HARRISHEALTH SYSTEM

BOARD OF TRUSTEES

Governance Committee

Tuesday, September 12, 2023
11:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

The meeting may be viewed online at: **http://harrishealthtx.swagit.com/live**

Notice: Some Board Members may participate by videoconference.

Mission

Harris Health is a community-focused academic healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care, and education.

AGENDA

I.	**Call to Order and Record of Attendance**	**Dr. Cody Pyke**	**2 min**
II.	**Approval of the Minutes of Previous Meeting** • Governance Committee – August 8, 2023	**Dr. Cody Pyke**	**2 min**
III.	**Consideration of Approval of the Amendment to Harris Health Policy No. 2.02, Participation in Board Meetings and Board Committee Meetings Via Videoconference Call – *Ms. Elizabeth Winn***		**20 min**
IV.	**Discussion and Possible Action Regarding Board Standard Operating Procedures – *Ms. Sara Thomas***		**15 min**
V.	**Discussion Regarding Committee Vacancies**	**Dr. Cody Pyke**	**15 min**
VI.	**Presentation Regarding Governance Committee Accomplishments – *Ms. Olga Rodriguez***		**5 min**
VII.	**Adjournment**	**Dr. Cody Pyke**	**1 min**

HARRIS HEALTH SYSTEM
MINUTES OF THE BOARD OF TRUSTEES
GOVERNANCE COMMITTEE MEETING
Tuesday, August 8, 2023
11:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Dr. Andrea Caracostis, Presiding Officer, called the meeting to order at 11:01 a.m. It was noted there was a quorum present and the attendance was recorded. Dr. Caracostis announced that while some Board members are in the room, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. Only participants scheduled to speak have been provided dial in information for the meeting. All others who wish to view the meeting may access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live.	
II. Approval of the Minutes of the Previous Meeting Governance Committee – July 11, 2023		**Moved by Ms. Alicia Reyes, seconded by Dr. Andrea Caracostis, and unanimously approved the minutes of the previous meeting. Motion carried.**
III. Updates and Possible Action Related to Location of the Presiding Officer Under the Texas Open Meetings Act	Ms. Sara Thomas, Chief Legal Officer/Division Director, Harris County Attorney's Office, led the Discussion Related to the Location of The Presiding Officer Under the Texas Open Meetings Act (TOMA). She stated that in the Open Meetings Action there is a section which states that the location where the member of the governmental body presiding over the meeting is physically present shall be open to the public during the open portions of the meeting. Unless Harris Health notices a meeting at the presiding officer's location (i.e., house, office) and opens it to the public, TOMA requires that the presiding officer be at the physical location of the meeting. Ms. Thomas mentioned that Administration has recommended revisions to Harris Health's Videoconferencing Policy to further clarify that the presiding officer be present at the physical location of the meeting. A copy of the executive summary is available in the permanent record.	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
IV. Update Regarding Revised Onboarding Process	Ms. Maria Cowles, delivered an update regarding the Revised Onboarding Process. She stated that Harris Health has oriented its two (2) new Trustees and will continue to incorporate everyone's feedback and suggestions on ways to better improve the onboarding process. Ms. Olga Llamas Rodriguez, Vice President, Community Engagement & Corporate Communications, announced Harris Health's First Friday tours and urged the Board members to participate in the upcoming tours. She also noted that an invitation was extended to Harris County Commissioner's Court and was well received. Ms. Alicia Reyes recommended extending the invitation to the Council At-Large members. Additionally, Ms. Reyes recommended including a report on the maternal mortality rates and statistics to the onboarding materials.	**As Presented.**
V. Discussion Regarding Continuing Education Calendar and Governance Committee Priorities	Ms. Olga Llamas Rodriguez, led the discussion regarding Continuing Education Calendar and Governance Committee Priorities. She presented the task and priorities completed throughout the year. Based on the 2022 Board Self-Assessment Survey, Ms. Rodriguez addressed recommendations for education topics, identified action items, strategies, and resources available to the Committee. Ms. Rodriguez touched upon upcoming conferences and continuing education opportunities. Dr. Caracostis recommended consideration of bi-monthly Governance Committee meetings. She also recommended a historical document memorializing the great work that has been done within the Governance Committees over the past year. A copy of the presentation is available in the permanent record.	**As Presented.**
VI. Adjournment	Moved by Ms. Alicia Reyes, seconded by Dr. Cody M. Pyke, and unanimously approved to adjourn the meeting. There being no further business, the meeting adjourned at 11:34 a.m.	

I certify that the foregoing are the Minutes of the Meeting of the Governance Committee of the Board of Trustees of the Harris Health System held on August 8, 2023.

Respectfully submitted,

Andrea Caracostis, M.D., Presiding Officer

Recorded by Cherry Pierson

Tuesday, August 8, 2023

Harris Health System Board of Trustees Board Meeting – Governance Committee Attendance

Note: For Zoom meeting attendance, if you joined as a group and would like to be counted as present, please submit an email to: BoardofTrustees@harrishealth.org before close of business the day of the meeting.

GOVERNANCE COMMITTEE MEMBERS PRESENT	GOVERNANCE COMMITTEE MEMBERS ABSENT	ADDITIONAL BOARD MEMBERS PRESENT
Dr. Andrea Caracostis *(Chair)*	Ms. Marcia Johnson	Ms. Jennifer Tijerina
Dr. Ewan D. Johnson *(Ex-Officio)*		
Ms. Alicia Reyes		
Dr. Cody M. Pyke		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Antoinette Cotton	Louis Smith
Carolynn Jones	Maria Cowles
Cherry Pierson	Dr. Matasha Russell
Daniel Smith	Nick Bell
Derek Holmes	Olga Rodriguez
Elizabeth Winn (*Harris County Attorney's Office)*	Patricia Darnauer
Jeffrey Baffour	Patrick Casey
Dr. Jennifer Small	Randy Manarang
Jennifer Zarate	Dr. Sandeep Markan
Jerald Summers	Sara Thomas (*Harris County Attorney's Office)*
John Matcek	Dr. Steven Brass
Kari McMichael	Victoria Nikitin
Katie Rutherford (*Harris County Attorney's Office)*	

Tuesday, September 12, 2023

Consideration of Approval of the Amendment to Harris Health Policy No. 2.02, Participation in Board Meetings and Board Committee Meetings Via Videoconference Call

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I.

Background

Members of the Harris Health Board of Trustees may participate in board and committee meetings via videoconference in compliance with Texas Open Meetings Act (TOMA). Harris Health has established an internal policy, consistent with TOMA, Policy 2.02 "Participation in Board Meetings and Board Committee Meetings via Videoconference Call" (the "Videoconferencing Policy") to provide guidance on the manner in which a board member can participate via videoconference. The Videoconferencing Policy, and TOMA as outlined below, require that the public notice include the physical location of the meeting at which a quorum and the presiding officer of the meeting will be physically present.

Legal Analysis

Subchapter F of TOMA governs meetings using telephone, videoconference or internet. *See* Tex. Gov't Code Ann. §551.121-.131. Subchapter F explicitly requires that the presiding officer of a governmental body be present at the physical location of a meeting if the entity is a state governmental body or a governmental body that extends into three or more counties. *See* Tex. Gov't Code Ann. §551.127(c). This is consistent with the same requirement for other entities written explicitly in other areas of the law. *See e.g.* Tex. Loc. Gov't Code Ann. §81.001 (b). TOMA impliedly requires the presiding officer of a hospital district such as Harris Health to be present at the physical location of a meeting through the notice section of Subchapter F. That section states that the location where the member of the governmental body presiding over the meeting is physically present shall be open to the public during the open portions of the meeting. Tex. Gov't Code Ann. §551.127(e). Unless Harris Health notices a meeting at the presiding officer's location (i.e., house, office) and opens it to the public, TOMA requires that the presiding officer be at the physical location of the meeting.

Harris Health's policy requiring that the presiding officer of the board or committee meeting be present at the physical location of the meeting is consistent with TOMA and the opinion of the Texas Attorney General's Office.

How the language will appear in the policy if changes are accepted:

The below language was added to the Meeting Requirements in Article IV, new subsection C:

IV. Meeting Requirements.

C. The Presiding Officer of the Board/Committee Meeting must attend the meeting in person.

Remaining subsections in IV will be re-lettered.

II.

Additional technological edits were made as a result of changes to minimum standards adopted effective September 15, 2022 (47 TexReg 5479) and proposed by the Texas Department of Information Resources.

TITLE: PARTICIPATION IN BOARD MEETINGS AND BOARD COMMITTEE MEETINGS VIA VIDEOCONFERENCE CALL

PURPOSE: This policy provides guidance on the manner in which a member of the Harris Health Board of Trustees ("Trustee(s)") may participate in a Board Meetings or a Board Committee Meeting ("Board/Committee Meeting") subject to the Texas Open Meetings Act ("TOMA") via videoconference call ("videoconference").

POLICY STATEMENT:

Harris Health System conducts its public meetings in compliance with the TOMA, including when one or more of its Trustees participate in a Board/Committee Meeting via Videoconference in accordance with the TOMA.

POLICY ELABORATION:

I. Purpose.

This policy provides guidance on the manner in which a Trustee may participate in a Board/Committee Meeting via videoconference.

II. Procedures.

A. General Information.

i. All Trustees may participate in a Board/Committee Meeting subject to the TOMA (i.e., open and executive sessions) via videoconference as described in this policy. (Tex. Gov't Code § 551.127(a))

ii. A Trustee participating via videoconference and who remains visible and audible to members of the public will be considered present at the Board/Committee Meeting for all purposes. (Tex. Gov't Code § 551.127(a-2))

iii. Trustees who participate in a Board/Committee Meeting by videoconference call shall be considered absent from any portion of the meeting during which audio or video communication with the Trustee is lost or disconnected. In that event, the Board/Committee Meeting may continue only if a quorum of the body is

physically present throughout the meeting at the meeting location. (Tex. Gov't Code § 551.127 (a-3))

iv. A Trustee who is participating via videoconference may make motions, second motions, vote, and take any other action allowed by a Trustee as if physically present at the Board/Committee Meeting location. (Tex. Gov't Code § 551.127 (a-2))

III. Responsibilities of Trustees Participating Via Videoconference.

A. Notice by Trustee.

i. If a Trustee wants to participate in a Board/Committee Meeting via videoconference, the Trustee shall notify the Program Director of Board Governance for the Harris Health Board of Trustees ("Program Director") via email communication no later than Seven business days before a regular meeting (less time may be permitted at the discretion of the Board or Committee Chair, respectively) or by a deadline designated by the Board or Committee Chair in the case of a special-called or emergency meeting. Except as provided by Section (III)(5), Trustee requests are prioritized based on the date and time of receipt.

ii. To avoid being counted as absent and to maintain a quorum at the Board/Committee Meeting location, the Trustee must receive written notification from the Program Director prior to the meeting that they may participate via videoconference.

iii. This notification will prevent having more than the maximum number of Trustees attempting to participate via videoconference.

B. How to Access a Board/Committee Meeting Via Videoconference.

i. Trustee must enter the remote meeting room at least 10 minutes prior to the scheduled time of the Board/Committee meeting.

ii. Trustee must use equipment (e.g., desktop computer, laptop, etc.) that includes a webcam. It is recommended that the equipment screen being used is a standard laptop size, as long as the screen size provides optimum viewing for multiple images simultaneously.

iii. Trustee must have the proper software installed to enable the Trustee to join the meeting via videoconference.

iv. Trustee must avoid noisy areas when participating in a Board/Committee Meeting remotely. If Trustee is unable to avoid noisy areas, the Trustee's audio may be muted or the Trustee's videoconference session may be terminated to limit disruptions to the entire meeting.

v. When not speaking, Trustee must mute their volume to minimize background noises.

IV. Meeting Requirements.

A. Camera and microphone access shall be provided at the Board/Committee Meeting location by Harris Health so that members of the public and persons making presentations may participate in the meeting.

B. A quorum of the Board/Committee's Membership must be physically present at the meeting location. (Tex. Gov't Code § 551.127(b))

C. The Presiding Officer of the Board/Committee Meeting must attend the meeting in person.

D. For Board/Committee Meetings at which the anticipated in-person attendance levels are expected to be greater than necessary to achieve a quorum, a maximum of two Trustees may participate in the meeting via videoconference (the number allowed may be less than two depending on the size of the Committee, and the Board/Committee Chair may utilize discretion to increase the maximum number of Trustees participating via videoconference if extenuating circumstances arise).

