reproducibility; Joint Tech Infrastructure Standards; System dependency mapping. [Sections VII (A) (9), VII (C) (4) (c)]
Legal & Intellectual Property Risk	Unauthorized use of copyrighted, proprietary, licensed, or third-party confidential information in AI systems, as well as legal exposure from AI-generated content.	Authorization before uploading copyrighted/proprietary data; AI IP Training; Legal review where required; content review prior to publication; IP ownership rights. [Sections VII (C) (4) (b) (ii), VII (C) (4) (f)]
Third-Party Vendor Risk	External AI vendors lack adequate transparency, security, or oversight.	Vendor Requirements for AI; Vendor due diligence; AI risk assessments; audit rights; transparency requirements; contractual safeguards. [Sections VII (C) (4) (b) (iii), VII (C) (4) (f)]
Hallucinations & Inaccuracy	AI generates incorrect, misleading, or fabricated content.	Human verification required; source citation where feasible; user training; testing and validation before use. [Section VII (C) (4) (c) (iv)]

Policy Title: Artificial Intelligence Oversight and Governance Policy		
Policy No.:		
Effective Date: DRAFT		
Last Review Date:		
Policy Owner:		
Executive Sponsor:		
Attachments:		
☒ **Central Health**	☒ **CommUnityCare**	☒ **Sendero Health Plans**

I. PURPOSE

Central Health (CH), CommUnityCare (CUC), and Sendero Health Plans (collectively, the "System") recognizes Artificial Intelligence (AI) as a strategic enabler of operational excellence, workflow productivity, improved access to care, and cost efficiency. This AI Policy ("Policy") establishes a comprehensive framework for the responsible development, procurement, deployment, and use of AI technologies. The Policy is necessary to ensure the safety of our patients, as well as our health plan members and healthcare coverage enrollees (collectively, "participants"), protect privacy, mitigate bias, maintain regulatory compliance, and align AI use with the System's mission to serve underserved populations while responsibly leveraging emerging technologies to improve efficiency, accuracy, and experience for team members, participants, and patients in clinical and administrative operations.

II. SCOPE

This Policy governs AI use across the System: Central Health, CommUnityCare, and Sendero Health Plans and applies to all System employees, learners, volunteers and contractors.

III. DEFINITIONS

- **Agentic AI:** A category of AI Systems capable of autonomously setting goals, planning, and executing multi-step decision making actions, often by combining reasoning, tool use, and workflow orchestration. Examples include interconnected multi agents across AI ecosystem. The System considers Agentic AI to be a Heightened Scrutiny AI System.
- **AI Bias:** When AI Systems produce skewed or unfair results due to bias embedded in their training data, algorithms, or human input, resulting in distorted outputs that disproportionately affect certain groups, perpetuating discrimination, or systemic inequalities.
- **AI Ecosystem:** An end-to-end platform of interconnected technologies, data, tools, people, processes, and governance structures collaboratively enabling the development, deployment, and scaling of AI solutions within the System.

- **AI Impact Assessment:** Systematic evaluation of potential risks, benefits, and ethical implications of an AI System before deployment.
- **AI-related Incident**: An event where the AI System produces materially incorrect information or harmful outputs; is used in violation of this Policy; results in a security or privacy breach (including unauthorized access); demonstrates bias or unfairness requiring intervention; patient, participant, and team members safety is compromised; or the vendor experiences an incident affecting our systems.
- **AI Model:** A component of an information system that implements AI technology and uses computational, statistical, neural networks, deep learning or machine-learning techniques to produce outputs from a given set of inputs.
- **AI System:** Any machine-based system that, for any explicit or implicit objective, infers from the inputs the system receives how to generate outputs, including content, decisions, predictions, or recommendations, that can influence physical or virtual environments.
- **Artificial Intelligence (AI):** Engineered or machine-based systems that generate outputs such as predictions, recommendations, decisions influencing real or virtual environments designed to operate with varying levels of autonomy.
- **Fairness:** Whether the AI System yields equitable outcomes across Protected Groups. Fairness seeks to ensure Protected Groups achieve similar levels of performance as the broader population.
- **Generative AI:** A category of AI Systems capable of creating new content (e.g., text, images, code) based on learned patterns. Examples include GPT, Gemini, and similar technologies.
- **Heightened Scrutiny AI System:** An AI System specifically intended to autonomously make, or be a controlling factor in making, a consequential decision. The term does not include an artificial intelligence system intended to: (i) perform a narrow procedural task; (ii) improve the result of a previously completed human activity; (iii) perform a preparatory task to an assessment relevant to a consequential decision; or (iv) detect decision-making patterns or deviations from previous decision-making patterns.
- **Model Drift**: Degradation of AI Model performance over time as real-world data distributions change.
- **Predictive AI:** A category of AI Systems that uses historical data to identify patterns and forecast future outcomes, behaviors, or risks. Examples include disease progression modeling and Patient Risk Prediction.
- **Protected Groups:** Populations who are at risk of disproportionate harm or marginalization due to characteristics such as race, ethnicity, national origin, gender identity, sexual orientation, age, disability, income, education, or access to healthcare. This includes those who have historically faced barriers to equity and access, as well as those whose representation in data used for AI training is limited, biased, or misrepresented, leading to potential outcome disparities
- **Shadow AI:** The use of AI tools or capabilities by team members, contractors, or third parties for organizational work without approval through established AI governance,

security, and data protection process. Examples include Public AI chatbots, generative AI tools, or AI features embedded within approved software when used outside sanctioned configurations.

IV. POLICY

It is the policy of the System that AI may only be developed, procured, deployed, or used in accordance with this Policy, applicable laws and regulations, and approved oversight processes. AI Systems shall not replace human judgment in clinical decision-making, must include appropriate human oversight, and must be implemented in a manner that protect patients, team members and participants' safety, privacy, equity and organizational integrity.

To the extent applicable to each entity, the System adopts the AI Code of Ethics and shall follow the related ethical principles as established by the Department of Information Resources (DIR) under Chapter 219 of Title 1 of the Texas Administrative Code (1 TAC 2019). Similarly, the System adopts the applicable minimum standards established by the DIR under 1 TAC 219 Subchapter B, including AI Risk Management, AI Risk Assessment for Heightened Scrutiny AI Systems, AI Impact Assessments, and Guidelines for Frameworks, Policies and Trainings.

The implementation of this Policy and the AI lifecycle shall follow the internal processes of each entity.

V. RELEVANT STATUTES, REGULATIONS OR GUIDANCE

- FDA Software as a Medical Device (SaMD) Guidance
- 45 CFR § 92.210
- Health Insurance Portability and Accountability Act (HIPAA)
- National Institute of Standards and Technology (NIST) AI Risk Management Framework (AI RMF 1.0, January 2023)
- NIST Trustworthy and Responsible AI Resource Center (AIRC) (Guidance)
- Texas Business & Commerce Code, Chapters 551 and 552
- Texas Government Code, Chapter 2054
- Texas Health & Safety Code § 183.005
- 1 TAC 219
- Texas Public Information Act
- Commissioner's Bulletin # B-0003-26 (Texas Department of Insurance, June 12, 2026)

VI. RELATED POLICIES AND PROCEDURES

A. AI Lifecycle and Risk Management Standard Operating Procedures (SOP)

VII. PROCESS

A. GENERAL PRINCIPLES

AI is a strategic enabler and should support the core mission of the System. The System recognizes that AI can advance administrative efficiency, workforce productivity, well-being, care access, cost containment, and improved clinical outcomes. Business enablement and value realization must be achieved in conjunction with regulatory compliance and risk management. The development, procurement, and deployment of AI Systems must follow the DIR's AI Code of Ethics, uphold the highest ethical standards and align with organizational values. AI Systems must be evaluated not only for technical performance but also for their impact on health equity and accessibility. AI deployment must not create barriers to the care or services provided to our patients and participants. All AI implementations will be evaluated for alignment with the following principles, as appropriate to the use case and corresponding risk tiers:

1. **Clinical and Patient-centered care and safety:** AI Systems must enhance, not replace, the therapeutic relationship between team members and patients. The deployment and use of AI Systems must not endanger patient safety, compromise quality of care, or create barriers to accessing services.
2. **Non-Clinical and Administrative support services**: AI System must enhance operational efficiency and workforce productivity while maintaining human oversight and accountability.
3. **Fairness, equity, and bias mitigation:** AI Systems must be evaluated for potential bias that could perpetuate or exacerbate health disparities. This includes bias monitoring and mitigation, and evaluation of the AI Systems to detect disparities through review of performance metrics.
4. **Impact and Efficiency:** Impact and efficiency are key to ensuring that the AI Ecosystem delivers measurable benefits. AI Systems within the AI Ecosystem should achieve their intended goals efficiently, considering factors such as resource use, maintainability, and scalability. The System encourages the innovative use of AI within regulatory and ethical frameworks. It is imperative that the use of AI Systems is managed effectively, that the desired outcomes are met, and that the costs of the AI tools do not exceed the benefit.
5. **Transparency:** Patients will be informed of AI use through general consent to treat, and through direct communication when responding to patient questions regarding AI. Additional disclosures will be provided as required by law or clinical context when AI is used directly in diagnosis, treatment, or patient/participant/consumer/public interaction.
6. **Privacy and Data Protection:** Implementation of privacy-by-design principles ensuring that protected health information (PHI) and personally identifiable information (PII) are protected throughout the AI lifecycle.

Team members must ensure that only minimum data necessary for the intended purpose is used when using any AI System.

7. **Accountability and Human Oversight:** Qualified team members must review, validate, and retain ultimate decision-making authority over AI-generated outputs for clinical or operational decisions.
8. **Explainability, Validity, Reliability, and Continuous Monitoring:** AI Systems must demonstrate acceptable levels of accuracy, precision, and reliability for their intended use. We commit to:
    a. Ensuring that AI Systems are validated before deployment where necessary using appropriate test datasets.
    b. Continuously monitoring AI performance in production at defined intervals.
    c. Detecting and responding to Model Drift or performance degradation.
    d. Ensuring that AI Ecosystem are periodically revalidated, and AI Systems are updated as needed.
9. **Security and Resilience:** AI Systems, whether developed internally or procured, must comply with the System's Joint Technology infrastructure standards, information security policies, cyber security requirements, and acceptable use guidelines. Adequate security controls must be implemented to protect both the AI Models themselves and the data they process. Disaster recovery and business continuity plans must account for AI System dependencies.

B. ROLES & RESPONSIBILITIES

1. **System AI Council:** The System AI Council is responsible for the System leadership oversight of AI initiatives to support strategic decision-making, Policy development and prioritization of initiatives that gain efficiency, improve patient, participant, and team member experience while advancing organizational goals, maintaining compliance, avoiding duplication of resources, and monitoring for appropriate use of AI Systems. The System AI Council may create committees and work groups tasked with carrying out specific directives, monitoring compliance, and supporting the Council's strategic priorities. As needed, the System AI Council will report to one or more System executive leadership teams to ensure alignment and sharing of information.

   To promote efficiency and scalability, and to support the rapid testing and adoption of appropriate AI solutions, the System AI Council shall establish a formal delegation framework defining: Risk-based approval tiers; Decision-making authority by role or committee; Clear thresholds for escalation to the Council; and Standard turnaround expectations.
2. **AI Risk Officer:** The AI Risk Officer is responsible for promoting ethical procurement, development, deployment, and use of AI Systems in accordance with the AI Code of Ethics, the NIST AI RMF, and other applicable laws and regulations. If the System deploys a Heightened Scrutiny AI System, the AI Risk

Officer must ensure that a risk assessment is completed, review the assessment, and ensure that the Heightened Scrutiny AI System deployment aligns with the required minimum standards established by 1 TAC 219 and this Policy.