E. If more than two videoconference requests for a Board/Committee Meeting are submitted in compliance with the notice requirements in Section IIIA(a) above, the Board/Committee Chair has the sole discretion to give priority to the Trustee who submitted the request sooner in time and/or whose stated purpose of the request evidences a need to join the meeting using videoconference technology.

V. The video and audio feed of the videoconference call:

A. Must be broadcast live. (Tex. Gov't Code § 551.127 (a-1))

B. Must permit all Trustees to be able to see and hear each other during the entire Board/Committee Meeting.

C. Must permit members of the public and persons making presentations to be able to see and hear all Trustees during the entire Board/Committee Meeting.

D. Must permit all Trustees to be able to see and hear any members of the public and persons making presentations who are permitted to speak during the Board/Committee meeting while they are actually speaking. (Tex. Gov't Code § 551.127(h))

E. Members of the public who wish to speak at a Board meeting must do so at the physical location of the meeting.

F. Audio/video signals must be of sufficient quality so that members of the public and persons making presentations can observe the demeanor and hear the voice of each participant during the open portion of the Board/Committee Meeting. (Tex. Gov't Code § 551.127(j))

VI. Public Notice.

A. In addition to the regular notice requirements, the notice must specify the physical space where the quorum ~~and the person presiding over that particular~~ of the Board/Committee's Membership is physically present at ~~Meeting are located as~~ "the meeting location." (Tex. Gov't Code § 551.127(d)(e)). The notice shall also indicate that Trustees may participate in the meeting via videoconference.

B. The notice of any Board/Committee meeting, which includes Trustees participating via videoconference, must be posted in the same manner as the regular meetings posted at the site of the Internet broadcast. (Tex. Gov't Code § 551.128)

VII. Minimum standards for audio and video signals prescribed by the Texas Department of Information Resources (DIR) are:

A. Videoconferencing equipment must meet International Telecommunications Union (ITU) standards for appropriate transmission medium:

i. ITU H.320 or H.324 for videoconferencing over a public switched telephone network (PSTN), private line facility, or integrated switched digital network (ISDN).

ii. ITU H.323/SIP (Session Initiation Protocol) for videoconferencing over the ~~public~~ Internet.

iii. Use of videoconferencing equipment with proprietary vendor protocols may be used if the vendor certifies that its equipment and proprietary software protocol release version meets or exceeds the ~~above referenced~~required ITU standards. Prior to use, DIR recommends reviewing technical specifications and contacting the vendor to inquire as to whether the deployed technology meets ITU standards.

~~B. All videoconferencing shall employ a minimum 384 KB transmission speed. Note that bandwidth requirements for various resolutions of high-definition video are vendor specific based on the manufacturer's equipment.~~

B. At least one monitor must be available at the primary Board/Committee Meeting site for the audience to view remote meeting participants and be a minimum of 27 inches in size (as measured by the industry). When using a computer web conferencing system at the primary site, a large monitor and adequate speakers shall be used.

C. Audio signals from a remote dedicated video room environment(s) shall be of similar quality and volume as the local audio at the primary dedicated video room environment.

D. At least one monitor shall be available at the primary dedicated video room environment site for the audience to easily see remote meeting participants. When using a computer web conferencing system at the primary site, a large monitor and adequate speakers shall be used. The audience and members of the governmental body shall have full view of at least one monitor at each meeting location. Additional monitors shall be placed, as necessary, to ensure a clear view by all in attendance.

E. If a governmental body uses a dedicated video room environment for the dedicated camera and speaker equipment but is using a computer-based videoconferencing application that is not part of the proprietary dedicated video room equipment setup, then the entity must comply with all minimum standards for computer-based application software and is not subject to the requirements of a dedicated video room environment. 1 T.A.C. § Pt. 10, Ch. 209, Subch. B, Rule 209.11

VII. Definitions.

A. Open Meeting means a meeting that is open to the public pursuant to Tex. Gov't Code Ch. 551.

B. Executive Session means a properly-convened meeting or part of a properly-convened meeting that is closed to the public as a result of an exception under state law that permits closure such as consultation with attorney, confidential personnel matters, etc.

C. Videoconference call means a communication conducted between two or more ~~Trustees~~ persons in which one or more of the ~~Trustees~~ participants communicate with the other participatantsing ~~Trustees~~ through duplex audio and video signals transmitted over a telephone network, a data network, or the Internet. (Tex. Gov't Code § 551.001(8)); 1 T.A.C. § Pt. 10, Ch. 209, Subch. A, Rule 209.1

D. Codec means a device or computer program which encodes or decodes a digital data stream or signal.

E. Compressed video means video data that has been digitized and, in the process, condensed by the use of one or more of the common video compression processes (i.e., lossy, lossless, inter frame compression, etc.). A codec produces compressed video and uncompressed video at the remote end. 1 T.A.C. § Pt. 10, Ch. 209, Subch. A, Rule 209.~~-~~

F. ITU-International Telecommunication Union.1 T.A.C. § Pt. 10, Ch. 209, Subch. A, Rule 209.1.

REFERENCES/RESOURCES

International Telecommunications Union (ITU) standards.1 T.A.C. § Pt. 10, Ch. 209, Subch. A, Rule 209.

Minimum standards for Meetings Held by Video Conference.1 T.A.C. § Pt. 10, Ch. 209, Subch. B.
~~1~~

Texas Open Meetings Act. Tex. Gov't Code, Ch. 551

See Section 3 above for specific subsections.

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Board of Trustees

REVIEW/REVISION HISTORY

Effective Date	Version # (If Applicable)	Review/Revision Date (Indicate Reviewed or Revised)	Approved by:
09/01/2021	1.0	Reviewed 08/26/2021	Board of Trustees Motion # 21.08-81

BOARD OF TRUSTEES

Governance Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Discussion and Possible Action Regarding Board Standard Operating Procedures

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~~BOARD APPROVAL~~
~~Agenda Item: V.B.~~
~~Date: 12.03.2020~~
~~Motion: 20.12-146~~

HARRISHEALTH SYSTEM

Board of Trustees
Standard Operating Procedures

1. The Harris Health Board of Trustees adopts and implements the Board Standard Operating Procedures to outline the procedural rules for the performance of the Board's duties including complying with the Bylaws, and where applicable, Board policies.

~~1.~~2. A Board Member is a fiduciary. As such, a Board member owes allegiance to Harris Health and the public and must act in the best interest of Harris Health and the public when acting in his or her official capacity. While members are appointed by a specific Commissioner or the County Judge, their duty is to the Harris Health System as a whole. A Board member must always exercise honest and unbiased judgment in pursuit of Harris Health's interests.

~~2.~~3. A Board Member's primary obligation is to participate in the governance of Harris Health and to act within the boundaries of his or her governance authority. ~~The Board of Trustees has delegated to the~~ The Harris Health President/CEO, is responsible for ~~all~~ matters related to operations and administration as is defined in the Bylaws of the Board of Trustees ("Bylaws"), ~~and~~ Chapter 281 of the Texas Health and Safety Code, applicable law regulations, and policies.

~~3.~~4. Board Members must comply with all applicable laws, regulations and policies. ~~and abide by the Board of Trustees Conflict of Interest and Nepotism policy, which requires the disclosure of certain interests and business and familial relationships prior to discussion or voting on an item implicated by the interest or relationship.~~

a. ~~A Board Member shall not vote on or participate in discussions or deliberations on matters when a conflict is deemed to exist.~~

b. ~~A Board Member shall complete the required conflict of interest affidavit and assure that Board or Committee meeting minutes properly record his or her recusal or abstention from voting on any matter for which a conflict may exist.~~

~~4.~~5. When appointed, a Board Member is expected to attend ~~must attend~~ the Board of Trustees' orientation and become knowledgeable of the Bylaws and a hospital district's responsibilities.

~~5.~~6. A Board Member is expected to attend ~~must attend~~ Board meetings and applicable committee meetings and ~~carefully~~ review and evaluate background materials contained in the appropriate "agenda book" published on Diligent. ~~to be prepared~~.

~~6.~~7. A Board Member is entitled to rely upon information, opinions, reports, and statements prepared or presented by Harris Health staff, counsel, accountants, or other Board Members whom the Board Member reasonably believes to be reliable and competent on the matter presented. Board members may request additional information through parliamentary motions when matters require additional inquiry.

~~7.~~8. Board meetings are managed and conducted in a way that promotes transparency and high levels of effectiveness and efficiency, while complying with the Texas Open Meetings Act and allowing for appropriate questions. Pursuant to the Bylaws, meetings are conducted in accordance with Robert's Rules of Order.

Commented [TLS1]: Board member feedback incorporated to facilitate discussion during the September Governance Committee,

Commented [TLS2]: Addition drafted in response to board member comment that procedures should define the process for complying with Bylaws and where applicable, board policy.

Commented [TLS3]: Proposed edits in response to board member comment that Board member fiduciary duties extend to the public.

Commented [TLS4]: There is an inference in state law that Administration is generally responsible for operations and the Board is responsible for Governance. Much of the express authority of the board is outlined by State law.

Commented [TLS5]: Deletions in response to Board member request to remove references already addressed in Board Conflicts of Interest and Nepotism Policy and broaden applicability to all policies.

Commented [TLS6]: Edits suggested by Board member

Commented [TLS7]: Board member comment that this provision is too broad and that although board members may rely on experts to a certain point, certain matters require additional inquiry. Suggest further discussion among board members.

~~BOARD APPROVAL~~
~~Agenda Item: V.B.~~
~~Date: 12.03.2020~~
~~Motion: 20.12-146~~

~~8.~~9. A Board Member must not disclose any information learned in the course of a closed session meeting or any confidential material supplied by Harris Health. If a Board Member is uncertain whether information is confidential, the Board Member should consult with Harris Health's legal counsel to avoid allegations of abuse of office. Violations of the Texas Open Meetings Act could result in civil and criminal penalties.

~~9.~~10. A Board member should listen to and respect the opinions and perspectives of all other members and be willing to respectfully express a dissenting opinion and vote no when their opinion warrants.

~~10.~~11. A Board Member should bring matters of interest to the attention of the Board Chair so appropriate matters can be included on an agenda of a future Board meeting. Board officers and Committee Chairs may participate in reviewing and finalizing draft Board and Committee agendas as part of agenda planning process. The Board Chair and Board Officers may exercise discretion and professional judgment during the agenda planning process.

~~11.~~12. The Board employs and evaluates the President and Chief Executive Officer ("CEO") alone. The Board delegates full authority to the CEO to direct Harris Health's affairs (including supervising its work and activities; formulating strategies and managing its operations) and communicates policies and decisions that may constrain the CEO's authority.

~~12.~~13. ~~A~~Individual Board Members are ~~is~~ not empowered to provide instruction to the CEO of Harris Health or any Harris Health employee unless the Board determines, during a properly called meeting of the Board of Trustees, that such instruction will enable the Board to satisfy their fiduciary duties (e.g., instruction to produce information material to a future Board decision).

~~13. Neither the CEO of Harris Health, nor its employees should be held accountable for fulfilling requests from individual Board Members outside of formal Board action.~~

14. The Board's authority is carried out through actions taken by a majority of the Board who are present and voting during a duly called meeting of the Board of Trustees. If a Board member is absent for a meeting, actions and decisions made will not automatically be reconsidered due the Board member's absence.

15. ~~A Board member should fully support the Board's decisions once they have been made.~~

16. The Board speaks with one voice through the Board Chair unless otherwise authorized by the Board Chair or the Board.

17. A Board Member must direct all media requests to the Board Chair in addition to Harris Health's Office of Corporate Communications at (346) 426-1832.

Commented [TLS8]: In response to board member question of "What is agenda planning process?" Additional board member feedback received stating that Board Chairs and Committee chairs should be required to actively solicit board member feedback on agenda items monthly. Further discussion suggested.

Commented [TLS9]: Board member feedback suggesting deletion of this provision as not appropriate for SOP.

Commented [TLS10]: Deleted upon response to Board member feedback that this is provision is unclear and that Board members should not be required to support decisions that they believe are wrong or unlawful.

Commented [TLS11]: From a historical perspective, the Board Chair served as the spokesperson when there was a request for comments related to a Board action. The 2020 Board wanted it to be clear that the Board Chair should speak in these circumstances. The committee should discuss whether this provision is still necessary and desired.