3. **Executive Sponsor and AI Business Owner:** Each approved AI initiative shall designate an Executive Sponsor and an AI Business Owner, who are accountable for value realization, adoption, and tracking performance against defined ROI metrics. The Executive Sponsor and AI Business Owner, in coordination with the Contract Owner are responsible for recommending the decommissioning or modification of an AI System when it fails to deliver sufficient value relative to its cost, risk, or operational burden. The Executive Sponsor and AI Business Owner must ensure business outcome accountability complements clinical accountability and ensure that the AI System remains aligned with strategic and operational objectives. Executive Sponsors and AI Business Owners are responsible for following business case development and submission processes for annual budget cycles or off-cycle proposals.

C. AI USAGE

1. **Purposes:** The System, subject to appropriate governance and oversight, may utilize AI for various purposes including clinical, non-clinical and administrative services and operations. All use cases must have a designated Executive Sponsor and AI Business Owner and must follow the established risk-based approval process, including verification that the AI tool meets applicable regulatory, information security, and compliance requirements. To promote rapid adoption of appropriate AI solutions, reduce approval bottlenecks and align oversight with various risk levels, the System AI Council may delegate approval authority for AI use cases meeting certain criteria to one or more committees or individuals.
2. **Regulatory Requirements and Compliance**. AI Systems must be implemented and used in compliance with all applicable internal policies and procedures, federal and state laws, regulations, and regulatory guidance addressing privacy, data and system security, patient/consumer disclosure and notification, antidiscrimination, bias mitigation, documentation, human oversight, etc. As the healthcare AI legal and regulatory landscape is continuously developing and rapidly evolving, the System will continue to monitor emerging regulations and best practices and ensure alignment.
3. **Prohibited AI Uses**
    a. **Autonomous Clinical Judgement**: Using AI to perform autonomous clinical decision-making without human or the appropriate healthcare provider review or oversight, including diagnoses, treatment recommendations, medication prescribing, or clinical assessments, or to replace required human interaction for counseling, informed consent, or other situations that require direct human judgment, empathy, or patient communication.

b. **Autonomous Coverage Denials:** Autonomous coverage or prior authorization denials without human oversight or review.

c. **Generating False or Misleading Information**: Creating fabricated, inaccurate, misleading or incomplete patient records, test results, clinical documentation or other medical or administrative information.

d. **Use of Public or Free AI Tools (Shadow AI) with PHI/PII:** Uploading, inputting, processing, or otherwise exposing patient information or other PHI to public or free AI tools (e.g., ChatGPT, public Claude, Gemini, or similar tools) that are not covered by an executed Business Associate Agreement (BAA).

e. **Bias Amplification and Discrimination**: Using AI in a manner that introduces, reinforces or amplifies bias, or results in discrimination against individuals or Protected Groups.

f. **Circumventing Security or Privacy Controls:** Using AI to bypass established security or privacy safeguards, or to extract, infer, or reconstruct, or re-identify protected or sensitive data.

4. **AI Risk Management** - The System adopts an AI solution risk-tiering framework that is domain-agnostic and applicable across all areas of the healthcare enterprise, including clinical, administrative, financial, human resources, revenue cycle, compliance, population health, and IT/digital operations.

   a. **AI Risk Assessment for Heightened Scrutiny AI Systems:** AI uses cases classified as Heightened Scrutiny must comply with the requirements outlined in this section, including a written AI risk assessment which must be conducted to consider the probability and severity of harm that could occur as the result of implementation before the System develops, procures, deploys, or uses a Heightened Scrutiny AI System and at the time that a material change is made to the system. The risk assessment shall consider and document:

      i. The Heightened Scrutiny AI System's known security risks and mitigation steps available to limit those risks;

      ii. The performance metrics relating to accuracy and operational efficiency; and

      iii. The Heightened Scrutiny AI System's transparency, including information about the AI System’s algorithms and how the AI System makes decisions, the data used to train the AI Model, and the availability of inputs and outputs to monitor the AI System’s decision-making over time.

      The Business Owner and Executive Sponsor, in consultation with the AI Risk Officer, shall ensure the completion of a written risk assessment prepared for all Heightened Scrutiny AI Systems prior to deployment. Any disagreement shall be addressed through the risk tier escalation pathway.

Each entity shall maintain a record of all completed written risk assessments and all relevant documents as provided in each entity's retention schedule.

b. **Risk Mitigation for AI Ecosystem:**
   i. **Unauthorized Use or Disclosure of Sensitive or confidential information:** Only approved AI tools may be used with organizational data. Users must not enter PHI, PII, or confidential information into unapproved tools.
   ii. **Legal and Intellectual Property risks:** Users are prohibited from uploading proprietary, copyrighted, or third-party confidential information without explicit written authorization. All AI generated content must be reviewed for accuracy, compliance, and appropriateness before use.
   iii. **Third-Party & Vendor Risks:** All AI vendors and services must undergo security, privacy, legal, and procurement review and approval prior to adoption.

c. **Adversarial Manipulation and Unsafe or Unintended Model Behavior:** AI System may be vulnerable to adversarial manipulation, including prompt injection, jailbreaking, and other unsafe or unintended behaviors. Accordingly:
   i. All Predictive AI and Generative AI Systems will be operated under a zero-trust security approach.
   ii. All inputs, outputs, AI Model states, tool invocations, and intermediate actions must be treated as untrusted by default and subjected to defined validation, verification, and monitoring controls prior to use or execution.
   iii. Technical and administrative controls must be implemented and enforced across the AI Ecosystem to detect, prevent, and respond to adversarial or unsafe behavior. Required controls include, at a minimum:
      a. Least-privilege and least-capability access controls for all users, AI Models, tools, service accounts, and data sources, with monitoring across inputs, actions, and outputs.
      b. Human-in-the-loop authorization for high-risk actions, including access to sensitive data or deviations from approved system intent.
      c. Input validation and output filtering to mitigate adversarial manipulation and prevent disclosure of sensitive information.
      d. Abuse prevention and assurance mechanisms, including rate limiting, anomaly detection, and regular security and adversarial testing.
   iv. The following hallucination prevention controls must be implemented to address the risk of AI System susceptibility of producing plausible sounding but factually incorrect information:
      a. All outputs generated by AI must be verified against authoritative and reliable sources.

b. Clinical or patient-related information generated by AI must be reviewed and validated by qualified healthcare professionals prior to use or reliance. Where appropriate, verified source information should be incorporated into prompts or workflow to ground AI outputs in validated data.

c. Confidence scores, uncertainty indicators, or similar reliability signals must be used or disclosed when such functionality is available.

d. **Data Privacy:** The use of AI must comply with all applicable state and federal privacy laws, as well as the System's Privacy Policies, Data Loss Prevention (DLP) controls and data use standards.

e. **Model Versioning and Reproducibility:** To ensure accountability, traceability, and auditability, the version of each AI System or AI Model in use must be documented and maintained. New or updated versions must be tested and evaluated prior to deployment, and AI-generated outputs must be traceable to the specific model version that produced them for audit, investigation, or review purposes. Where feasible, the ability to reproduce historical AI outputs must be preserved.

f. **Vendor Requirements for AI:** Vendors providing AI systems must comply with all applicable regulatory, security, and privacy requirements, including execution of BAAs where required, and implement appropriate safeguards such as encryption and access controls. Vendors are required to provide transparency into AI Systems, including model design, intended use, data sources, limitations, and performance characteristics and to support organizational oversight through audit rights, incident reporting, explainability, and ongoing performance monitoring. Use of organizational data for model training, fine tuning or enhancement requires prior written authorization. Ownership and all intellectual property rights in custom-developed AI solutions must be assigned to the System, and vendors must return or securely delete System's data upon termination. Vendors are required to promptly report security incidents or material model failures.

5. Enforcement And Accountability

a. **Policy Violations:** Violations of this AI Policy may result in disciplinary action in accordance with each entity's policies and procedures, as applicable to the violator. Violations include, but are not limited to:

i. Using unauthorized or unapproved AI tools or AI Systems.

ii. Uploading, inputting, or exposing PHI or PII to unapproved external AI System or services.

iii. Deploying or using AI Systems without required review or approval.

iv. Failing to report known or suspected AI-related Incidents, risks, or misuse.

v. Circumventing established AI governance, security, or privacy controls.

vi. Misrepresenting the capabilities, limitations, or outputs of AI Systems.

b. **Audit Rights:** Each entity reserves the right to do the following within its own organization:
   i. Periodically audit AI Ecosystem and related processes for compliance with this Policy.
   ii. Review AI System documentation, monitoring results, and performance data.
   iii. Conduct vendor audits in accordance with contractual audit rights and applicable agreements.

CENTRAL HEALTH BOARD OF MANAGERS

Artificial Intelligence Oversight and Governance Policy

August 26, 2026

Agenda

01 AI in Healthcare

02 Advancing Our Mission Through Responsible AI

03 Federal, Public-Entity & Healthcare Mandates

04 Evaluation & Monitoring

05 Examples of AI Use Cases

06 Policy Overview

AI Oversight and Governance Policy Overview

POLICY PURPOSE

A system-wide approach and framework for responsible AI — protecting patients, staff, providers & public funds.

KEY POLICY PROVISIONS

System Roles and Responsibility

System AI Council, AI Risk Officer, and Business Owners share defined accountability.

Risk-Tiered Approval

Formal evaluation framework sets risk-based approval tiers and escalation thresholds.

Data, Access Controls & Vendor Oversight

Least-privilege access, zero-trust security, vendor management and PHI/PII safeguards across the AI Ecosystem.

Human Oversight

Qualified staff review, validate, and retain final responsibility over AI-generated outputs.

Prohibited Uses

No autonomous clinical decisions, coverage denials, shadow AI or PHI/PII in public AI tools.

Heightened Scrutiny

AI that autonomously drives consequential decisions requires a written risk assessment before use.

What Is Artificial Intelligence?

At its core, AI refers to computer systems that perform tasks which normally require human intelligence — recognizing patterns, interpreting language, making predictions, and supporting decisions.

1

Learns from data

Rather than following fixed rules, most modern AI improves its performance as it is exposed to more examples.

2

Finds patterns

AI excels at spotting relationships in large, complex datasets that would take humans far longer to identify.

3

Supports, not replaces

In healthcare today, AI is most commonly deployed to support clinicians and staff.

Types of AI, by Functionalities

The building blocks behind the tools described as “AI-powered.”

Automation AI

Uses predefined rules to automate repetitive, manual tasks with little or no decision-making.

Predictive AI

Analyzes historical and real-time data to predict future outcomes, risks, or events.

Generative AI

Creates new content such as text, images, audio, code, summaries, and recommendations based on patterns learned from data

Agentic AI

Plans, reasons, and executes multiple tasks across systems to achieve a defined objective while operating within established guardrails.

Autonomous AI

Independently makes decisions and executes actions with minimal or no human intervention.

The AI Healthcare Landscape

Clinical

Diagnostic Imaging
Ambient Documentation
Clinical Decision Support
Drug Interaction & Dosing Checks

Operational

Revenue Cycle & Coding
Scheduling & Staffing
Patient-Facing Chatbots
Remote Monitoring
Compliance

Autonomous Clinical

Imaging Triage
Clinical Monitoring and Early Warning Systems
Treatment Recommendations
Care Pathway Management

Finance

Finance Planning and Analysis
Procurement and Purchasing

HR and Workforce

Talent Acquisition and Recruiting
Employee Helpdesk
Learning Management

Administrative

Documentation
Scheduling
Workflow Support
Contact Centers
Information Retrieval
Information Technology

Advancing Our Mission Through Responsible AI

01 CURRENT STATE

AI is embedded in the applications, medical devices, provider systems, and administrative tools we use today.

02 OUR RESPONSIBILITY

Protect public trust through responsible oversight and a system-wide approach to AI security.

03 MISSION VALUE

Responsible AI creates opportunities to support strategic priorities across patient access, strengthen care coordination, and increase operational effectiveness.