~~BOARD APPROVAL~~
~~Agenda Item: V.B.~~
~~Date: 12.03.2020~~
~~Motion: 20.12-146~~

BOARD OF TRUSTEES

Governance Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Presentation Regarding Governance Committee Accomplishments

HARRISHEALTH SYSTEM

Governance Committee
September 12, 2023

Olga L. Rodriguez, MPA, MBA

VP Corporate Communications, Community Engagement & Board Services

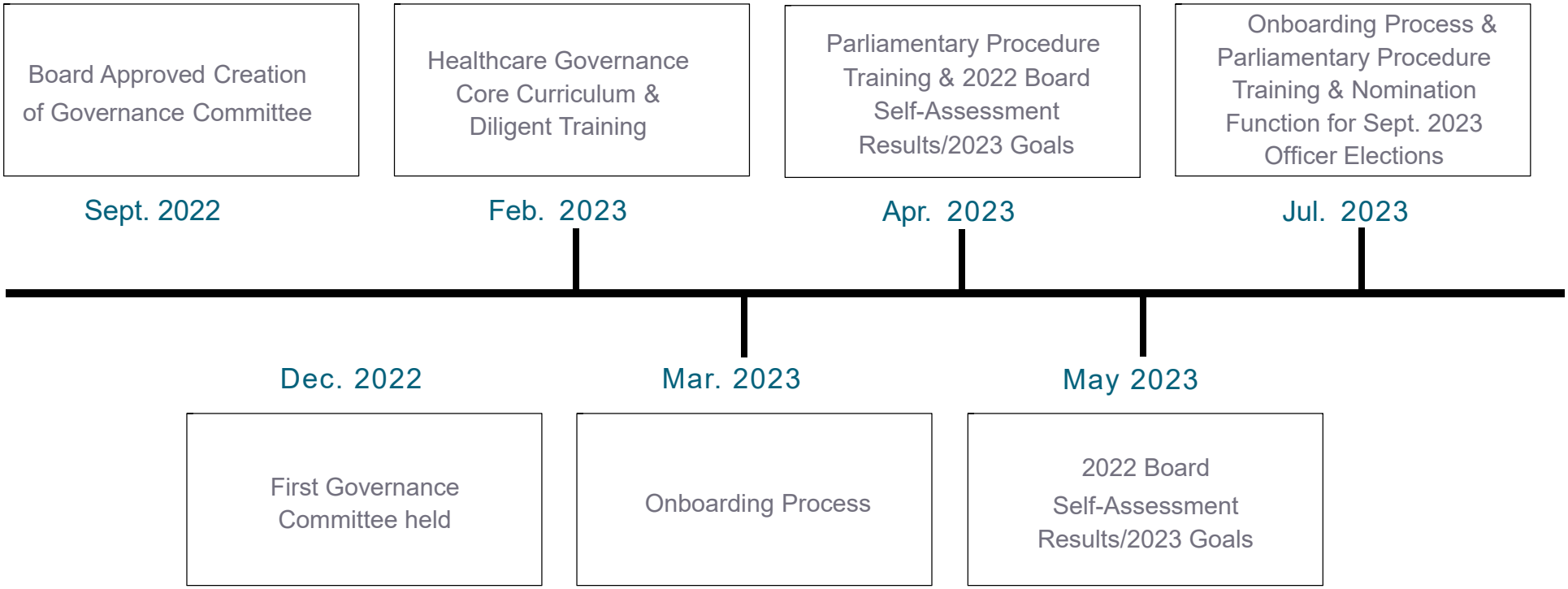
Why Governance Committee Is Necessary

Critical Roles
• Help institutionalize best practices
• Creates formal processes for policies and procedures to be adopted
• Allows board to run more efficiently

Focus Areas of Governance Committee

Focus Areas
• Parliamentary Procedures
• Board Self-Evaluation
• Nomination Process
• Board Engagement
• Onboarding Process

Timeline 2022 - 2023



Next Steps

- Continue to accomplish priorities taken from 2022 Board Self-Assessment
- Consider meeting bimonthly in 2024
- Prepare for 2023 Board Self-Assessment and identify priorities for 2024

HARRISHEALTH SYSTEM

BOARD OF TRUSTEES

Quality Committee

Tuesday, September 12, 2023
12:00 P.M.
(*or immediately following the Governance Committee*)

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

The meeting may be viewed online at: **http://harrishealthtx.swagit.com/live**.

Notice: Some Board Members may participate by videoconference.

Mission

Harris Health is a community-focused academic healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care, and education.

AGENDA

I.	**Call to Order and Record of Attendance**	**Dr. Cody Pyke**	**1 min**
II.	**Approval of the Minutes of Previous Meeting** • Quality Committee Meeting – August 8, 2023	**Dr. Cody Pyke**	**2 min**
III.	**Harris Health Safety Message: Sharing Near Misses, Unsafe Conditions – *Dr. Steven Brass***		**5 min**
IV.	**Presentation Regarding Just and Accountable Culture – *Mr. Omar Reid*** **[Strategic Pillar 1:** Quality and Patient Safety**]**		**10 min**
V.	**Presentation Regarding the Cardiology Service Line – *Ms. Amineh Kostov***		**10 min**
VI.	**Presentation Regarding Population Health: Hypertension Remote Patient Monitoring – *Dr. Esperanza Galvan***		**10 min**
VII.	**Consideration of Recommendation for Approval of Revisions to the Harris Health System 2023 Quality Manual – *Dr. Joseph Kunisch***		**5 min**
VIII.	**Executive Session**	**Dr. Cody Pyke**	**45 min**
	A. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002, to Receive Peer Review and/or Medical Committee Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services ***– Dr. Steven Brass and Dr. Yashwant Chathampally***		*(42 min)*

B.	Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Texas Health & Safety Code §161.032, and Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Carolynn Jones***		*(3 min)*
IX.	**Reconvene**	**Dr. Cody Pyke**	**1 min**
X.	**Adjournment**	**Dr. Cody Pyke**	**1 min**

HARRIS HEALTH SYSTEM
MINUTES OF THE BOARD OF TRUSTEES
QUALITY COMMITTEE MEETING
Tuesday, August 8, 2023
12:00 PM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Dr. Andrea Caracostis, Chair, called the meeting to order at 12:02 p.m. It was noted that a quorum was present and the attendance was recorded. Dr. Caracostis announced that while some Board members are in the room, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. Only participants scheduled to speak have been provided dial in information for the meeting. All others who wish to view the meeting may access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live.	
II. Approval of the Minutes of Previous Meeting Quality Committee Meeting – July 11, 2023		**Moved by Ms. Alicia Reyes, seconded by Dr. Cody M. Pyke, and unanimously approved the minutes of the previous meeting.**
III. Harris Health Safety Message: Just Culture	Dr. Steven Brass, Executive Vice President & Chief Medical Executive, delivered a Minute for Medicine video series related to a Just Culture. Copies of the video series and the presentation are available in the permanent record.	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
IV. Presentation Regarding Maternal Health Service Line	Ms. Amineh Kostov, Vice President of Operations, System Service Lines, delivered a presentation regarding Maternal Health Service Line. She shared that the Maternal Health Service Line at Ben Taub Hospital (BTH) was named one of America's Best Maternity Hospitals by Newsweek. Current initiatives include participation in the Texas Healthy Mothers and Babies Collaborative for Post-Partum Hypertension in the Emergency Department, Texas Alliance for Innovation of Maternal Health (AIM) participation, and Baby Friendly Designations. Ms. Kostov reported that the Maternal Health Service Line has met its timely inpatient treatment of severe hypertensions in pregnancy and the Modified Early Warning Score (MEWS) compliance targets, is working with infection prevention on measure specifications and target for Surgical Site Infection (SSI) – Cesarean Delivery per 100 procedures, has revised its Drug Abuse Screening Test reporting and is now working to develop action plans for underperforming locations across the System, and lastly, has developed new reporting related to Syphilis Testing, HIV Testing, Post-Partum Visit Scheduling, Prenatal Depression Screening and Post-Partum Depressing Screening. Dr. Caracostis requested to see graphs relevant to the data presented which depicts the progress Harris Health has accomplished and benchmarking on how the System is performing against other like entities. Additionally, Dr. Caracostis requested additional upstream strategies to ensure mother's access to prenatal care during the first trimester as opposed to second trimester. Dr. Cody M. Pyke inquired whether Harris Health's pediatric and/or obstetric providers were aware of the billing guidelines and reimbursement for postpartum maternal depression screening. Ms. Kostov stated that she would follow - up regarding Dr. Pyke's inquiry. A copy of the presentation is available in the permanent record.	**As Presented.**
V. Presentation Regarding Contracted Services Update	Ms. Monica Carbajal, Vice President, Contract Administration, delivered a presentation and update regarding Contracted Services. She provided an overview of the Quality Assurance and Performance Improvement (QAPI) Contracted Services Program, stating that Harris Health continues to maintain and mature its program. She stated that contracts are stored in the PeopleSoft Supplier Contracts Module system and all patient-facing contracts have at least one (1) performance metric being monitored to identify and address non-performing vendors. Ms. Carbajal noted that contracted services does have a robust vendor evaluation process in place. In addition, Ms. Carbajal mentioned that that the QAPI Contracted Services Committee meets on a monthly basis. A copy of the presentation is available in the permanent record.	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
VI. Executive Session	At 12:24 p.m., Dr. Caracostis stated that the Quality Committee of the Board of Trustees would go into Executive Session for items 'A through D' as permitted by law under Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002.	
	A. Report Regarding Harris Health System Correctional Health Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002 to Receive Peer Review and/or Medical Committee Report	**No Action Taken.**
	B. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002, to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Healthcare Services	**No Action Taken.**
	C. Annual Reports Regarding Neonatal and Maternal Health Programs for Ben Taub and LBJ Hospitals, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §160.007, and Tex. Occ. Code Ann. §151.002, and Possible Action Regarding this Matter Upon Return to Open Session	**Moved by Ms. Alicia Reyes, seconded by Dr. Cody M. Pyke, and unanimously accepted that the Committee recommends that the Board approve Item VI. C. Motion carried.**
	D. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Texas Health & Safety Code §161.032, and Possible Action Regarding this Matter Upon Return to Open Session	**No Action Taken.**
VII. Reconvene	At 1:24 p.m., Dr. Caracostis reconvened the meeting in open session; she noted that a quorum was present. The Board Committee will now take action on item 'C' of the Executive Session agenda.	
VIII. Adjournment	Moved by Ms. Alicia Reyes, seconded by Dr. Ewan D. Johnson, and unanimously approved to adjourn the meeting. There being no further business, the meeting adjourned at 1:26 p.m.	

I certify that the foregoing are the Minutes of the Meeting of the Quality Committee of the Board of Trustees of the Harris Health System held on August 8, 2023.

Respectfully submitted,

Andrea Caracostis, M.D., MPH, Chair

Recorded by Cherry A. Pierson

Tuesday, August 8, 2023

Harris Health System Board of Trustees Board Meeting – Quality Committee Attendance

Note: For Zoom meeting attendance, if you joined as a group and would like to be counted as present, please submit an email to: BoardofTrustees@harrishealth.org before close of business the day of the meeting.

QUALITY COMMITTEE BOARD MEMBERS PRESENT	QUALITY COMMITTEE BOARD MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Andrea Caracostis *(Chair)*		Ms. Jennifer Tijerina
Dr. Ewan D. Johnson *(Ex-Officio)*		
Ms. Alicia Reyes		
Dr. Cody M. Pyke		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Amineh Kostov	Jerry Summers
Amy Smith	Jessey Thomas
Antoinette "Toni" Cotton	Joseph Kunisch
April Adams	John Matcek
Carolynn Jones	Joseph Garcia-Prats
Celesta Chelf	Kelli Phillips
Cherry Pierson	Louis Smith
Chethan Bachireddy	Maria D'Souza
Daniel Smith	Monica Carbajal
Derek Curtis	Nicholas Bell
Dr. Glorimar Medina	Olga Rodriguez
Dr. Jennifer Small	Pamela Berens
Dr. Jackie Brock	Patricia Darnauer
Dr. Martha Mims	Patrick Casey
Dr. Matasha Russell	Randy Manarang
Dr. Michael Nnadi	L. Sara Thomas (*Harris County Attorney's Office)*
Dr. Otis R. Egins	Shawn DeCosta
Dr. Sandeep Markan	Sophia Tsakiri
Dr. Steven Brass	Suzy Lundeen
Dr. Tien Ko	Teresa Criswell
Dr. Yashwant Chathampally	Theresa Wilson
Dr. Hemant Kumar Roy	Tiffani Dusang
Jannice Phillips	Victoria Nikitin
Jeff Baffour	Victoria Orozco
Jennifer Zarate	

Tuesday, September 12, 2023

Harris Health Safety Message

HRO Safety Message (Video): Harris Health Minute for Medicine

- Sharing Near Misses, Unsafe Conditions

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HRO Safety Message

Sharing Near Misses Unsafe Conditions

Steven Brass, MD, MBA
Chief Medical Executive

Board of Trustees Quality Committee
September 12, 2023

SAFETY MESSAGE

HARRIS HEALTH SYSTEM | ZERO HARM

Safety 1st. Always.