The Federal Compliance Floor

Federal regulations establish minimum compliance requirements that apply regardless of state law. Five key agencies govern healthcare AI across the Central Health System:

FDA

Regulates clinical AI/ML medical devices and Software as Medical Device (SaMD), with 1,250+ authorized AI-enabled devices

CMS

Oversees Medicare/Medicaid AI applications, prior authorization requirements, and coverage determination processes

ONC

Health IT certification requirements, including EHR-integrated AI transparency mandates effective January 1, 2025

OCR

Enforces Section 1557 nondiscrimination requirements and HIPAA privacy/security rules for AI systems

FTC

Consumer protection authority targeting deceptive AI accuracy claims and unauthorized health data sharing

Public-Entity and Healthcare Mandates

Central Health – as a governmental entity and healthcare provider – is subject to both public-entity and healthcare-specific regulatory obligations.

Governmental / Public-Entity Status

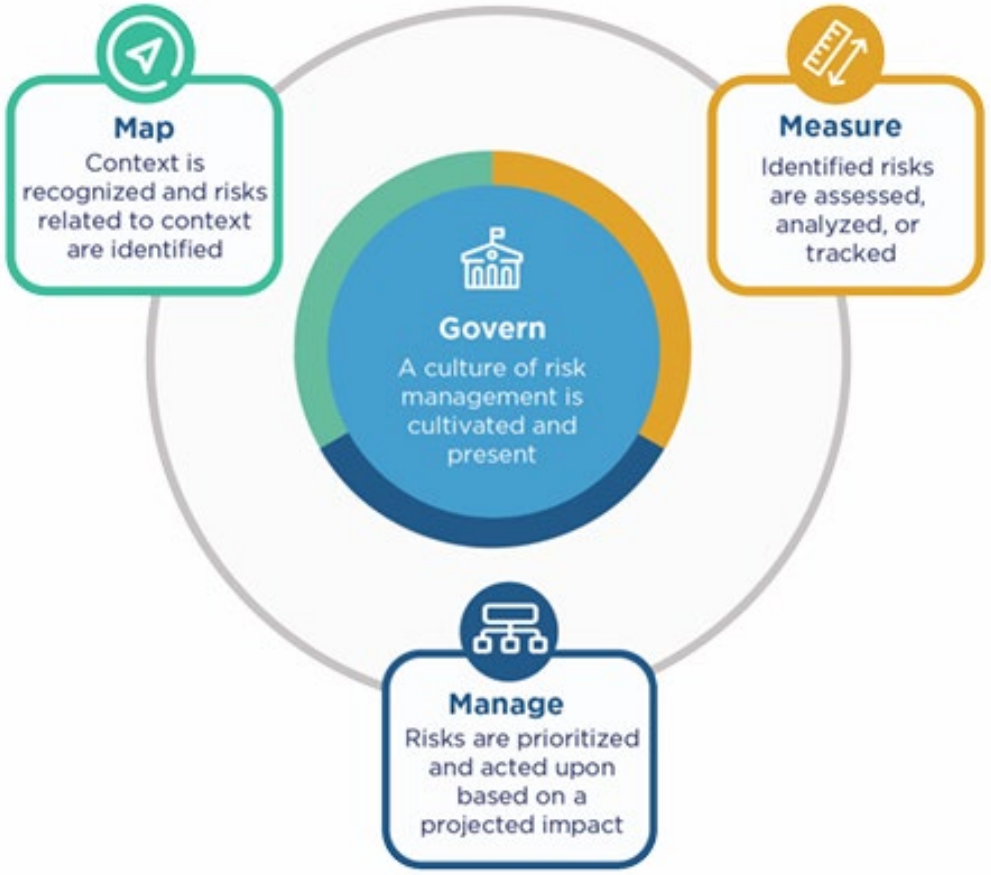
- Texas Public Information Act — open records & transparency
- Texas Government Code, Ch. 2054 — state technology & AI oversight
- 1 TAC 219 — DIR AI Code of Ethics & minimum standards
- Travis County Commissioners Court — budget, tax rate, & board appointment oversight

Healthcare-Specific Regulation

- HIPAA — patient privacy & data security
- FDA Software as a Medical Device (SaMD) Guidance
- 45 CFR § 92.210 — nondiscrimination in health programs
- Texas Health & Safety Code § 183.005 - State requirements for using AI in diagnosis and treatment planning
- Texas Business & Commerce Code, Ch. 551–552 – Consumer and Patient Disclosure

National Institute of Standards and Technology (NIST) AI Risk Management Framework

Our AI Policy is anchored to the NIST AI Risk Management Framework (AI RMF 1.0, Jan. 2023) and the NIST Trustworthy & Responsible AI Resource Center (AIRC) — the standard the System uses to identify, evaluate, and manage AI risk.



WHY THIS MATTERS

Industry Standard: Widely adopted framework across healthcare and technology sectors.

Vendor Alignment: Sets shared expectations with the AI vendors and partners we work with.

Patients & Stewardship: Protects patients and care teams while safeguarding responsible use of public funds.

Vetting and Monitoring Sustain Trustworthy AI

AI tools must continually demonstrate efficacy, fairness, safety, and responsible use.

01 ASSESS BEFORE ADOPTION

Vet the tool, vendor, and intended use before adoption.

- Define use, affected populations, KPIs, and risk tier.
- Validate data sources, privacy, security, and regulatory fit.
- Test performance by population; set approval thresholds.

02 ENABLE CONTROLLED USE

Launch with clear accountability and human authority.

- Assign owners, approvals, audit trails, and escalation triggers.
- Pilot in a controlled environment before phased deployment.
- Train users and preserve human review of consequential outputs.

03 MONITOR AND ACT

Measure outcomes continuously to ensure ongoing efficacy.

- Track efficacy, safety, drift, and disparities across populations.
- Investigate performance gaps and signs of harmful bias.
- Reconfigure, retrain, suspend, or retire when thresholds are missed.

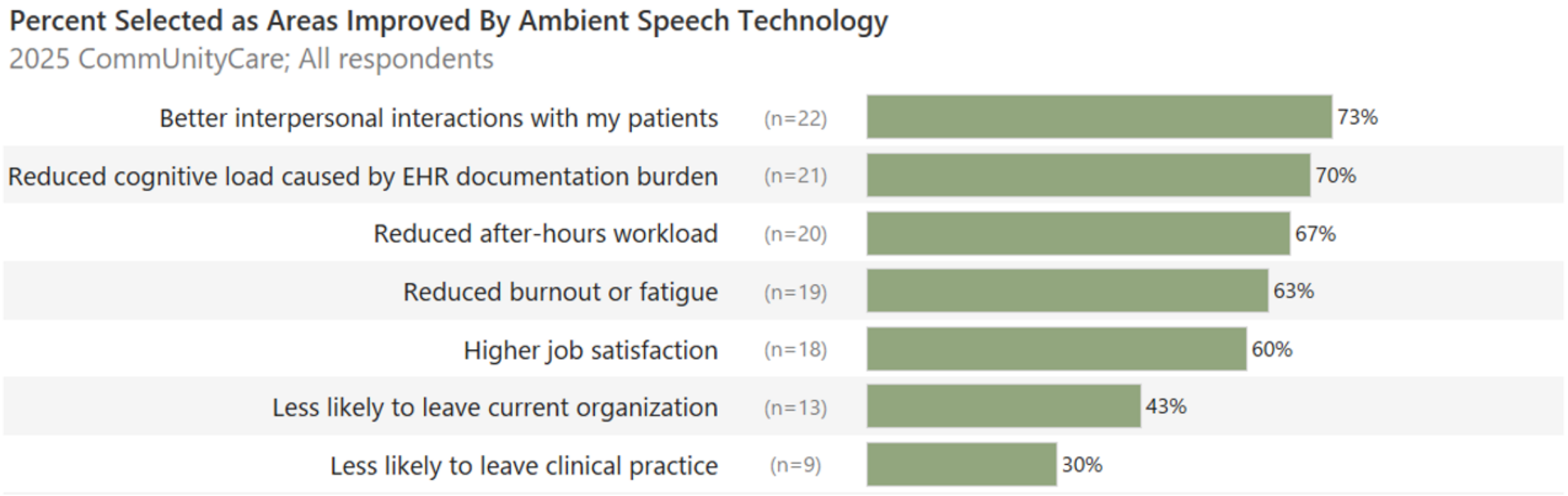
CUC AI in Epic: Provider Efficiency & Wellness

- “Physician burnout rate drops below 50% for first time in 4 years” -AMA 2024

- “HIT-related stress is measurable, common (about 70% among respondents), specialty-related, and independently predictive of burnout symptoms.” -JAMIA 2019

- “Physicians in outpatient settings spend half to two thirds of their professional time on activities other than direct patient care.” – Pediatrics 2022

2025 CommUnityCare EHR Experience Outcomes



"Dax Copilot was frequently mentioned among improvements in the last 12 months. Additionally, Ambient Speech users have the highest NEES compared to all documentation methods.... Those who haven't or cannot adopt Ambient Speech are interested"

KLAS RESEARCH | Arch Collaborative

Potential Additional AI Use Cases

LLM

Use LLM tools to reduce admin work and streamline workflows.

Interpretation

Improve access and experience while reducing delays and variations in service quality.

User Support

Increase self-service, automate ticket routing, and lower support costs.

Epic (EMR)

Reduce care team documentation burden, increasing time for patient care.

Eligibility Agent

Automate review of eligibility documentation to improve turn-around time and reduce manual processing.

ED / Hospital Readmissions

Predictive analytics to support early clinical intervention.

Patient/Member Navigation Center

Answer FAQs, automate call routing, reducing call center wait times and offer patient self-scheduling options.

Plenful

Automate 340B audits to reduce manual work and compliance risk.

Prior Authorization

Automate routing of determination letters to reduce manual processing and improve response times.

AI Oversight and Governance Policy Overview

POLICY PURPOSE

A system-wide approach and framework for responsible AI — protecting patients, staff, providers & public funds.

KEY POLICY PROVISIONS

System Roles and Responsibility

System AI Council, AI Risk Officer, and Business Owners share defined accountability.

Risk-Tiered Approval

Formal evaluation framework sets risk-based approval tiers and escalation thresholds.

Data, Access Controls & Vendor Oversight

Least-privilege access, zero-trust security, vendor management and PHI/PII safeguards across the AI Ecosystem.

Human Oversight

Qualified staff review, validate, and retain final responsibility over AI-generated outputs.

Prohibited Uses

No autonomous clinical decisions, coverage denials, shadow AI or PHI/PII in public AI tools.

Heightened Scrutiny

AI that autonomously drives consequential decisions requires a written risk assessment before use.

Appendix

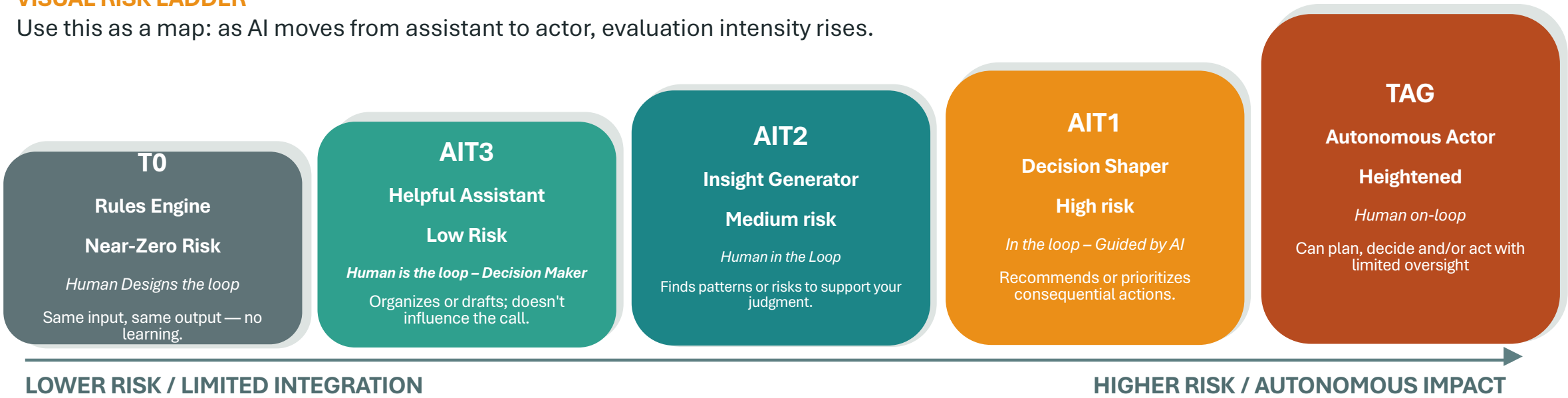
AI Evaluation & Risk Framework

Five-layer evaluation process for safe, scalable AI adoption

The more AI shapes a decision, the more evaluation and monitoring support it needs.

VISUAL RISK LADDER

Use this as a map: as AI moves from assistant to actor, evaluation intensity rises.



Why this matters

- AI use varies by autonomy.
- Controls match risk.
- Human oversight scales.

Executive implications

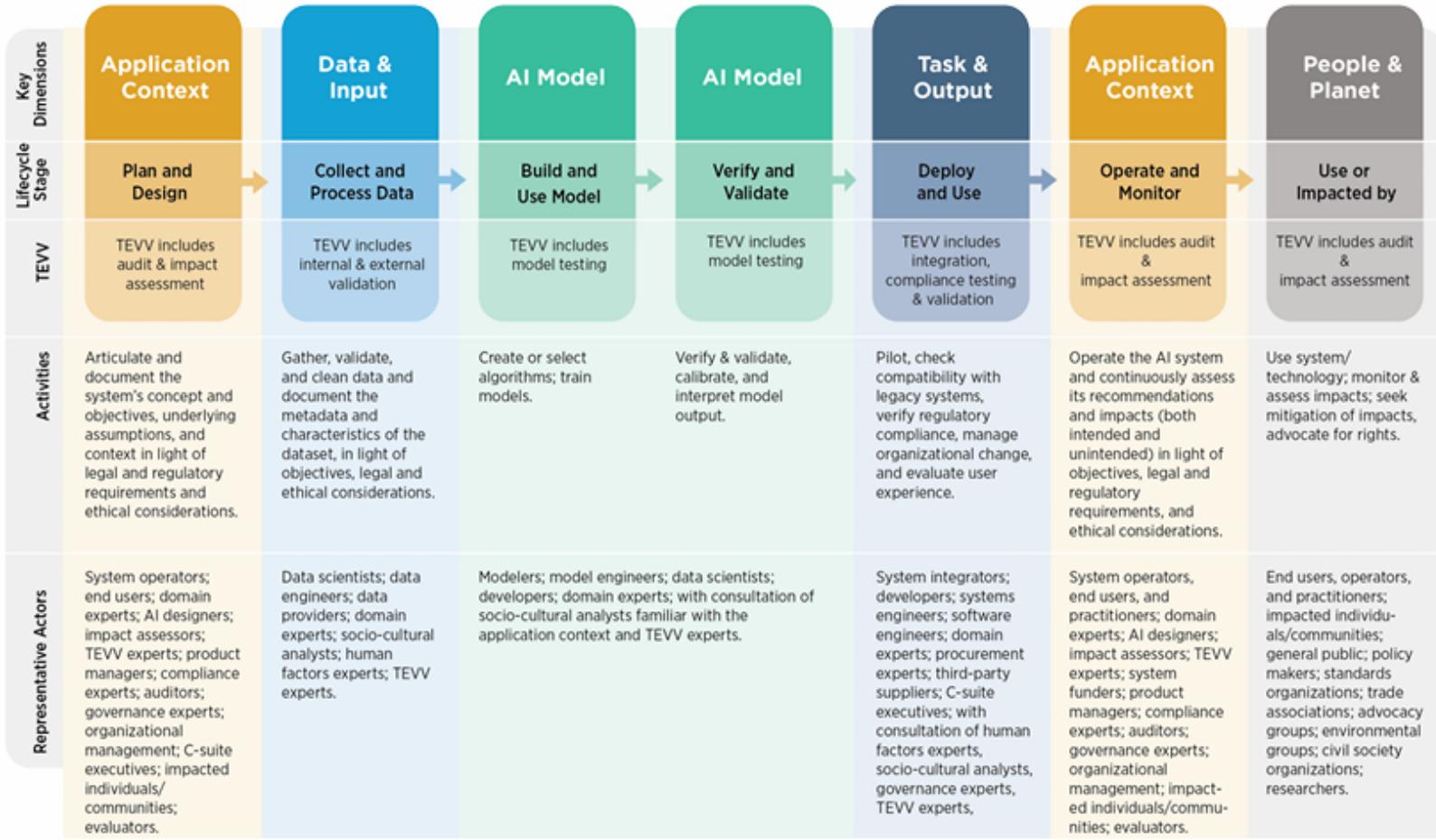
- Approve use stage.
- Govern before purchase.
- Equip guardrails.

Owner escalation triggers

- No human QA.
- Sensitive context.
- Critical external impact.
- Material model change.

Faster where safe. Deeper where risk warrants. Right people, right rhythm, right oversight.

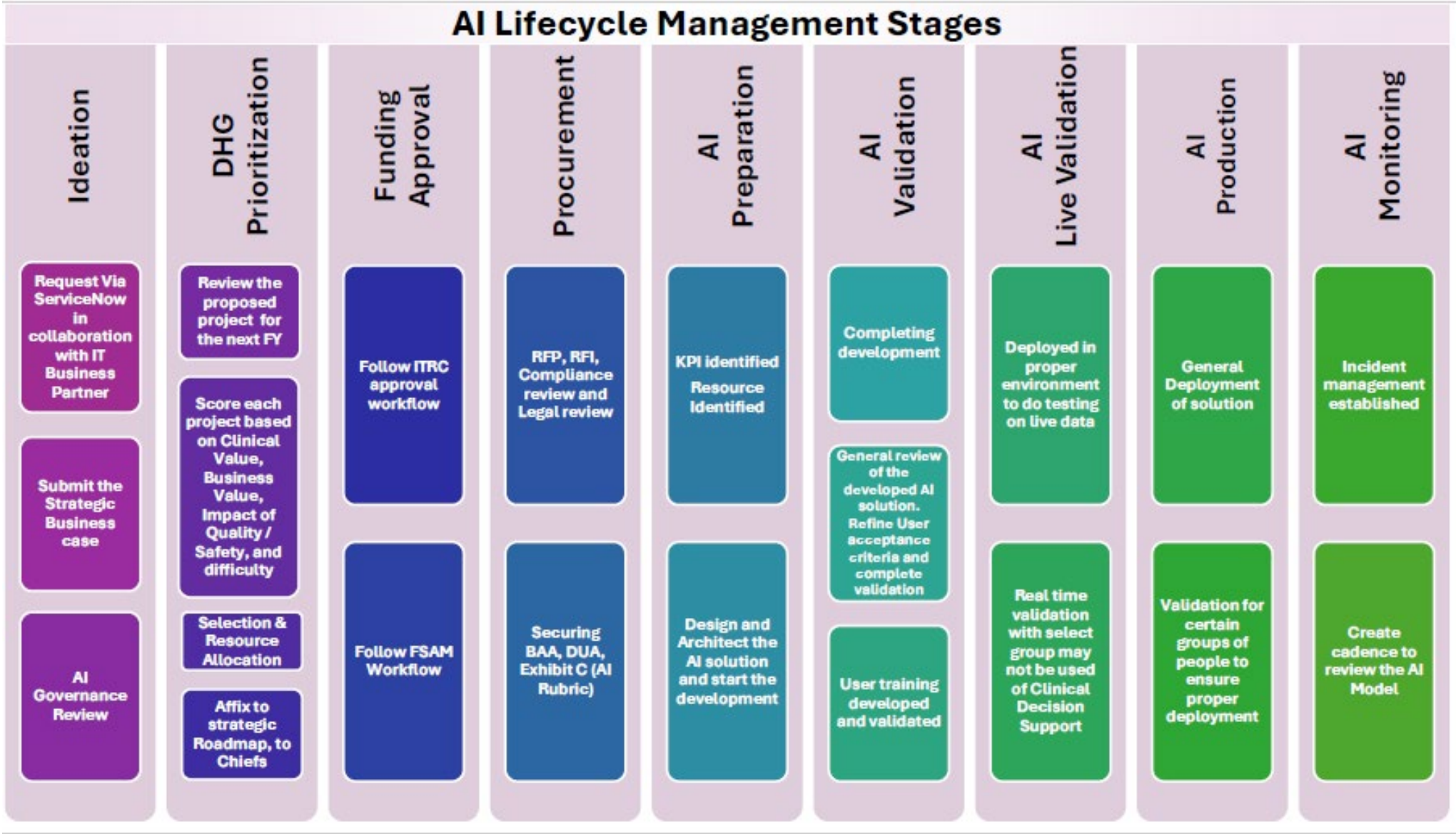
NIST Framework RMF 1.0



Key Dimensions	Application Context	Data & Input	AI Model	AI Model	Task & Output	Application Context	People & Planet
Lifecycle Stage	Plan and Design	Collect and Process Data	Build and Use Model	Verify and Validate	Deploy and Use	Operate and Monitor	Use or Impacted by
TEVV	TEVV includes audit & impact assessment	TEVV includes internal & external validation	TEVV includes model testing	TEVV includes model testing	TEVV includes integration, compliance testing & validation	TEVV includes audit & impact assessment	TEVV includes audit & impact assessment
Activities	Articulate and document the system's concept and objectives, underlying assumptions, and context in light of legal and regulatory requirements and ethical considerations.	Gather, validate, and clean data and document the metadata and characteristics of the dataset, in light of objectives, legal and ethical considerations.	Create or select algorithms; train models.	Verify & validate, calibrate, and interpret model output.	Pilot, check compatibility with legacy systems, verify regulatory compliance, manage organizational change, and evaluate user experience.	Operate the AI system and continuously assess its recommendations and impacts (both intended and unintended) in light of objectives, legal and regulatory requirements, and ethical considerations.	Use system/ technology; monitor & assess impacts; seek mitigation of impacts, advocate for rights.
Representative Actors	System operators; end users; domain experts; AI designers; impact assessors; TEVV experts; product managers; compliance experts; auditors; governance experts; organizational management; C-suite executives; impacted individuals/ communities; evaluators.	Data scientists; data engineers; data providers; domain experts; socio-cultural analysts; human factors experts; TEVV experts.	Modelers; model engineers; data scientists; developers; domain experts; with consultation of socio-cultural analysts familiar with the application context and TEVV experts.		System integrators; developers; systems engineers; software engineers; domain experts; procurement experts; third-party suppliers; C-suite executives; with consultation of human factors experts, socio-cultural analysts, governance experts, TEVV experts,	System operators, end users, and practitioners; domain experts; AI designers; impact assessors; TEVV experts; system funders; product managers; compliance experts; auditors; governance experts; organizational management; impact-ed individuals/commu-nities; evaluators.	End users, operators, and practitioners; impacted individu-als/communities; general public; policy makers; standards organizations; trade associations; advocacy groups; environmental groups; civil society organizations; researchers.