Having a High-reliability Organization's Mindset

High-reliability Organizations (HROs) are those that successfully complete their missions despite massive complexity and high risk. Examples include the Federal Aviation Administration's Air Traffic Control system, aircraft carriers, and nuclear power plants. In each case, even a minor error could have catastrophic consequences. Yet, adverse outcomes in these organizations are rare. The key components of High Reliability Organizations (HROs), including leadership, a safety-focused culture, and a dedication to continuous learning and improvement.

HRO Mindset:

Harris Health System Minute For Medicine: Sharing Near Misses - Unsafe Conditions

https://youtu.be/bQU2UcW4MxQ

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BOARD OF TRUSTEES

Quality Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Presentation Regarding Just Culture and Accountable Culture

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Just and Accountable Culture

Omar C. Reid
EVP, President & Chief People Officer

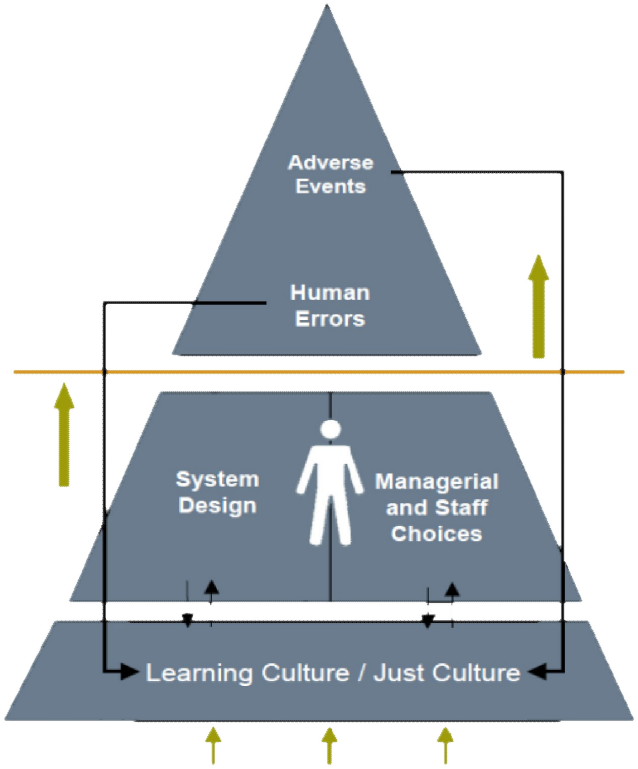
Board of Trustees Quality Committee
September 12, 2023

The single greatest impediment to error prevention in the medical industry is "that we punish people for making mistakes."

Dr. Lucian Leape
Professor, Harvard School of Public Health
Testimony before Congress on
Health Care Quality Improvement

Just Culture is about…

- Creating an open, fair, and just culture
- Creating a learning culture
- Designing safe systems
- Managing behavioral choices



Three Types of Behaviors

HARRISHEALTH SYSTEM

Human Error	At-Risk Behavior	Reckless Behavior
Product of our current System Design	*A Choice: Risk believed insignificant or justified*	*Conscious disregard of unjustifiable risk*
Manage through changes in: • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives for at-risk behaviors • Creating incentives for healthy behaviors • Increasing situational awareness	Manage through: • Remedial action • Disciplinary action
Console	Coach	Punish

At-Risk Behavior:

A behavioral choice that increases risk without perceiving the risk or is mistakenly believed to be justified

Driven by perception of consequences:

Immediate and certain consequences are strong

Delayed and uncertain consequences are weak

Rules are generally weak

Reckless Behavior:

Conscious Disregard of Substantial and Unjustifiable Risk

Manage through:

- Disciplinary Action
- Punishment as a deterrent
- What is in the best interest of your organization and its learning culture?

- **Remediation is always available…**

Creating a Just & Accountable Culture

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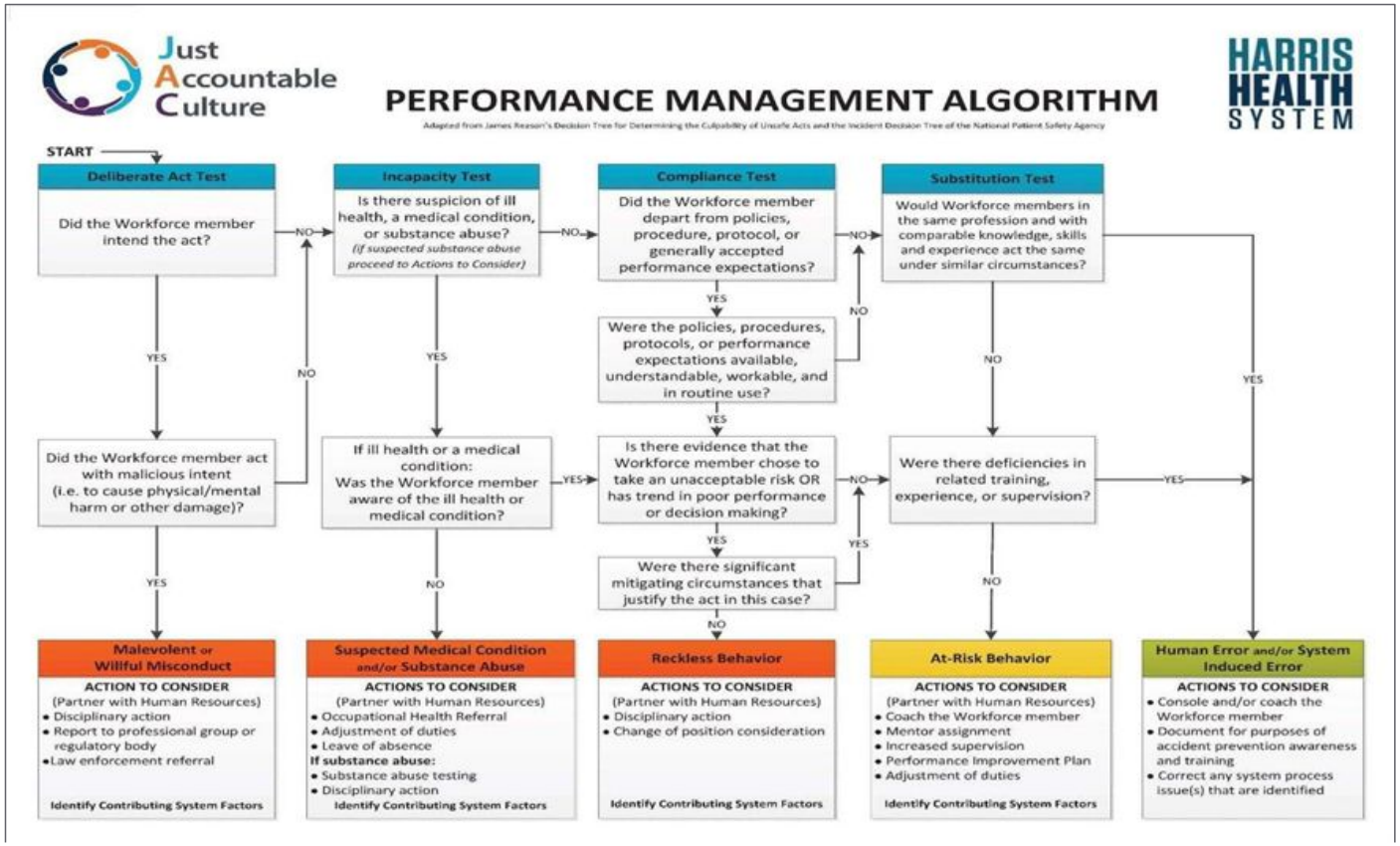

Creating a Just & Accountable Culture

Harris Health's adoption of the Just and Accountable Culture concept establishes an organization-wide mindset that positively impacts the work environment and work outcome in several ways.

JustCulture is about…

Creating an open, fair, and just culture..
Creating a learning culture..
Designing safe systems..
Managing behavioral choices.

BOARD OF TRUSTEES

Quality Committee

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Tuesday, September 12, 2023

Presentation Regarding the Cardiology Service Line

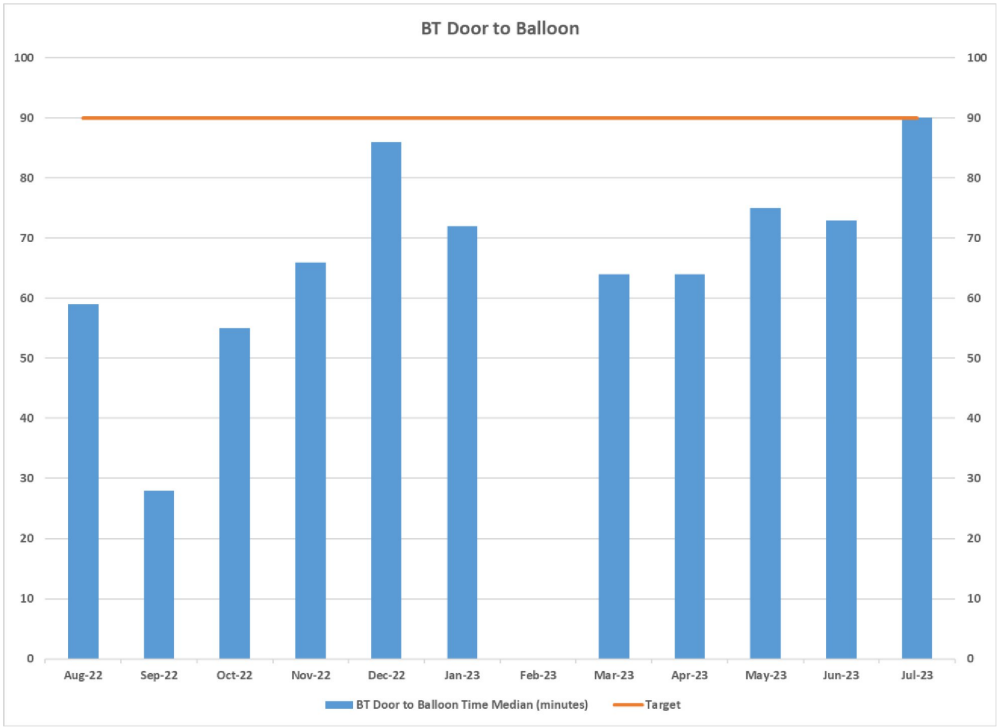
HARRISHEALTH SYSTEM

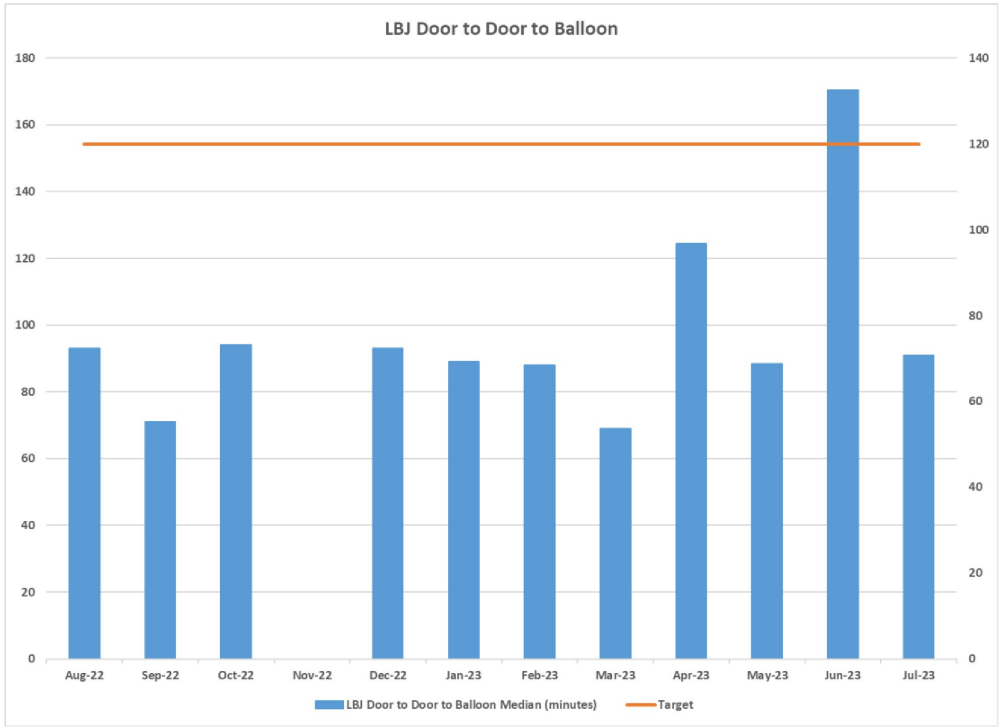
Cardiology Service Line

Amineh Kostov, FACHE, CMAC, CHFP
VP, System Service Lines
System Service Lines

Board of Trustees Quality Committee
September 12, 2023

Chest Pain Door to Balloon Measures





Cardiology Service Line Measures

- We will analyze the LBJ Door In Door Out time between the three Acute Coronary Syndrome Algorithm pathways separately to identify opportunities to improve times.
- Meeting all Heart Failure measure targets. In 2024, we will be adding additional Heart Failure measures to our scorecard.
- Outpatient Transthoracic Echocardiogram (TTE) Turnaround times did not meet target due to both technician and provider vacancies as well as increases in outpatient requests. All other measures are meeting target.
- Currently meeting all Echocardiogram (ECHO) interpretation quality measures.

Cardiology Service Line Goals

- Develop a comprehensive system wide pathway for diagnosis and referral of lipid management in high risk patients
- Improve prescribing rate of Mineralocorticoid receptor antagonists (MRAs) at Discharge (Target Goal 75%)
- Develop a clinical pathway to determine the appropriate stress test for ordering providers
- Develop comprehensive system wide pathway for diagnosis, management, & referral of heart failure patients in the outpatient setting

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Quality Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Presentation Regarding Population Health: Hypertension Remote Patient Monitoring

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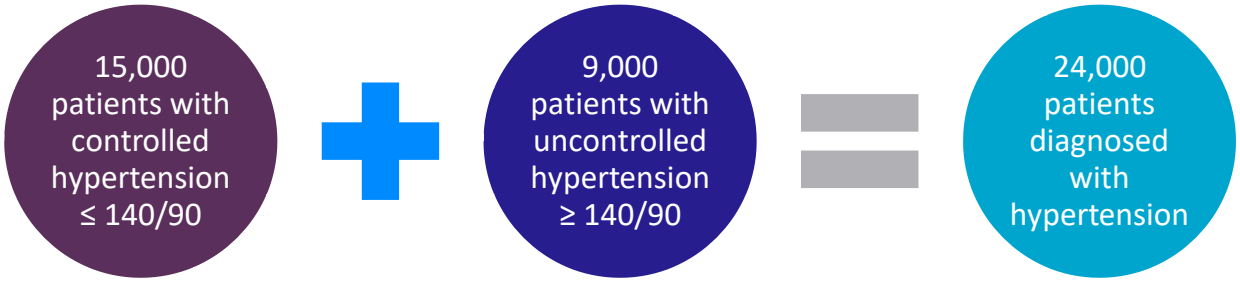
Population Health Hypertension Remote Patient Monitoring

Esperanza Galvan, PhD, MS, CVRN-BC, CDCES
VP, Population Health

Board of Trustees Quality Committee
September 12, 2023

Hypertension at Harris Health Overview
Harris Health Addressing Health Disparities



Falling short of expectations
- **63.8%** controlled (≥ 140/90)
- NCQA 75th percentile goal is ≥ **76.00%**

Healthcare **affordability**, limited **access** to care, and **health related social needs** exacerbate hypertension control challenges.

Positive impact is **achievable and sustainable** via a multidisciplinary blood pressure strategy that:
- Is **patient-centric**
- Is rooted in **evidence-based practice**
- Addresses **disparities**
- Enables disease **self-management**

Harris Health responds with HealthyConnect RPM

Why Remote Patient Monitoring (RPM)?

- Demonstrated success of RPM across the nation
- Poor hypertension control with **standard approach** to managing hypertension in primary care
- Patients needed an **at-home** solution

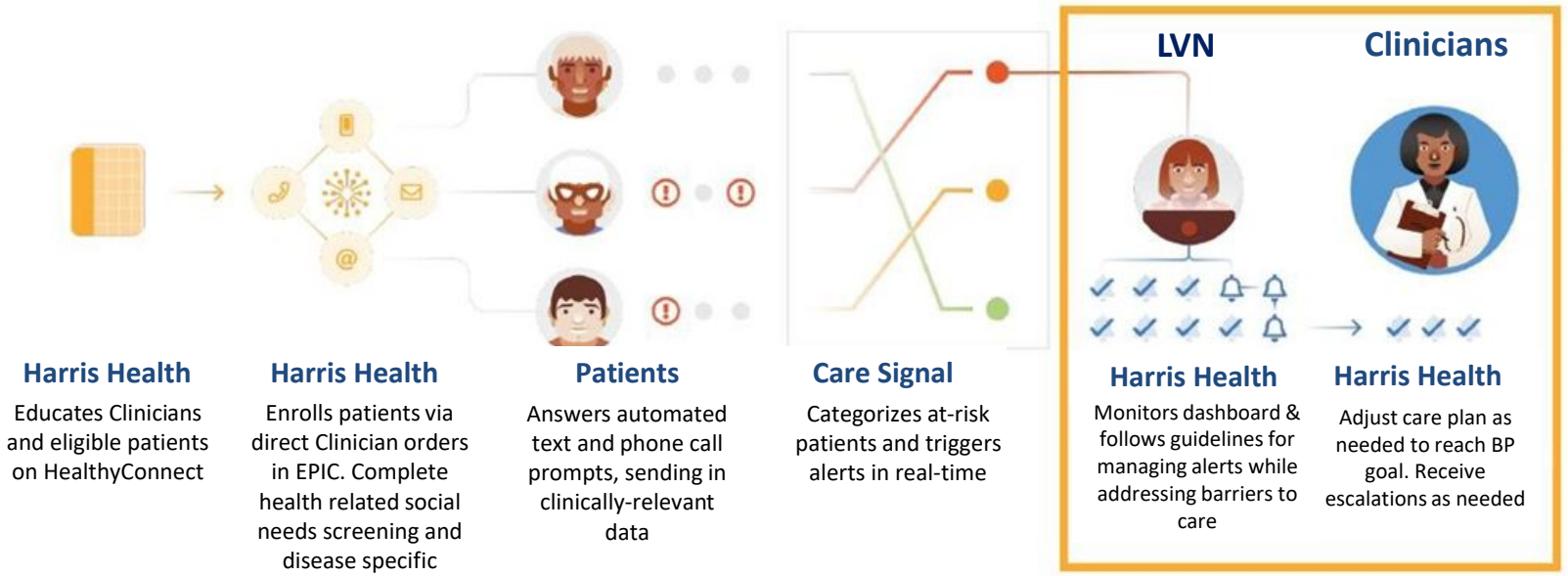
Multisector approach

- Role of primary care provider
- Involvement of **interdisciplinary** team
- Medication management
- Alert management vs. **wrap-around** services
  - » Health related social needs screening + linkage
  - » System navigation
  - » Care coordination
  - » Community partnerships

Pilot sites

- **2,637** patients with uncontrolled hypertension across **3 initial implementation sites**

HealthyConnect Patient Journey



Harris Health
Educates Clinicians and eligible patients on HealthyConnect

Harris Health
Enrolls patients via direct Clinician orders in EPIC. Complete health related social needs screening and disease specific education

Patients
Answers automated text and phone call prompts, sending in clinically-relevant data

Care Signal
Categorizes at-risk patients and triggers alerts in real-time

Harris Health
Monitors dashboard & follows guidelines for managing alerts while addressing barriers to care

Harris Health
Adjust care plan as needed to reach BP goal. Receive escalations as needed

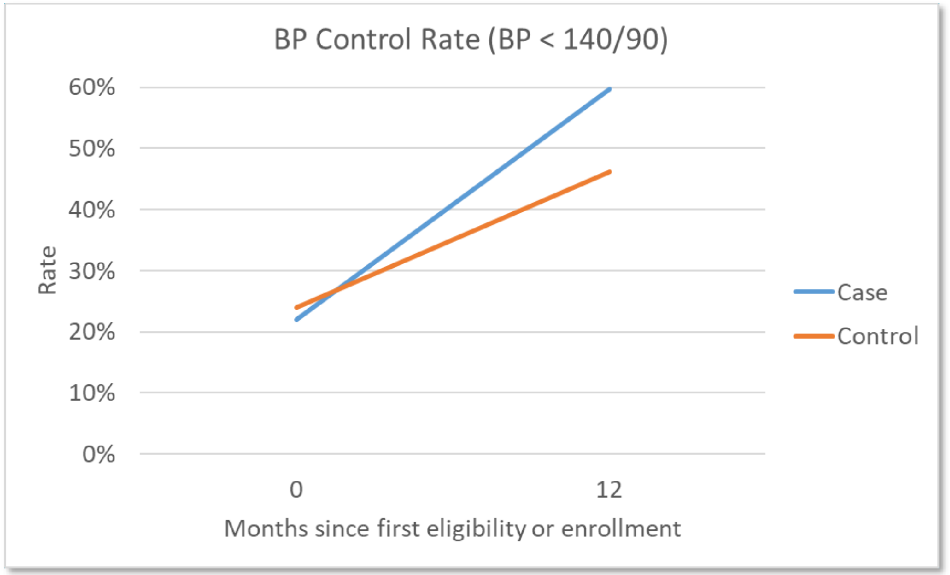
Results

RPM program led to substantial and statistically-significant improvement in rate of blood pressure control

- Blood pressure control rate was **29% higher** among RPM population than non-RPM population
- **80%** of high-risk patients improved (patients with >160 systolic or <90 diastolic (n=84)

Patients recommend the program

- **94.12 Net Promoter Score** (NPS is a gauge of overall satisfaction. Benchmark >70 Excellent)



VITAL2023 Connect. Inspire. Lead

On the national stage: The VITAL2023 conference occurred on June 15th, hosted by the America's Essential Hospitals. Krystal Gamarra, Population Health Administrative Director, and Dr. Matasha Russell, ACS CMO, were invited and presented this work as a mini-session under the VITAL2023 Innovations in Healthcare track.

BOARD OF TRUSTEES

Quality Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Consideration of Recommendation for Approval of Revisions to the Harris Health System 2023 Quality Manual

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Consideration of Recommendation for Approval of the Changes made to the Harris Health System 2023 Quality Manual.

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Harris Health System Quality Manual 2023 Revisions

Joe Kunisch PhD, RN, CPHQ
VP, Quality Programs

Board of Trustees Quality Committee
September 12, 2023

Harris Health Quality Manual Revision Summary

1. Added Diversity, Equity and Inclusion to the Strategic Plan Overview (pg. 8)
2. Removed Reference to Interdisciplinary Clinical Committee (ICC) as Clinical Care Committees have replaced these functions (pg. 13)
3. Added Executive Corporate Compliance Survey Readiness Subcommittee (ECCSR) activities (pg. 13)
4. Added section for Clinical Care Committee framework that replaces ICC functions (pgs. 14-15)
5. Updated Harris Health System Scorecard to reflect newer Balanced Score Card (BSC) version (pg. 17)
6. Removed reference to "Risk Based Thinking" and referred to Harris Health Patient Safety/ Risk Management Manual (pg. 18)
7. Removed Reference to Innovation Department as it no longer exists (pg. 19)
8. Added verbiage to designate the Quality Board of Trustees as the final approver of the BSC Metrics (pg. 21)
9. Revamped Quality and Patient Safety Structure reporting diagram to remove reference to MEC/MEB as those entities have their own reporting structure to the Harris Health Board of Trustees and updated the Quality and Patient Safety Organizational Structure diagram (pg. 24)
10. Updated "Corrective Action" verbiage to "Quality Improvement" to transition from a punitive to a supportive vernacular (throughout document)

HARRISHEALTH SYSTEM

Quality Manual

~~2021~~20233~~2~~

Approved by:
Harris Health System
Board of Trustees
March 202~~1~~3~~2~~

Table of Contents

~~V.~~I. INTRODUCTION

~~The~~ Harris Health System is a community-owned, healthcare system dedicated to providing high quality, cost effective, compassionate health care to residents of Harris County regardless of their ability to pay. Harris Health System is a teaching system for Baylor College of Medicine and The University of Texas Health Science Center at Houston (UT Health). Harris Health~~We~~ trains the next generation of healthcare providers, nurses and allied health professionals.