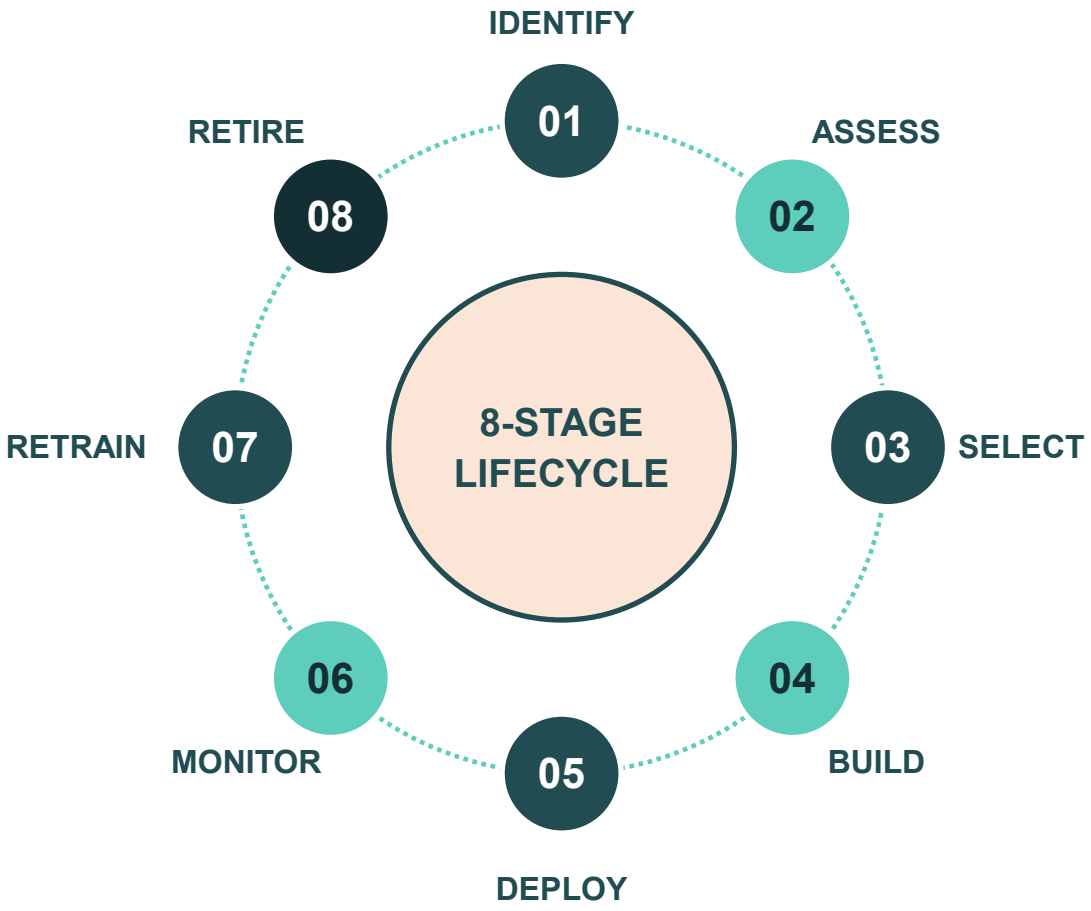
Fig. 3. AI actors across AI lifecycle stages. See Appendix A for detailed descriptions of AI actor tasks, including details about testing, evaluation, verification, and validation tasks. Note that AI actors in the AI Model dimension (Figure 2) are separated as a best practice, with those building and using the models separated from those verifying and validating the models.

Parkland Health District – Example



AI Use Case Lifecycle

An 8-stage journey from initial idea through decommission



01 IDENTIFY

Surface AI opportunities from clinical, operational, or strategic needs. Define the problem and ROI/KPIs.

KEY: Operational Value (KPIs)

02 ASSESS

Evaluate feasibility, data privacy risk, regulatory requirements, and organizational readiness.

KEY: Risk Tier

03 SELECT

Choose the tool or vendor. Prefer proven solutions; Risk Tier may require approval before build.

KEY: Contract

04 BUILD

Configure, integrate with workflows, validate in sandbox, and train staff before go-live.

KEY: Use Case Lifecycle Ownership

05 DEPLOY

Phased rollout to end users. Establish feedback loops, escalation paths, and user support.

KEY: Staff Training

06 MONITOR

Track performance, safety, equity, and clinical outcomes. Owned by the business/Executive Sponsor.

KEY: Value & Performance

07 RETRAIN

Optimize models or configurations from monitoring findings. Loop back to Assess if changes are significant.

KEY: Update AI Models as Needed

08 RETIRE

Formally retire the tool. Remove access, archive data, document lessons learned.

KEY: Continuous Feasibility Analysis

CENTRAL HEALTH

Our Vision
Central Texas is a model healthy community.

Our Mission
By caring for those who need it most, Central Health improves the health of our community.

Our Values
Central Health will achieve excellence through:
Stewardship - We maintain public trust through fiscal discipline and open and transparent communication.
Innovation - We create solutions to improve healthcare access.
Right by All - By being open, anti-racist, equity-minded, and respectful in discourse, we honor those around us and do right by all people.
Collaboration - We partner with others to improve the health of our community.

EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 4

Discuss and take appropriate action on a Central Health System Immunization Policy. (*Action Item*)

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	09/09/2026
Who will present the agenda item? (Name, Title)	Dr. Alan Schalscha, EVP & Chief Medical Officer
Notetaker (Name, Title)	Jeannie Virden, EVP & Chief People Officer
General Item Description	System Wide Immunization Policy
Is this an informational or action item?	Action Item
Fiscal Impact	0
Recommended Motion (if needed – action item)	Approve the system wide immunization policy.

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Updated immunization policy to align across the system and with local health care partners.
2) Is in line with current best practices and strengthens our position for regulatory and accreditation readiness.
3)
4)
5)

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Draft Immunization Policy
Estimated time needed for presentation & questions?	15 Minutes
Is closed session recommended? (Consult with attorneys.)	No
Form Prepared By/Date Submitted:	Jeannie E. Virden, EVP & Chief People Officer

Policy Title: Team Member Immunization and Screening Program	
Policy No.:	
Effective Date: MONTH/YEAR	
Last Review Date: MONTH/YEAR (not necessary for new policy creations)	
Policy Owner: (Department Ownership; Ex. Compliance Department)	
Executive Sponsor:	
Attachments:	
☐ **Central Health Specific**	☒ **System-wide**

I. PURPOSE

The purpose of this policy is to reduce the risk of transmission of vaccine-preventable diseases and tuberculosis (TB) and to protect patients, team members, and the community. The organization requires team members to maintain immunization and/or documented immunity appropriate to their assigned duties, work environment, occupational exposure risk, and applicable laws, regulation, and evidence-based guidance.

II. SCOPE

This policy applies to all team members, as defined in section III.

III. DEFINITIONS

- **Team Member:** For the purpose of this policy, "team member" refers to all individuals working within or on behalf of the organization, including employees, licensed independent practitioners, contractors, volunteers, students, vendors, and other individuals providing services, regardless of employment status.
- **Tuberculosis (TB):** An infectious disease caused by *Mycobacterium tuberculosis*, most commonly affecting the lungs.
- **Tuberculin Skin Test (TST):** A diagnostic test used to detect TB infection through intradermal injection and evaluation of the immune response.
- **Interferon-Gamma Release Assay (IGRA) (e.g., QuantiFERON-TB Gold):** A blood test used to detect TB infection by measuring immune response to TB-specific antigens.

IV. REGULATORY AND GUIDANCE REFERENCES

This policy is aligned with applicable regulatory and accreditation requirements, including but not limited to:

- Centers for Disease Control and Prevention (CDC)

- Advisory Committee on Immunization Practices (ACIP)
- Occupational Safety and Health Administration (OSHA)
- Centers for Medicare & Medicaid Services (CMS)
- The Joint Commission (TJC)
- Texas Department of State Health Services (DSHS)
- Texas Health and Human Services Commission (HHSC)

Where requirements differ, the organization will evaluate the applicable federal, state, local, regulatory, accreditation, and organizational requirement(s) applicable to the specific team member, work setting, and circumstance.

V. RELATED POLICIES

- Infection Prevention and Control Plan
- Work Restrictions for Healthcare Workers Exposed to Communicable Diseases

VI. PROCEDURE

A. IMMUNIZATION REQUIREMENTS AND SCREENINGS (ONBOARDING AND ONGOING)

1. **Documentation Records:**
   Team members whose assigned job duties, work environment or anticipated activities involve direct patient contact, potential exposure to infectious diseases, blood or other potentially infectious materials (OPIM), or other identified occupational exposure risks will be required to provide documentation of immunization status and/or evidence of immunity appropriate to their identified occupational risk prior to hire or placement.

   Acceptable documentation may include:

   - Immunization records or other documentation of vaccination.
   - Laboratory evidence of immunity (when applicable).
   - Documentation of a history of vaccine-preventable disease, when accepted as evidence of immunity.
   - Documentation of an approved medical exemption, religious accommodation, or declination, when applicable.

   Serologic testing (antibody titers) will be performed only when indicated in accordance with current CDC and ACIP guidelines for healthcare personnel. Routine post-vaccination serologic testing is not recommended, except for Hepatitis B, for which post-vaccination serologic confirmation of immunity is required for team members with

occupational risk of exposure to blood or other potentially infectious materials (OPIM), in alignment with the OSHA Bloodborne Pathogens Standard requirements.

2. **Required Immunizations:**

   a. MMR (Measles, Mumps, Rubella):

   - Documentation of 2 doses OR
   - Laboratory evidence of immunity

   b. Varicella (Chickenpox):

   - Documentation of 2 doses OR
   - Laboratory evidence of immunity OR
   - Provider-documented history of disease

   c. Tetanus, Diphtheria, Pertussis (Tdap):

   - One dose of Tdap for adults who have not previously received Tdap, followed by Td or Tdap every 10 years, or as otherwise recommended by CDC/ACIP.

   d. Hepatitis B (for team members with occupational exposure risk):

   - Hepatitis B vaccination will be offered at no cost to the team members with occupational exposure, in accordance with OSHA Bloodborne Pathogens Standard requirements.
   - Post-vaccination serologic testing will be performed 1–2 months after completion of the vaccination series for team members with occupational exposure to blood or other potentially infectious materials, in accordance with current CDC/ACIP recommendations.
   - Team members who do not develop an adequate antibody response will be managed in accordance with current CDC/ACIP recommendations.

   e. Influenza:

   - Annual vaccination required (see Section B).

3. **Applicability**

   Immunization documentation requirements apply to team members whose assigned duties, work environment, or anticipated activities involve direct patient contact, potential exposure to infectious diseases, blood or other potentially infectious material (OPIM), or other identified occupational exposure risks requiring specific immunization or evidence of immunity. Requirements may also apply to team members who are

subject to immunization requirements under applicable law, regulation, accreditation standards, or organizational policy. Influenza vaccination requirements are addressed separately in Section B and apply according to the organizational influenza vaccination requirements.
This includes team members who:

- Provide direct patient care or clinical services.
- Routinely work in patient-care areas or have potential contact with patients as part of their assigned duties.
- Have occupational exposure to blood, body fluids, or other potentially infectious materials (OPIM).
- Have other identified occupational exposure risks requiring specific immunization or evidence of immunity.

Team members who work fully remotely and have no routine occupational exposure, including those who may occasionally report onsite for administrative meetings, trainings, or similar activities without patient contact or occupational exposure risk, are not subject to immunization documentation requirements solely because they enter an organizational worksite. This does not affect the separate influenza vaccination requirements outlined in Section B.

Team Member Health will determine applicable immunization documentation requirements based on the team member's assigned duties, work environment, potential occupational exposure, and applicable regulatory or organizational requirements.

Contracted personnel, volunteers, and vendors who are subject to this policy are required to meet applicable immunization and communicable disease prevention requirements. Compliance is the responsibility of the employing or contracting entity, and documentation must be provided upon request.

Immunization Gaps and Non-Compliance:
Team members who do not meet established immunity requirements must complete required immunizations within the timeframe established by Team Member Health, unless an approved medical exemption or religious accommodation is on file.

Non-compliance and immunization gaps will be managed in accordance with Section G, including applicable work restrictions and corrective actions.