A nine (9)-member Board of Trustees appointed by the Harris County Commissioners Court governs Harris Health System and approves this Manual. The Board of Trustees appoints the Harris Health System President /Chief Executive Officer to oversee operations of the system.

~~VI.~~II. PURPOSE

The Quality Manual outlines Harris Health System's organizational approach to monitoring and improving quality of care, patient safety, and overall satisfaction. The manual supports our commitment to our patients in that it supports Harris Health System's mission, vision, values, and strategic goals. The manual also establishes a systematic, organization–wide approach to quality that cultivates a culture of patient safety and continual performance improvement. The Quality Manual documents the Quality Assessment and Performance Improvement (QAPI) requirements of the CMS Conditions of Participation (COP).

~~VII.~~III. GUIDING PRINCIPLES

Creating a culture of safety, including providing safe care and a safe environment, and continual improvement, is the work of the entire organization. Harris Health System has adopted the Institute of Medicine (IOM) six (6) domains of Health Care Quality as the guiding principles for our Quality Manual. These six (6) aims (S.T.E.E.E.P.) guide our work to facilitate performance excellence:

A. Safe: Avoiding harm to patients from care that is intended to help them.

B. Timely: Reducing waits and sometimes-harmful delays for both those who receive and those who give care.

C. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively.)

D. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

E. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

F. Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

~~VIII.~~IV. JUST AND ACCOUNTABLE CULTURE

It is inevitable that people will make mistakes. Thus, a Just and Accountable Culture creates an

open, fair, and learning culture by recognizing that individuals demonstrate certain behaviors, which organizational leaders should identify and manage appropriately. Behavioral choices include Human Error, At-Risk Behavior, and Reckless Behavior.

A Just and Accountable Culture promotes learning so employees are engaged and encouraged to speak up and share near misses, etc. to~~so that we could~~ learn from ~~the~~ event~~s~~ and prevent future occurrences.

A Just and Accountable Culture recognizes that many errors represent predictable interactions between human operators and the systems in which they work.~~-~~ So, when mistakes are made, we must learn from them, and then design safer systems and processes to prevent them from occurring again.

A Just and Accountable Culture balances leadership management of the behavioral choices with individual accountability.~~-~~ Human error and at-risk behavior will be managed appropriately, but there will be zero tolerance for reckless behavior.

~~IX.~~V. QUALITY POLICY – MISSION, VISION, VALUES, PROMISE

Harris Health System will continually improve its quality management system in order to fulfill its mission, vision, values, and promise in delivering high quality health care to Harris County residents.

Our Mission:

Harris Health is a community-focused academic healthcare system dedicated to improving the health of those most in need in Harris County through quality care delivery, coordination of care, and education.

Our Vision:

Harris Health will become the premier public academic healthcare system in the nation

We Value:

~~Harris Health values~~ **QUALITY**~~:~~

Q~~-~~ Quality and Patient Safety
U~~-~~ United as One Harris Health System
A~~-~~ Accountable and Just Culture
L~~-~~ Leadership and Integrity
I~~-~~ Innovation, Education, Research
T~~-~~ Trust, Recognition, Respect
Y~~-~~ You: Patients, Employees, Medical Staff

~~X.~~VI. STRATEGIC GOALS AND QUALITY OBJECTIVES

Harris Health System leadership, in collaboration with the Board of Trustees and affiliated Medical Staff, has cooperatively developed strategic pillars related to Quality and ~~patient~~ Patient ~~safety~~Pafety, ~~people~~People, ~~one~~ Pne Harris Health System, ~~population~~ Population ~~health~~ Health

Commented [SE1]: Should these be discussed added?

Commented [JCR2R1]: Pillar 6 needs to be added

~~management~~ Management ~~and infrastructure~~ Infrastructure ~~optimization~~Optimization and Diversity and Inclusion.

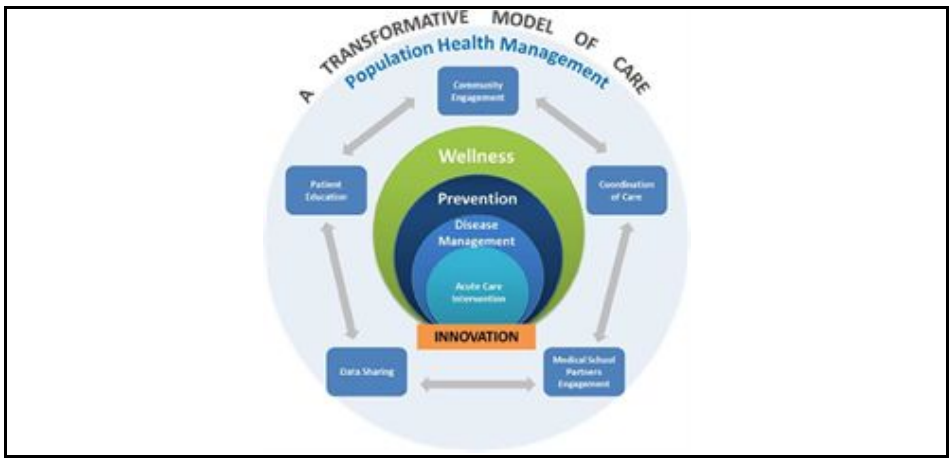
Goals and Objectives have also been developed to support the shared commitment to Safety, Quality and Performance Improvement. Refer to Harris Health System Strategic Plan 2021 - 2025 for Quality Strategic Goals and Objectives. The Strategic Plans are aligned with the targets and goals of each pavilion and further cascaded to the department levels.- Please refer to the Executive Dashboard and the ~~different~~ metrics as identified by the pavilions and service area ~~QAPI~~ Quality Improvement Committees.

Strategic Plan Overview:

- Quality and patient safety: Harris Health will become a high-reliability organization (HRO) with quality and patient safety as a core value where zero patient harm is not only a possibility but an expectation.
- People: Harris Health will enhance the patient, employee and medical staff experience and develop a culture of respect, recognition and trust by actively listening to feedback and developing strategies to address high-impact areas of opportunity.
- One Harris Health System: Harris Health will act as one system in its approach to the management and delivery of healthcare.
- Population health management: Harris Health will measurably improve patient health outcomes by optimizing a cross-continuum approach to health that is anchored in high-impact preventive, virtual and community-based services, deployed in coordination with clinical and social services partners, and underwritten by actionable population health analytics and technology.
- Infrastructure optimization: Harris Health will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety and meet the current and future needs of ~~the~~Harris Health System patients ~~we serve~~.
- Diversity, Equity and Inclusion: Harris Health will ensure equitable access to high-quality care for patients, foster a diverse and inclusive workplace, cultivate and sustain strategic relationships with supplies and community partners, and broaden its reach and understanding of the communities it serves.

The Pathway- A Transformative Model of Patient Care Delivery

> As we build toward the future, our patient care priorities will be implementation of a robust quality and patient safety, people, one Harris Health System, population health management and infrastructure optimization. We will also vigorously sustain the mission of training the next generation of health care professionals through teaching and research.



~~XIV.~~VII. SCOPE

The Quality Manual encompasses all Harris Health System departments and services (including those furnished under contract or arrangement) that impact patient care, safety, and health outcomes.

A. Overview:

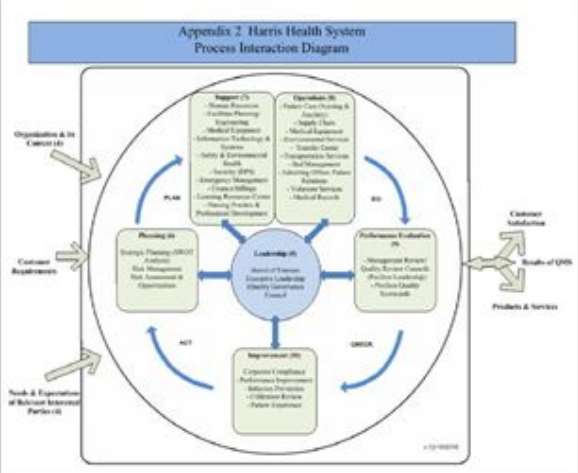
Harris Health System is a community-owned, comprehensive, integrated, healthcare system dedicated to providing high quality, cost effective, compassionate health care to all residents of Harris County regardless of their ability to pay.~~-~~ To fulfill its service mission, Harris Health System operates:

1. Two (2) acute care hospitals
2. ~~Six~~Fifteen (1~~5~~6) Community Health Centers;
3. ~~Three~~ Two (2~~3~~) Pediatric and Adolescent Health Centers;
4. ~~Nine~~Seven (7~~9~~) Homeless Shelter Sites;
5. ~~Five (5) School Based Clinics;~~
6. ~~6.~~5. ~~Six (6)~~ Mobile Health ~~Clinics~~Fleet;
7. ~~7.~~6. T~~wo~~hree (~~2~~3) Specialty Clinic Sites;
8. ~~8.~~7. ~~Five~~ Three (5~~3~~3) Same-Day Clinics;
9. ~~9.~~8. Dental Center;
9. Dialysis Center;
10. HIV Clinic;
11. Contracted Outside Medical Services;
12. "Ask My Nurse" 24/7 Telephone Nurse Triage line;
13. Emergency Medical Services Fleet;
14. Ambulatory Surgery Center

Commented [SE3]: Is this correct? Isn't it just Homeless Health?

Commented [KJ4R3]: Homeless Health is the program served at the homeless sites

B. Process Interaction:
The processes within Harris Health System Quality Management System are interrelated. The Harris Health System Process Interaction Diagram provides a high level illustration of these relationships.



C. Key Processes and Support Processes
Patient experience as a process approach can be grouped into 4 key processes:

1. Patient identification and assessment – includes patient intake, triage, registration, and health assessment leading to admission or discharge.
2. Development of treatment plan – includes care and treatment planning, provided either for inpatient or outpatient.
3. Delivery of care – includes delivery and coordination of care (treatment and ancillary services such as diagnostic, therapeutic, and custodial.
4. Transition of care – includes assessment of treatment plan effectiveness, analysis of patient outcomes, patient status determination to either continue treatment, change treatment or discharge, and patient feedback.

~~Services:~~
~~The services provided are detailed in the Harris Health System Schedule of Benefits – Authorization Matrix. Refer to Harris Health Intranet Site.~~

~~XV.~~VIII. GOVERNANCE, STRUCTURE, AND LEADERSHIP RESPONSIBILITIES

A. Harris Health System designed quality structure and processes to enhance engagement and collaboration, to define accountability and improve outcomes.

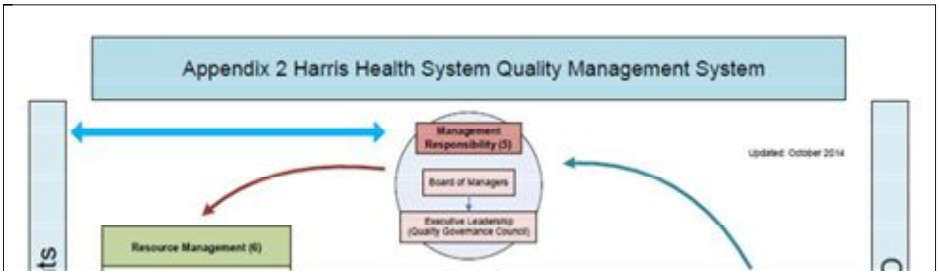
Commented [SE5]: Not sure what this means

Commented [KJ6R5]: Custodial care is non-medical care provided to assist people with daily living. Custodial-care services may include bathing, cooking, cleaning, and other necessary functions. Medicare and Medicaid both partially cover custodial care services, but only in specific situations and conditions.

Commented [SE7]: Not sure this is on the website as stated here.

Commented [KJ8R7]: I believe this was a legacy carry over. I also could not find it on our intranet except for an old document from 2012 in the archives

10



1. Governance:
   Board of Trustees
   The Harris Health System Board of Trustees (BOT) is the governing body of Harris Health System. It has the ultimate authority and responsibility for the review, approval, and monitoring of Harris Health System's Quality Management System. The BOT ensures that an integrated plan is implemented throughout Harris Health System. The BOT designates the President/Chief Executive Officer as the executive agent who oversees the operations of the organization's Quality Management System. Refer to the Harris County Hospital District Board of Trustees Bylaws.