4. Tuberculosis (TB) Screening and Testing

TB screening and testing are conducted using a risk-based approach consistent with CDC recommendations and applicable state and regulatory requirements.

Baseline (Pre-Placement) Screening

Team members whose assigned duties or work environment may place them at occupational risk for TB are subject to baseline TB screening upon hire or placement. Baseline screening includes:

- An individual TB risk assessment.
- A TB symptom evaluation.
- A TB test (IGRA or TST).

Team members who are fully remote and have no expectation or requirement to work onsite are not routinely subject to the organization's occupational TB screening and testing program. TB screening or testing may be required based on individual risk factors, occupational exposure, a change in work assignment, or public health or regulatory requirements.

Additional TB screening or testing may be required when indicated by:

- Known or suspected exposure to TB.
- Symptoms or other findings concerning for TB disease.
- A change in work assignment or exposure risk.
- Ongoing transmission within a healthcare setting.
- Public health, regulatory, or clinical directions.

Ongoing TB Screening and Testing

Routine annual TB testing is not required. Periodic or repeat testing will be performed only when indicated by occupational exposure, ongoing transmission, symptoms, a change in risk, or applicable clinical, public health, or regulatory requirements. Team members should promptly report symptoms consistent with TB disease or known or suspected TB exposure to Team Member Health.

4. **Positive TB History or New Positive Results:**
   History of Prior Positive TB Test:
   - Team members with a documented prior positive TB test do not require TB testing.
   - A chest X-ray or documentation of a prior normal chest X-ray is required to document that TB disease has been excluded. Repeat chest imaging is not routinely required unless symptoms develop or otherwise clinically indicated.
   - When additional evaluation is required, Team Member Health will provide instructions regarding the evaluation and acceptable documentation. The team member is responsible for completing the evaluation within the timeframe established by Team Member Health, unless an organizational resource is designated.

New Positive TB Test:

- Requires medical evaluation, including chest imaging, to rule out active TB disease.
- Work status will be determined based on clinical findings, symptoms, and applicable public health guidance.
- Asymptomatic team members may continue working once cleared by Team Member Health or an occupational health provider.
- Team members with symptoms or findings concerning for active TB disease will be restricted from work as appropriate until cleared.

B. ANNUAL INFLUENZA REQUIREMENTS AND COMPLIANCE

5. **Influenza Vaccine (Mandatory):**
   All team members are required to receive the annual influenza vaccine each influenza season by the established deadline, except team members who are fully remote and have no expectation of reporting onsite for any reason. This requirement is a condition of employment.

   New hires who are subject to the influenza vaccination requirement must comply prior to the start of work if hired after the established annual deadline.

6. **Compliance Deadline:**
   Documentation of vaccination or an approved medical exemption or religious accommodation must be submitted to the appropriate department (e.g., Team Member Health or Leaves Department, as applicable) by the established annual deadline (typically the last business day of October).

7. **Additional Precautions for Approved Exemptions or Accommodations**
   Team members with approved medical exemption or religious accommodation must comply with additional infection prevention measures, which may include masking, work reassignment, or other precautions as determined by the organization.

   Remote and Offsite Team Members:
   For purposes of the policy, “fully remote” is defined as a team member whose position is formally designated by the organization as remote and who has no assigned, expected, or incidental requirement to report to any organizational worksite.

   All team members are required to receive the annual influenza vaccination by the established compliance deadline, except those who are fully remote and have no expectation of reporting onsite for any reason. Fully remote team members who subsequently become required to report onsite must meet the influenza vaccination requirement before reporting onsite.

All team members, including those designated as fully remote, are strongly encouraged to receive the annual influenza vaccination to support workforce health and reduce community transmission.

C. EXEMPTIONS, ACCOMMODATIONS, AND DECLINATIONS

1. **Hepatitis B Declination:**
   Team members declining Hepatitis B vaccination must sign a declination statement in accordance with OSHA Bloodborne Pathogens requirements.

2. **Immunity Requirements and Other Vaccines:**
   Team members must demonstrate evidence of immunity or obtain an approved medical exemption or religious accommodation for required vaccines, including MMR, Varicella, Hepatitis B, and Tdap, as applicable.

3. **Influenza Medical Exemptions and Religious Accommodations:**

   Team members may request an approved medical exemption or religious accommodation from the Influenza vaccination requirement.

   - Medical exemption: Provider documentation required.
   - Religious accommodation: Supporting information or documentation may be requested as part of the accommodation review process, as appropriate.

   Requests are submitted to the Leaves Department for review and approval each influenza season prior to the established deadline and are evaluated on a case-by-case basis.

4. **Review of Other Vaccine Exemptions:**
   Requests for medical exemption or religious accommodation from vaccines other than influenza are reviewed by Team Member Health in collaboration with Infection Prevention and applicable People Department resources, as appropriate. Requests are evaluated based on clinical, regulatory, and organizational requirements.

5. **Alternative Measures:**
   Team members with an approved medical exemption or religious accommodation must comply with applicable infection prevention measures during influenza season, including medical-grade masking when required by the approved exemption or accommodation agreement.

6. **Compliance:**
   Non-compliance with immunization or exemption requirements may result in corrective action, up to and including termination of employment or engagement.

D. POST-EXPOSURE WORK RESTRICTIONS

Team members who are non-immune or unvaccinated may be subject to work restrictions following exposure to a communicable or infectious disease. Actions may include:

- Work reassignment.
- Remote work (if feasible).
- Temporary exclusion from work.

Return-to-work based on:

- Regulatory guidance.
- Completion of prophylaxis (if indicated).
- Symptom status.
- Clearance from Team Member Health.

Outbreak Situations:
Additional restrictions may apply to protect patients and staff.

E. VACCINE ADMINISTRATION

- Coordinated by Team Member Health.
- Administered by qualified healthcare providers through designated clinics or partner services.
- Documentation is required for all vaccines administered.

F. CONTRACTED TEAM MEMBERS

- Must meet all immunization and TB requirements as outlined in this policy.
- Proof of compliance must be maintained by the contracting employer and provided upon request.
- Must comply with influenza vaccination requirements outlined in Section B.

G. ACCOUNTABILITY AND COMPLIANCE

Team members are responsible for complying with applicable immunization and TB screening requirements as a condition of employment or assignment, as applicable.

Team members must:

- Provide complete, accurate, and timely documentation of required immunizations and immunity status prior to hire or placement in a position requiring such documentation, and thereafter within the timeframe established by Team Member Health when additional documentation or updates are required based on assigned duties, work location or organizational requirements.

- Maintain compliance with all required immunizations, including annual influenza vaccination.
- Complete and maintain compliance with required TB screening and testing based on assigned duties, work environment, risk assessment, and occupational exposure.
- Promptly report symptoms consistent with communicable diseases, including TB, or any known exposures to Team Member Health.

Organizational leaders are responsible for:

- Ensuring team members meet immunization and TB screening requirements in a timely manner.
- Supporting enforcement of compliance requirements, including work restrictions, reassignment, or other infection prevention measures when indicated.
- Partnering with Team Member Health to identify roles with increased exposure risk, including patient-facing positions.

Team Member Health is responsible for:

- Coordinating, monitoring, and tracking immunization and TB screening compliance, including review and validation of documentation.
- Determining appropriate follow-up for non-compliance, positive screening results, exposures, or symptoms.
- Maintaining documentation, including protected health information (PHI), in the designated electronic Employee Health/EHR system in accordance with applicable regulatory requirements and organizational policies.
- Ensuring access to team member health records and PHI is limited to authorized personnel with a legitimate business need and appropriate access privileges.
- Maintaining the confidentiality, security, and integrity of team-member health records in accordance with applicable privacy, security, regulatory and organizational requirements.

Failure to comply with immunization or TB screening requirements may result in delayed start dates, removal from the work environment, or other corrective action up to and including termination, in accordance with organizational policy.

Organizational Authority:

The organization reserves the right to implement additional immunization, screening or infection prevention requirements based on risk assessment, exposure events, public health guidance, or regulatory requirements including emerging infectious diseases or public health emergencies.

Compliance with this policy is monitored through ongoing auditing and reporting processes to ensure adherence with regulatory and accreditation standards.

ADDENDUM A

Corrective Action Timeline for Influenza Vaccine Non-Compliance

ADDENDUM B

Hepatitis B Declination Statement

ADDENDUM C

Immunization Declination Form

ADDENDUM A

Corrective Action Timeline for Influenza Vaccine Non-Compliance

Team members subject to the organization's mandator influenza vaccination requirements must comply by the established annual deadline.

Day/Week	Action	Responsible Party	Description
Day 1	Initial Non-Compliance Notification	Team Member Health RN/People Dept.	Notification of missed deadline and required actions.
Day 3-5	Final Compliance Notice	People Dept./Team Member Health	Final opportunity to comply; consequences outlined.
Day 5-7	People Dept. Review/ Corrective Action	People Dept.	Formal disciplinary documentation initiated.
Day 7-10	Suspension (if applicable)	People Dept. / Leadership	Suspension pending compliance.
Day 10-14	Termination (if applicable)	People Dept.	Employment separation is initiated if unresolved.

1. Initial Non-Compliance Notification (Day 1)

Team Member Health or the People Dept. will notify the team member and their leader of missed compliance. The notification will include:

- Requirement status (non-compliant)
- Immediate instructions to obtain vaccination or initiate approved medical exemption or religious accommodation process

- Applicable interim infection control requirements – masking required during non-compliance

2. Final Compliance Notice (Days 3–5)

If compliance is not achieved, a formal final notice will be issued to the team member. This notice will:

- Reaffirm vaccination requirement and deadline for compliance
- Outline consequences for continued non-compliance, up to and including termination of employment
- Reinforce availability of Team Member Health support for immediate compliance

The department leader will be notified at this stage.

3. The People Department Review and Corrective Action Initiation (Days 5–7)

If the team member remains non-compliant, the people department will initiate formal corrective action in consultation with Team Member Health and department leadership. This may include:

- Formal documentation of non-compliance (Corrective Discipline Notice or equivalent)
- Assignment of applicable disciplinary points or corrective action status per organizational policy

4. Suspension (If Applicable) (Days 7–10)

Continued non-compliance after the final notice may result in suspension without pay for up to three (3) days, pending resolution of compliance status or further disciplinary action.

5. Termination of Employment (Days 10–14)

If the team member remains non-compliant following suspension and has not obtained vaccination or an approved medical exemption or religious accommodation, termination of employment may be initiated in accordance with organizational policy.

Notes

- Team members may achieve compliance at any point during this process, which will halt further corrective action.
- Approved medical exemption or religious accommodation must be submitted and reviewed through the established Leaves process.

ADDENDUM B

HEPATITIS B VACCINE DECLINATION STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____
Print Name

_____
Signature

_____
Date

_____
Witness / TMH representative

Please return to Team Member Health
Email: TeamMemberHealth@centralhealth.net

ADDENDUM C

CENTRAL HEALTH TRAVIS COUNTY HOSPITAL DISTRICT COMMUNITYCARE HEALTH CENTERS SENDERO HEALTH PLANS

TEAM MEMBER HEALTH
IMMUNIZATION DECLINATION FORM

Date: _____

I have been informed that I am susceptible to _____, a communicable disease. I understand the benefits of immunizations and the risks associated with not receiving the following recommended immunizations:

____ Measles, mumps, rubella (MMR)

____ Varicella

____ Tetanus, diphtheria, acellular pertussis (Tdap)

I understand that refusing any of these immunizations may increase my risk of infection. I acknowledge these risks and decline the recommended immunizations at this time. If in the future I decide to be vaccinated, I may receive the vaccination(s) in accordance with organizational policy.

I understand that if I am unable to be vaccinated and work in an area based on assignment or exposure risk, I may be reassigned. In the event of an outbreak, I may be reassigned or excluded from the workplace if I am susceptible to the disease. If I contract the disease, I will not be permitted to return to work until written clearance is provided by my healthcare provider.