2. BOT Quality Committee
   This is a committee of the Board of Trustees that oversees the Quality, Patient Safety, and Performance Improvement (PI) Programs ~~Harris~~ of Harris Health System in order to maintain a high reliability environment supporting quality, patient and staff safety, and overall satisfaction within Harris Health System.

3. Quality Governance Council (QGC)
   The QGC provides executive oversight for Harris Health Quality Management System to support and facilitate the continual improvement of quality health care. The QGC has the responsibility and authority to determine if the Quality Management System (QMS)/Quality ~~Assessment~~ Assurance and Performance Improvement (QAPI) plan has been effectively implemented and maintained. The QGC ensures conformance to the National Integrated Accreditation for Healthcare Organizations (NIAHO) standards and other statutory requirements as stipulated by State and Federal agencies. The QGC performs the management review functions as defined by the ISO 9001 standard requirements. According to the ISO 9001:2015 standard 9.3 Management Review, top management shall review the organization's quality management system~~,~~ at planned intervals~~,~~ to ensure its continuing suitability, adequacy, effectiveness and alignment with the strategic direction of the organization. This review shall include assessing for risks, opportunities, and the need for changes to the quality management system, including the quality policy and quality objectives.

   The review includes information on:
   a) The status of actions taken from previous management reviews;
   b) Changes in external and internal issues that are relevant to the quality management system;
   c) Information on the performance and effectiveness of the quality management system, including trends in:
      - Customer satisfaction and feedback from relevant interested parties;
      - The extent to which quality objectives have been met;
      - Process performance and conformity of products and services;
      - Nonconformities and ~~corrective actions~~ quality improvements;
      - Monitoring and measurement results;
      - Audit results;
      - The performance of external providers;
   d) The adequacy of resources;
   e) The effectiveness of action taken to address risks and opportunities;
   f) Opportunities for improvement.

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The review also includes the decisions and actions related to:
a) Opportunities for performance and quality improvement;
b) Any need for changes to the quality management system;
c) Resource needs.

Refer to QGC Bylaws for its membership composition and committee's oversight responsibility.

4. Pavilion Quality Review Council (QRC)
The QRC provides oversight for the Quality Management System/QAPI Plan at the Pavilion level. Each Pavilion has its own QRC. The QRC has the responsibility and authority to determine that the Quality Management System has been effectively implemented and maintained at the Pavilion level. The QRC acts at the direction of the QGC and reports to the QGC. ~~—~~The QRC is responsible for measurement, monitoring, and analysis of the National Integrated Accreditation for Healthcare Organizations (NIAHO) QM.7 Standard Requirements (SR).1-SR.19 quality of care metrics and other regulatory survey findings. The QRCs develop performance goals that are in alignment with the Harris Health System strategic objectives. In addition, all accredited and ~~/~~certified programs are required to routinely report (minimum of once per year) outcomes and performance metrics to QRC. The different service area ~~QAPI~~ Committees are to report up to the QRCs. The QRCs may also initiate performance improvement teams for issues that are unique to the departments within the pavilion. Refer to Ben Taub Hospital QRC Bylaws, Lyndon B. Johnson Hospital QRC Bylaws, and Ambulatory Care Services QRC Bylaws for their respective membership composition and oversight responsibility.

5. Medical Executive Board and Pavilion Medical Executive Committees
The Medical Executive Board (MEB) is a delegated BOT authority to oversee the operations of the Medical Staff. The Medical Executive Board and Pavilion Medical Executive Committees receive quality information and share Medical Staff quality information at the appropriate Harris Health System quality forum(s).- See Medical Staff Bylaws for the committees' membership composition and oversight responsibility.

6. System Level Committees
Harris Health System has multiple forums with specific functions that support the Quality Management System. When supporting the Quality Management System, these committees~~,~~ act at the direction of the QRC/QGC. ~~-~~ These committees include but are not limited to the following:

Service Area ~~QAPI~~ Committees
The Service Area ~~Quality Assessment and Performance Improvement (QAPI)~~ C~~c~~ommittee~~s~~ are~~is~~ responsible for ensuring that quality and safe care is delivered to its patients. Each area~~The QAPI~~ c~~C~~ommittee shall ensure that the service and~~rea~~ quality management system is established that includes a leadership structure, key processes, ~~and~~ key support processes, outcome metrics, performance improvement processes, and reporting processes from the service delivery up to the board. Each service area ~~QAPI~~ c~~C~~ommittee is responsible for implementing and reviewing the effectiveness of its charter.

12

Commented [SE9]: Is this true?

Commented [KJ10R9]: Yes, the QGC is the oversight committee for the QRCs

Commented [SE11]: Is this true? Some of the below committees do not seem to fit.

Commented [KJ12R11]: Yes, as it relates to quality, all items reviewed by each of these committees should go through approval of the QGC

-Evidence Based Practice Committee (EBPC)
This committee supports the development of clinical practice guidelines, standing delegated orders and care protocols for Harris Health System. It ensures that the care provided to patients is current and based on evidenced based practices.

Policy and Procedure Committee~~s~~
Structure and Organizational Standards (SOS) Committee: A system-level executive Policy committee that maintains executive approval authority for system-level Policies, Procedures, Standards, and Standard Operation Procedures (SOPs) involving non-clinical operations.- The SOS also serves as executive-level decision point of authority for all non-clinical and clinical practice and operations Policies, Procedures, Standards, and Standard Operating Procedures.

~~Interdisciplinary Clinical Committee (ICC)~~
~~A system-level executive policy committee that maintains executive approval authority for system-level Policies and Procedures, Standing Medical and Delegation Orders, and Clinical Practice Guidelines, Clinical Pathways, and Protocols (non-Research) involving clinical practice and operations. ICC membership is restricted to identified Harris Health executive clinical decision makers and executive medical staff members appointed by the Harris Health Chief Executive Officer (CEO).~~

Physical Environment
This committee ensures that the Physical Environment and supporting functional area processes are implemented, maintained, measured and improved so that the condition of the physical plant and overall healthcare environment is developed and maintained for the safety and well-being of patients, visitors and staff. Refer to Physical Environment Committee Charter.

Executive Corporate Compliance Survey Readiness Subcommittee (ECCSR)~~- Vivian to provide verbiage (CV texted 4.18.23)~~
This is a subcommittee of the Harris Health System Executive Corporate Compliance. The subcommittee serves as an oversight body to ensure a state of survey readiness and to maintain compliance with federal, state, local, accreditation and other certification standards that govern the quality and safe care to Harris Health patients. This committee meets six (6) time annually. The provision of maintaining regulatory compliance is an interdisciplinary, collaborative effort and therefore, a system-wide management approach is implemented across the health system. The Survey Readiness Subcommittee is designed to fulfill the following objectives:

- Continuously evaluating for compliance to federal, state or local laws and regulations to maintain licensure/accreditation/certification status and fiduciary responsibilities;
- Taking a proactive stance to developing & implementing policy or procedure to meet the intent of regulatory requirements;
- Standardizing the process for management of survey activity including staff involvement, awareness, and delineating roles & responsibilities;

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Commented [SE13]: Not sure this is a committee that is under Quality/QGC?

Commented [KJ14R13]: It's not to indicate the committee is under QGC but quality of care related P&Ps should be approved by the QGC for example, the restraint P&P

Commented [SE15]: This committee is no longer in existence correct?

Commented [KJ16R15]: Correct

- Identifying opportunities, improve processes and provide resources, as appropriate, to deliver quality and safe care and maintain regulatory compliance; and
- Developing an approach for achieving an integrated health system

On a monthly basis, information relating to accreditation survey activities, previous year survey's ~~corrective action plan~~ quality improvement plan~~, and other improvement project~~ discussed at this subcommittee also forwarded to the pavilion-based Quality Review Councils or System Quality Governance Council, as requested, to ensure standard compliance and process compliance are integrated as one. At the Board level, a summary of the presentations and decision made in this committee is presented to the Board Audit and Compliance Committee for oversight.

Refer to ECCSR Plan and Charter for additional information.

7. Department/Service Committees/Councils
   As part of the Quality Management System, each service and/or department conducts quality and patient safety focused activities as described in the documented procedures outlined in Section VIII of this Manual. The Harris Health System Process Interaction Diagram lists Harris Health System Departments/Services.

8. Clinical Care Committees (CCC)
   The purpose of a CCC is to seek and implement ways to improve the delivery of high reliability care to patients within the Harris Health System. This CCC will oversee clinical practice activities related to patient care with a focus on standardizing care across the system and serve as the authoritative decision making body as it relates to the area of focus. Specifically, the CCC:

   A. Identifies and implements specific initiatives and projects that:
      I. Are consistent with the overall goals and purposes of the entire Harris Health System in advancing the delivery of care to the patient population
      II. Articulate, clearly, the requisite resources required and the associated work plan, and
      III. Have a clear, demonstrable end point that results in readily measurable improvements in patient outcomes and/or readily measurable reductions in patient mortality and length of stay
      IV. Articulate, clearly, the requisite resources required and the associated work plan including an explicitly stated time frame for their completion and implementation.
   B. Identifies patient care best practices as supported by scientific evidence and facilitate their usage throughout the system.
   C. Works to eliminate unnecessary variations in patient care processes to achieve the highest outcomes in efficiency and safety.
   D. Develops and reviews clinical outcomes performance reports and shares them with the providers and pavilions to improve patient care.
   E. Provides meaningful communication of its initiatives to Harris Health Executives by leveraging the Quality Reporting Committee framework

9. Composition

The CCC is composed of a Multidisciplinary group representing all clinical and ancillary departments with significant influence on the delivery of care to a septic patient. The CCC is supported by a dedicated Harris Health System Quality Performance Improvement Program Manager who will assist the CCC Chairs with setting the agenda and coordinating the meeting logistics including meeting minutes and maintaining documents. Each CCC will maintain a Charter approved by the QGC. The CCC is composed of the 4 types of members:

1. Chairs- this consists of 2 designated leaders that will guide the committee in the direction of improving overall patient care at Harris Health
2. Voting Members- this consists of designated physicians designated by the Chief Medical Executive and Registered Nurse leaders designated by each Pavilion Chief Nursing Officer (CNO). These members will be the official votes counted for any motions introduced by either of the 2 Chairs. Every voting member may temporarily designate a representative to vote for them when they cannot attend.
3. Non-Voting Members- This consists representatives from various clinical and non-clinical areas that provide input on any topic of discussion. Each assigned non-voting member can pull other staff members from their respective areas to participate to lend their expertise when certain topics are discussed.
4. Non-Voting Adhoc Member- This consists of staff members that serve as either back-ups to the other permanent non-voting members or are added to specific meetings to lend their expertise.

Commented [SE17]: Should we refer to the committee bylaws/charter as we have done for the other committee composition in this document?

Commented [KJ18R17]: Added verbiage

D. Recommendations and Reports

a. The CCC recommendations and performance improvement reports will be submitted monthly in writing to the Quality Reporting Committees which may consists of Pavilion level QRCs, QGC and Quality Board Subcommittee when appropriate. Within this Quality Assurance and Performance Improvement (QAPI) framework, any additional resources will be requested and assistance with any barriers to performance improvement will be presented.

~~8.~~9. Medical Staff Committees

Harris Health System Medical Staff Bylaws outlines Medical Staff Committees and their duties. These committees are coordinated through Harris Health System Medical Staff Services and are accountable for ongoing monitoring and reporting of key quality indicators as appropriate to the committee's scope. Medical Staff Committees receive the organization's quality information and share Medical Staff quality information with appropriate Harris Health System quality forums. Refer to the Medical Staff Bylaws for the various committees' membership composition and oversight responsibility.

B. Structure

The diagram below illustrates the structure and flow of quality information within Harris Health System. Refer to organization chart in Appendix A.

C. Leadership Responsibilities

The Harris Health System Quality Programs (QP) Department has an integral role in facilitating quality, patient safety, and performance improvement activities and forums. The QP Department collaborates with Medical Staff, Harris Health System leadership, and staff to facilitate measurement and improvement in an effective and timely manner. The QP

Department also assists in the implementation of an interdisciplinary approach and provides quality resources through an integrated delivery network and information management. The QP Department serves as an improvement subject matter expert and support resource. Accountability of metrics and improvements are~~is~~ owned by the leadership of the reporting service and/or department.