Signed _____Date _____

Printed name _____

Witness / TMH Representative_____ Date _____

Please return to Team Member Health
Email: TeamMemberHealth@centralhealth.net

CENTRAL HEALTH

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Collaboration - We partner with others to improve the health of our community.

EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 5

Discuss and take appropriate action on the process for Central Health Appointments to the Integral Care Board of Directors. (*Action Item*)

CENTRAL HEALTH

MEMORANDUM

To: Central Health Board of Managers Executive Committee

From: Briana Harris, Director of Board Governance

CC: Perla Cavazos, SVP & Chief Governance & Government Affairs Officer

Date: September 2, 2026

Re: Discuss and take appropriate action on the process for Central Health Appointments to the Integral Care Board of Directors.

Overview:

Staff requests direction from the Executive Committee on a process to either reappoint current Integral Care board appointees or issue an open call for new potential candidates which can be considered by the Central Health Board for appointments to the Integral Care Board. Terms for two Central Health appointees, Mr. Hal Katz and Dr. Guadalupe Zamora, expire September 30, 2026. Both individuals have expressed interest in reappointment.

Mr. Katz has served on the Integral Care Board of Trustees since 2010, and Dr. Zamora has served since 2014. Their biographies are attached for the Board's consideration. They will continue serving until they are either reappointed or a new member is appointed.

Background:

Integral Care is governed by a nine-member volunteer Board of Trustees. Central Health, the City of Austin, and Travis County each appoint three members, with the appointments intended to reflect the needs of the local community.

The Central Health Board has previously deliberated appointments and reappointments to external governing boards through the Executive Committee or, in more recent times, through an Ad Hoc Appointments Committee. As a reference we are attaching the process used in recent years.

The attached reappointment process outlines steps that may be considered when discussing the reappointments process. The attached document outlines a process that includes confirmation of interest, review of applicable eligibility requirements, consideration by an ad hoc Appointments Committee, and submission of a recommendation to the Board of Managers for final action.

CENTRAL HEALTH

Should the Board choose to consider new candidates for one or both positions, the attached new-appointment process outlines steps that may be considered, including identification of desired skills and needs, candidate recruitment and vetting, committee review and interviews, and Board of Managers action on a recommended candidate.

It should also be noted that the ad hoc Appointments Committee referenced in the attached processes was dissolved. Should the Board choose to use either process, the Board may consider whether the Executive Committee, another committee, or the full Board of Managers should carry out the review, interview, and recommendation functions previously assigned to the Ad Hoc Appointments Committee.

Fiscal Impact:
None.

Action Requested:

Staff requests direction from the Executive Committee on a process to either reappoint current Integral Care board appointees or issue an open call for new potential candidates which can be considered by the Central Health Board for appointments to the Integral Care Board.

HAL KATZ

APPOINTED 2010

Katz is a partner at Husch Blackwell and is board-certified in healthcare law by the Texas Board of Legal Specialization. He focuses his representation on clients doing business within the healthcare industry. His clients include physicians, hospitals, provider networks, managed care organizations, governmental entities, diagnostic centers and other healthcare providers across the state of Texas. Representation of these clients includes advising on corporate, transactional, regulatory and public policy matters. Katz was Chair of the CommUnityCare board, where he served from 1998-2010, and is the Vice Chair of the Austin Arts Commission. Katz is also on the **Integral Care Foundation** Board of Directors.

GUADALUPE ZAMORA, M.D.

APPOINTED 2014

Dr. Zamora has 24 years of experience as a practicing physician. When not on staff at St. David's Medical Center, he works at his own family medicine clinic in East Austin alongside his niece, Dr. Belda Zamora. He has served as the past president, secretary, and treasurer of the Travis County Medical Society, and was formerly on the advisory board for the Medical Access Program (MAP), prior to the existence of Central Health. Most recently, he served as treasurer of Healthy ATX, a local organization that supports the improvement of the local healthcare system.

October 25, 2023

Procedure for Making REAPPOINTMENTS to Governing Boards and Advisory Groups by the Central Health Board of Managers

Introduction:

The process for reappointing members to the external governing boards will require a review of their service, adherence to by-laws, and their reiterated interest in continuing to contribute to the board of the organization that they are currently appointed.

1. Expressing Interest for Reappointment:

The Central Health administrative staff should solicit the current board member's intention and willingness for reappointment.

2. A By-Law Review:

A review of the by-laws of the governing board to which the individual will be reappointed will be performed. This review will ensure compliance with organizational by-laws related to term limits and other conditions that might impact reappointment.

3. Convene an ad Hoc Appointments Committee Meeting:

An ad hoc Appointments Committee meeting will be scheduled to facilitate a dialogue with the potential re-appointee regarding their previous term(s). In this discourse, the individual being considered for reappointment should share insights into their experience, contributions, and vision, providing the Committee with information to make an informed decision regarding their reappointment.

The Committee may review with the potential re-appointee any responsibilities outlined in the *Minimal Experience of Board Appointees to Warrant Consideration* document.

At the end of this interview the ad hoc Appointments Committee will vote on a motion to "recommend appointment"

4. Submission for Approval:

The ad hoc Appointments Committee then submits their recommendation for reappointment to the Central Health Board of Managers for approval.

Procedure for Making NEW Appointments to External Governing Boards and Advisory Groups by the Central Health Board of Managers.

1. Identification of Needs:

The first step before appointing any member to a Board of Directors is identifying the needs and gaps that currently exist within the Board. This could include industry knowledge, financial expertise, diversity and inclusivity, and strategic leadership skills. Input can be requested from the board chair of the organization requesting the appointment, the Central Health Board of Managers, or the Central Health administrative staff, as well as sources within the community the organization serves.

2. Define the Role:

Once the need has been identified, it's important to clearly define the role and expectations of the new board member. This includes detailing the responsibilities, duties, and time commitment the role will require, as well as any specific skills or qualifications necessary.

3. Recruitment of Potential Candidates:

After defining the role, potential candidates will be identified. These candidates can come from a variety of sources, including suggestions from current board members of the Board of Directors receiving the new appointee, the Central Health Board of Managers, the Central Health administrative staff, industry contacts, and/or professional organizations. The sources are not limited to those outlined above. Also, recruitment can include using appropriate media and Internet resources.

4. Application process:

A standard application will be sent out to potential candidates. This application will include a standard set of questions to be responded to by the applicant in essay form. A dialog utilizing these questions will take place in the interview process. The application and responses to the questions will be returned to the Central Health administrative staff.

5. Initial Vetting:

An initial vetting of the potential candidates will be performed to ensure candidates have the necessary skills, no legal issues (especially conflicts of interest) that can affect their candidacy, and that they are aligned with the mission and objectives of the receiving organization.

6. Application Review:

Applications will be reviewed by the ad hoc Appointments Committee members and discussed in a committee meeting with a quorum present. At that time a vote will be taken on which candidates to invite for an interview. The Committee may deliberate on an alternate review process if the number of applications exceeds a level that can be efficiently reviewed by the committee members.

7. Interviews:

Candidates selected for interview will be invited to an ad hoc Appointments Committee meeting to discuss the responses to the questions that they submitted responses to in the Application Process (see above). The interview will be carried out by the ad hoc Appointments Committee members and should focus on the questions responded to by the candidates. All Central Health Board of Managers are invited to attend and ask questions that are germane to the responses that the candidates submitted responses to in the Application Process (see above), but only ad hoc Appointments Committee members will vote. Interviews will yield the best candidate of those that applied. This candidate will be forwarded to the full board for approval.

8. Board Approval:

Once the finalist has been selected, the ad hoc Appointments Committee will follow the *Central Health Board of Managers Approval Process for External Governing Board Appointees* for final approval.

9. Appointment Letter:

Upon full board approval, the new board member should be officially appointed through an appointment letter. This letter will be written and signed by the ad hoc Appointments Committee chairperson and it will formalize the role and include details such as term length, specific responsibilities (outlined in the "*Experience of Board Appointees to Warrant Consideration*" document), expected time commitment, etc. The ad hoc Appointments Committee may add additional responsibilities to the "*Experience of Board Appointees to Warrant Consideration*" document to clearly outline the Central Health Board's expectations of their appointees.

10. **Announcement:**

Finally, make a public announcement of the new board member appointment. This may involve posting the announcement on Internet sites or other public notification methods.

October 25, 2023

Central Health Board of Managers Approval Process
for External Governing Board Appointees

The ad hoc Appointments Committee will follow the following process of selecting a candidate(s) to recommend to the full board for approval:

1. The ad hoc Appointments Committee meetings are open for any interested Board member to attend. Board members attending will be allowed to ask questions only as those questions relate to the standard set of questions adopted by the ad Hoc Appointments Committee. Topics not included in the adopted list of questions will not be asked of the candidates.

2. The ad hoc Appointments Committee members will vote on the motion to "recommend appointment" which will be forwarded to the Board of Managers for approval. The item will either be on the Consent Agenda or the Regular Agenda at the discretion of the Chairperson of the Board of Managers. If on the Regular Agenda or if pulled from the Consent Agenda, the Chair of the Appointments Committee will lead the discussion. Backup materials (selected and approved by the ad Hoc Appointments Committee chair) will be included in the Board materials for review, regardless of whether it is a Regular Agenda item or a Consent Agenda item.

3. Upon approval, the steps for notification of the candidates will be performed per "Procedure for Making NEW Appointments to External Governing Boards and Advisory Groups by the Central Health Board of Managers."

Experience Criteria of Board Appointees to Warrant Consideration

The experience of a Board appointee can vary. However, below are experience criteria that can be considered when vetting and prioritizing candidates for Board appointment.

1. **Governance:**
Experience overseeing the strategic direction of an organization, establishing and enforcing governance policies, and ensuring ethical conduct.

2. **Strategy formulation:**
Experience reviewing, approving, and guiding the organization's mission, vision, and strategic direction.

3. **Executive oversight:**
Experience selecting, evaluating, and if necessary, replacing the chief executive.

4. **Financial oversight:**
Experience approving annual budgets and ensuring the organization's financial sustainability and integrity.

5. **Risk Management:**
Experience understanding and monitoring the organization's principal risks and ensuring the implementation of appropriate systems to manage these risks.

6. **Performance measurement:**
Experience regularly evaluating the performance of an organization in achieving its strategies.

7. **Compliance:**
Experience ensuring compliance with laws and regulations, and adherence to internal policies and procedures.

8. **Stakeholder Communication:**
Experience building relationships with stakeholders and acting as advocates for the organization in its community.

9. **Succession planning:**
Experience developing and periodically updating a succession plan for the CEO and top management.

10. Board development:
Experience identifying needed board member skills, selecting new members, and ensuring all board members are properly oriented and trained.

11. Communication:
Experience communicating with appointing authority on a regular basis to share information and strategy alignment.

The ad Hoc Appointments Committee may add additional responsibilities and/or experience as needed to clearly outline the Central Health Board's expectations of their appointees.

CENTRAL HEALTH

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 6

Review, discuss, and take appropriate action on a presentation from the Central Health Chief Compliance Officer regarding the process and timing for Board review and approval of District policies. (*Action Item*)

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	9/9/2026
Who will present the agenda item? (Name, Title)	Nakia Smith, Chief Compliance & Risk Officer
Notetaker (Name, Title)	
General Item Description	Proposed Policy Governance Framework
Is this an informational or action item?	Action Item
Fiscal Impact	None anticipated
Recommended Motion (if needed – action item)	Motion to approve the proposed Policy Governance Framework and authorize management to incorporate the approved governance structure into the existing Policy on Policies.

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Feedback sought on the proposed approval criteria and the phase implementation timeline (priority board-level policies).
2)
3)

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Policy Governance Framework presentation & Policy Approval Matrix
Estimated time needed for presentation & questions?	20 minutes
Is closed session recommended? (Consult with attorneys.)	No
Form Prepared By/Date Submitted:	Nakia Smith, August 19, 2026

CENTRAL HEALTH

Policy Governance Framework

August 26, 2026

Nakia Smith, Chief Compliance & Risk Officer

Central Health's policy landscape has grown organically over time; without a documented framework distinguishing which policies require Board level governance versus operational management.

OIG Compliance Program Guidance — Element 1: *"Implementing Written Policies, Procedures, and Standards of Conduct" is the first of the seven elements of an effective compliance program; a consistent, well governed policy structure is a recognized regulatory expectation, not just a best practice.*

TODAY

An Undefined Approval Structure

Policy approval has developed informally over time, without a documented structure distinguishing governance level policies from operational ones.

Bylaws Sec. (H): *the Board "approves...policies...unless otherwise delegated to the President and CEO." This delegation option has not yet been formalized in practice.*

THE OPPORTUNITY

Differentiate by risk and impact

- Compliance completed a full inventory of existing policies and procedures
- Assessed which documents warrant Board approval on legal, regulatory, fiduciary, and risk grounds
- Used to demonstrate how proposed criteria apply across the existing policy portfolio

PROPOSED

A tiered governance framework

- Three clear categories: Board Policies, Management Policies (or Admin Directives), Standard Operating Procedures
- Board authority and fiduciary oversight fully preserved
- Board visibility maintained through a centralized inventory and quarterly reporting

PROPOSED POLICY GOVERNANCE FRAMEWORK

Three Categories of Governing Documents

TIER 1

Board Policies

Establish governance requirements, regulatory obligations, strategic direction, and organizational expectations requiring Board oversight and approval.

Approved by: Board of Managers

TIER 2

Management Policies

Administrative directives approved under delegated executive authority. Implement Board Policies and govern operational areas delegated to management.

Approved by: CEO / Delegated Executive Authority

TIER 3

Standard Operating Procedures

Detailed instructions, workflows, and processes used by departments and staff to carry out day-to-day operational activities.

Approved by: Responsible Department

TIER 1

What Stays With the Board

Board approval is required whenever governance oversight is mandated by:

APPROVAL TRIGGERS

- Regulatory or accreditation agencies (e.g., CMS, HRSA, Joint Commission)
- The Texas Health and Safety Code
- The Texas Administrative Code
- The explicit direction of the Board
- CEO/designee determination; organizational impact, enterprise risk, regulatory exposure, financial significance, strategic importance, or reputational considerations

GOVERNANCE TOPIC AREAS

- Governance & fiduciary responsibilities
- Financial management & budget oversight
- Delegation of authority
- Procurement & contracting authority
- Enterprise risk management
- Compliance
- Fraud, Waste & Abuse
- Non-Retaliation
- HIPAA Privacy & Security
- Human Resources governance

Note: Policies governing the practice of medicine are reviewed and approved by the Medical Executive Board (MEB), consistent with Texas Occupations Code Title 3, Subtitle B.

** See Sample Policy Approval Matrix for policy categories*

TIERS 2 & 3

What Moves to Delegated Authority

MANAGEMENT POLICIES

Approved under delegated executive authority. Implement Board Policies and govern operational areas delegated to management; remains subject to policy governance and quarterly Board reporting.

Examples:

- Routine purchase order processing
- Vendor management requirements
- Contract routing processes
- Information technology standards
- Capital budget procedures
- Facilities management requirements
- Operational & administrative standards

STANDARD OPERATING PROCEDURES

Detailed instructions, workflows, and processes used by departments and staff to carry out operational activities. Reviewed periodically by the responsible department.

For clinical operations:

May include standing orders, clinical practice guidelines, and similar operational documents; approved through applicable medical governance processes.

Not Board-approved; owned and maintained at the department level, consistent with the Policy on Policies.

Discretionary review, anytime

The Board may request review of any Board Policy, Management Policy, or SOP at its discretion no policy is placed permanently out of reach.

Centralized inventory

Compliance maintains a complete inventory of organizational policies across all three tiers.

Quarterly reporting

The Board receives quarterly reporting on all policy activity newly issued, revised, retired, or reclassified Management Policies and SOPs.

Mandatory review cycles

Board Policies: at least every 3 years (or more often as law, regulation, or accreditation requires). Management Policies: at least every 3 years. SOPs: reviewed periodically by the responsible department.

RECOMMENDATION

Action Requested & Next Steps

ACTION REQUESTED

Board approval of the proposed Policy Governance Framework, and authorization to incorporate the approved governance structure into the existing Policy on Policies.

UPON APPROVAL, MANAGEMENT WILL:

- Implement the framework and maintain a centralized policy inventory
- Continue presenting Board-level policies for review/approval per law, regulation, Board direction, and risk considerations
- Provide quarterly reporting on Management Policy and SOP activity for Board visibility and oversight

NEXT STEPS

1

Policy Prioritization

In alignment with Board and Executive Committee input, develop a prioritized inventory of Board level policies focusing first on high-impact areas: finance, delegation of authority, contracting, compliance, and required regulatory policies.

2

Implementation Timeline

Establish a phased review and approval timeline, targeting completion of priority Board-level policies by the end of Q2 FY27 / December 31, 2026, as directed.

CENTRAL HEALTH

Central Health Policy Approval Matrix

Approval authority by policy category for Board discussion

Policy Category	Board Approval	CEO / Executive Approval	Committee Review
Board Bylaws	Approve	No	Board of Manager Meeting
Board Governance Policies	Approve	No	Board of Manager Meeting
Delegation of Authority Policy	Approve	No	Board of Manager Meeting
Board Committee Charters	Approve	No	Board of Manager Meeting
Code of Conduct	Approve	Approve	Executive Committee / Compliance Committee
Compliance Program Charter	Approve	No	Executive Committee / Compliance Committee
Compliance Program Policies	Approve	No	Executive Committee / Compliance Committee
Privacy & HIPAA Governance Policies	Approve	No	Executive Committee / Compliance Committee
Enterprise Risk Management (ERM) Framework	Approve	Approve	Finance & Audit / Compliance Committee
Cybersecurity Governance Framework	Approve	Approve	Finance & Audit Committee
Information Security Governance Policy	Approve	Approve	Finance & Audit Committee
Strategic Plan	Approve	Approve	Strategic Planning Committee
Community Health Needs Assessment Framework	Approve	Approve	Strategic Planning Committee
Annual Operating Budget	Approve	Approve	Budget & Finance Committee
Capital Budget	Approve	Approve	Budget & Finance Committee
Investment Policy	Approve	Approve	Budget & Finance Committee
Debt Management Policy	Approve	Approve	Budget & Finance Committee
Purchasing Policy	Approve	Approve	Budget & Finance Committee
Contracting Authority Policy	Approve	Approve	Budget & Finance Committee
Quality Oversight Framework	Approve	Approve	Medical Executive Board (as applicable)
Patient Safety Program Framework	Approve	Approve	Medical Executive Board (as applicable)
Human Resources Policy (Executive Officers)	Approve	Approve	Board of Manager Meeting
Executive Compensation Policy	Approve	Approve	Board of Manager Meeting
CEO Performance Evaluation Policy	Approve	No	Board of Manager Meeting
CEO Succession Planning Policy	Approve	No	Board of Manager Meeting
Employee Handbook	Material revisions only	Approve	Board of Manager Meeting as applicable
Administrative Policies	Delegated Oversight	Approve	As required
Operational Policies	Delegated Oversight	Approve	As required
Department Procedures	Delegated Oversight	Approve	None
Department SOPs	Delegated Oversight	Approve	None
Standards, Protocols, Guidelines	Delegated Oversight	Approve	As required
Checklists, Work Instructions	No	Approve	None
Forms	No	Approve	As required

Summary

Board Approval required	**26**
Delegated to management oversight	**5**
No Board approval required	**2**
Total policy categories	**33**

Legend

Approve	*Board or CEO holds independent approval authority*
Delegated Oversight	*Board approval delegated to CEO/Management*
No	*No approval required at this level*

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 7

Discuss and take appropriate action regarding a compliance update by the Chief Compliance Officer and receive a report from the Chief Compliance Officer regarding a pending investigation.[3,4] (*Action Item*)

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	9/9/2026
Who will present the agenda item? (Name, Title)	Nakia Smith, Chief Compliance & Risk Officer
Notetaker (Name, Title)	
General Item Description	Quarterly compliance program update covering FY2026 Q3 risk assessment, audit & monitoring plan, and work plan activities reported against the Office of Inspector General (OIG) Seven Elements framework.
Is this an informational or action item?	Action Item
Fiscal Impact	None anticipated
Recommended Motion (if needed – action item)	Receive and approve the FY2026 Baseline Risk Assessment, Audit & Monitoring Plan and Work Plan, as received by the Central Health Compliance Committee.

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Risk Assessment was reviewed by the CH Compliance Committee and Executive Committee of the Board. Top risk focused areas are being presented.
2) Compliance program continues to mature and focus on aligning the program against the OIG seven elements of an effective compliance program.
3) Board approval requested to finalize the FY2026-2027 work plan and audit plan items; feedback welcome on risk prioritization and reporting cadence.
4) Receive a report from the Chief Compliance Officer regarding a pending investigation.

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Q3 FY2026 Compliance Update Deck – Appendix includes high risk register, Privacy Investigations, Compliance Investigations, Conflict of Interest, and FY2026 Audit Plan update
Estimated time needed for presentation & questions?	20 minutes
Is closed session recommended? (Consult with attorneys.)	Pending investigation requires closed session

CENTRAL HEALTH

Form Prepared By/Date Submitted: Nakia Smith, August 19, 2026

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 8

Discuss and take appropriate action on the recommended Central Health Bylaws amendments.[3] (*Action Item*)

CENTRAL HEALTH

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	September 9, 2026
Who will present the agenda item? (Name, Title)	Chair Rodriguez
Notetaker (Name, Title)	
General Item Description	Discuss and take appropriate action on the recommended Central Health Bylaws amendments.
Is this an informational or action item?	Action
Fiscal Impact	
Recommended Motion (if needed – action item)	N/A

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Chair Rodriguez will provide an update.
2)
3)

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Memo and bylaws- sent attorney client privilege
Estimated time needed for presentation & questions?	20 minutes
Is closed session recommended? (Consult with attorneys.)	
Form Prepared By/Date Submitted:	Briana Harris/September 2, 2026

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 9

Review and take appropriate action on the policies necessary for the FY27 budget development process including:

a. General Procurement, and
b. Delegation of Purchasing Duties to Purchasing Authority and Certain Officers.[3] (*Action Item*)

AGENDA ITEM SUBMISSION FORM

This form is to provide a general overview of the agenda item in advance of posting for the Board meeting. Proposed motion language is a recommendation only and not final until the meeting and may be changed by the Board Manager making the motion. All information in this form is subject to the Public Information Act.

Agenda Item Meeting Date	September 9, 2026
Who will present the agenda item? (Name, Title)	Chair Rodriguez
Notetaker (Name, Title)	
General Item Description	Review and take appropriate action on the policies necessary for the FY27 budget development process including: a. General Procurement, and *b.* Delegation of Purchasing Duties to Purchasing Authority and Certain Officers. (*Action Item*)
Is this an informational or action item?	Action
Fiscal Impact	
Recommended Motion (if needed – action item)	

Key takeaways about agenda item, and/or feedback sought from the Board of Managers:

1) Chair Rodriguez will provide an update.
2)
3)

What backup will be provided, or will this be a verbal update? (Backup is due one week before the meeting.)	Memo - sent attorney client privilege
Estimated time needed for presentation & questions?	20 minutes
Is closed session recommended? (Consult with attorneys.)	Yes

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EXECUTIVE COMMITTEE

September 9, 2026

AGENDA ITEM 10

Confirm the next regular Executive Committee meeting date, time, and location. (*Informational Item*)