Commented [SE19]: Fix formatting

~~XVI.~~IX. MEASUREMENT, ANALYSIS AND IMPROVEMENT

Measurement of processes and outcomes are essential for performance improvement. Both process and outcome measures are monitored at system, pavilion and department levels of the organization to ensure quality performance.

Commented [SE20]: Where do we talk about Filter Committees? What other committees have been formed for quality that are not listed?

Commented [KJ21R20]: Patient Safety related items are in the Patient Safety Manual

A. Quality Measures

Key performance indicators are identified and monitored at the system, pavilion, and department levels of the organization. ~~These indicators are reflected in the department, pavilion and system scorecard.~~

Harris Health follows the guidance referenced in the National Integrated Accreditation for Healthcare Organizations (NIAHO) standard, Quality Management System section 7, 1-19 (QM.7 SR.1-19) to monitor for the effectiveness of the Quality Management System. It also correlates with the ISO (International Standard) 9001:2015 Clause 9 Performance Evaluation.

B. Internal Quality Audits

Internal quality audits (IQA) are conducted to determine the effectiveness of the quality management system~~/QAPI Plan~~. Please refer to the Annual IQA Program Plan. Results of the IQA Program provide a measure of Harris Health's compliance with Conditions of Participation (COPs) and other regulatory requirements and support a continual readiness program for regulatory, accreditation and certification surveys. Performance indicators related to quality audits are measured based on the compliance to the audit schedule as prescribed in the Internal Quality Audit Plan.

C. Reporting Communication

Effective communication is fundamental to Quality, Performance Improvement (PI), and ~~p~~Patient ~~s~~Safety. Many forms of communication exist to keep leadership and staff informed and engaged. Communication vehicles include scorecards and other quality reports that are disseminated throughout Harris Health ~~h s~~System in all forums. ~~, pavilions, and departmental quality councils, committees and other forums, as well as, departmental and unit leadership and staff meetings.~~ An annual reporting schedule is established for quality information across the system.

- See Appendix B for the Quality Reporting Procedure, Flow Diagram and Consent Agenda Guidance

~~E.~~D. Data Governance – Information Request, Design and Approval Process

1. Quality information request, design and approval

Harris Health System monitors and reports many performance indicators that reflect the quality and safety of services that we provide. Quality information request and design are facilitated by the Quality Programs Department, and approval is made at the QRC and QGC levels. ~~——~~Approval criteria includes the degree to which the indicator/quality information addresses patient safety, meets regulatory or compliance requirements, facilitates and documents achievement of national standards, monitors and supports operations performance and decision making, and supports PI. The focus is on monitoring the quality, effectiveness, and safety of patient care.

~~G.~~E. Data Management

1. Data Acquisition/Collection

Quality Programs Department provides data collection support for ~~some~~ key performance indicators (KPI~~) identified~~) identified under the Harris Health System Quality Programs~~Performance Improvement Framework~~. The data collection for ~~all other indicators~~service area KPIs are ~~is~~ the responsibility of the department where the specific measure is indicated. Acquiring and responding to real time data is the key to impact current performance/quality of patient care.

2. Data Sampling

When data sampling is used during the data collection process, the following minimum sample sizes are to be used to ensure the data set provides a statistically significant result when the data is analyzed for process improvement:

- For a population size fewer than thirty (30) cases, the sample size is one hundred percent (100%);
- For a population size of thirty to one hundred (30 -100), sample thirty (30) cases; Population size of one hundred and one to five hundred (101 – 500), sample fifty (50) cases; or
- For a population size greater than five hundred (500) cases, sample seventy (70) cases. Focus reviews sample size may vary.

3. Validation

The organization makes decisions based on the information reported, so the data and reports must undergo validation and verification to assure they are accurately representing what is intended. Implementing processes to assure the integrity and validity of data and reports is essential to maintain effective quality, safety, and PI processes. All data and reports will be validated, at the point of service, to assure correct, complete, and reliable information is being communicated.

4. Data Analysis Display and Report Development
   Harris Health System shall determine, collect and analyze appropriate data to demonstrate suitability and effectiveness of its quality management system. The organization will also evaluate where continual improvement of the effectiveness of the quality management system can be made. This process shall include data generated as a result of monitoring and measurement and from other relevant sources.

5. Data Analysis Tools and Methodology
   Several methods are used to analyze performance data to identify trends against established goals. For example, trend charts, fish bone diagrams, value mapping, bubble charts, statistical process control charts (SPCC's), Failure Mode and Effects Analysis (FMEA) and Root Cause Analysis (RCA) are being used. Several risk adjusted methodologies are available for patient outcome-based information [such as Vizient and National Surgical Quality Improvement Project (NSQIP)]. These electronic tools will be utilized to support the translation of the data analysis to action plans.

6. Benchmarking
   Harris Health System's performance is compared to other national organizations via participating in a variety of comparative databases. For example, but not limited to: Vizient, NSQIP, National Healthcare Safety Network (NHSN), CMS Core Measures, Value Based Purchasing, Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS), Healthcare Effectiveness Data and Information Set (HEDIS). When regional or national benchmarks are not available, Harris Health System will determine a one year baseline performance period than set internal improvement goals to assure the performance goal is tracking towards reducing variation and/or patient harm.

~~XVII.~~X. QUALITY GOALS

Harris Health System ~~Executive Quality~~Balanced Scorecard (BSC)

The Harris Health System ~~Executive~~ Quality Balanced Scorecard reflects nationally reported ~~benchmarks~~ quality measures that supports reducing patient harm and improves the delivery of quality patient care. ~~that measure achievements of quality of care.~~The Harris Health BSC is an interactive electronic dashboard with advanced analytic functions built to identify the quality metrics in close to real-time performance. This dashboard will have the ability to stratify the quality measures by individual pavilions with drill down capabilities to identify the drivers behind the metrics performance and where the areas of greatest opportunity exists. This dashboard will be used to track the specific areas of focus for Harris Health and updated on an annual basis to determine additional or removal of other quality metrics and readjust benchmarks and/or internal goals. The BSC will serve as the official quality scorecard for the entire organization.

~~XVIII.~~XI. CONTINUAL IMPROVEMENT (PERFORMANCE IMPROVEMENT)

A. Overview

Harris Health System utilizes improvement cycles to include but not limited to Define-Measure-Analyze-Improve-Control (DMAIC) supported by LEAN Six Sigma methodologies for performance improvement.~~–~~ Harris Health System shall continually improve its quality management system through the use of the quality policy, quality objectives, audit results, analysis of data, corrective and preventative actions and management review.~~–~~ System level improvement projects will be initiated and chartered via an effective planning and approval process at QGC. Pavilion level improvement projects will be initiated and chartered via an effective planning and approval process at the pavilion QRC and reported to QGC. A database of ongoing and completed performance improvement and quality improvement initiatives is available in the System PI Project Database (Repository).

B. Models for Improvement

1. DMAIC (Define, Measure, Analyze, Improve, and Control) these five steps represent an improvement cycle that is data driven and meant to improve processes by identifying best practices and standardizing work.

2. LEAN Six Sigma experts use the steps of the DMAIC (define, measure, analyze, improve, control) model, in a specific order, to develop, design and redesign a process so that there's effectively a minimal chance that an error will occur with the goal of zero harm. To attain their goal, the experts work to achieve six sigma, a measurement for standard deviation originating from statistics, to perfect their processes. This supports the Harris Health philosophy of doing no harm to patients. These experts will also use the methodologies to eliminate waste and optimize processes that supports the delivery of quality driven low cost healthcare.

~~Risk Based Thinking (Preventative Action)~~

~~Harris Health System also embraces the concept of risk-based thinking when planning for care and services. By doing so, it allows the organization to determine the risks and opportunities during the process improvement phase. Risk is the possibility of events or activities impeding the achievement of an organization's strategic and operational objectives. Risk can be defined by two (2) parameters:~~

- ~~Severity – Seriousness of the harm~~
- ~~Probability – Probability that harm will occur~~

~~Proactive risk assessment may be completed at any time as part of comprehensive systematic analysis. In a proactive risk assessment, the healthcare system evaluates the process to see how it could potentially fail, to understand the consequences of such failure and to identify parts of the process that need improvement. Determining why the breakdown or failures occurred and designing/re-designing of the process or underlying systems minimizes the risk of the effect on patients. Proactive risk reduction prevents harm before it reaches the patient.~~

Commented [KJ22]: Removed this section as it is addressed in the Harris Health Patient Safety/ Risk Management Manual as referenced below in XII

~~4.~~3. Project Management

The project management approach will be utilized in conducting performance and quality improvement initiatives. The process starts with identification of the gap or need from key performance indicators and other metrics, selection and prioritization

of projects are determined by multidisciplinary teams to determine the impact of care and resources available. ~~using an importance and complexity grid~~ I, ~~i~~dentification of the project team ~~including~~ includes the executive sponsor, process owner as team lead and project facilitator. The project facilitator shall ensure the project management process is carried out from planning, implementing, monitoring and reporting, closure and project handoff.

Performance and quality improvement projects can be performed as a team or as an individual, at the system level, service area, pavilion, and at the unit level.

~~Innovation~~

~~Harris Health System has a Center for Innovation with a goal of creating a culture of innovation throughout the organization. The innovation program was founded on the profound hope that each and every member of Harris Health will have the desire and opportunity to share their ideas to create better work or patient experience, enhance patient care, or improve processes. Harris Health believes that the only way a culture of innovation can truly emerge is when everyone is given permission to be innovative and is committed to bringing their vision to fruition.~~

Commented [KJ23]: No longer exists

C. Education/Training

For continual quality improvement and patient safety efforts to succeed, it is essential that all leadership, staff, and physicians participate in education/ training regarding process improvement and patient safety issues identification and reporting. A system-wide training plan on quality and patient safety shall be established, implemented and reviewed for effectiveness. Education on quality and patient safety will be provided to the members of the Board of Trustees, system and pavilion executive leaders, service area and department leaders, staff and physicians at orientation and on ongoing basis. Basic and advanced education modules that will include topics in PI, measurement and monitoring techniques, and the use of the DMAIC methodology as well as risk-based thinking are also provided on a recurring basis. The Performance Improvement Team within the Quality Programs Department provides on-line and face-to-face education sessions regarding performance improvement to the leadership and staff.

D. Coordination and Support

In order to coordinate and support PI activities, the ~~Department of~~ Performance Improvement ~~Team within the Quality Programs Department~~ for Harris Health System shall:

1. Establish a process for selecting and completing PI projects at the service area and system levels.
2. Establish a process for prioritizing PI initiatives based on importance and alignment with the Harris Health System strategic goals, as well as on the complexity of project management and implementation.
3. Monitor and report the status of PI projects to the QRCs, QGC, and other forum, as appropriate.
4. Establish a process for conducting identified PI projects from initiation, planning, implementing, monitoring, status reporting, to hand-off of project to process owners.
5. Ensure the availability, integrity, accurate analysis and validation of data used to document and evaluate outcomes.
6. Collaborate with PI teams and project sponsors to support the PI initiative through

completion and hand-off.

7. Establish and maintain a framework for educating the leaders and staff others on Harris Health System's PI methodologies for continual quality improvement.
8. Provide consult regarding PI activities at all levels to encourage and support continual improvement.
9. Provide project management and facilitation for PI teams, as needed.
~~9.~~10.

E. Point of Service Performance Improvement

Staff at all levels in the organization will be trained on Harris Health System's PI methodology. PI activities may be initiated at the point of service. These activities are encouraged and may evolve into formal PI initiatives at the point of service, department, and pavilion or system level. Depending on the support and resources required, issues/initiatives may also be addressed and resolved at the point of service, applying PI methodology, without formalizing the PI initiative through the approval process.

~~XIX.~~XII. PATIENT SAFETY/RISK MANAGEMENT

See the Harris Health System Patient Safety Plan for activities, responsibilities, processes, and risk reduction strategies.

~~XX.~~XIII. CONFIDENTIALITY & PRIVILEGE

BOT Quality Committee

The BOT Quality Committee is a medical peer review committee *only when* it is evaluating the competence of a Medical Staff member or the quality of medical and healthcare services provided by Harris Health System, and to the extent that the evaluation involves discussion or records that specifically or necessarily identify an individual patient or Medical Staff member. This committee meets in "executive session" to conduct medical peer review activities, and when the committee is conducting peer review activities, the committee's proceedings and records, as well as any communication made to the committee are confidential, legally privileged, and protected from discovery. Texas Health & Safety Code §161.0315; Tex. Occ. Code §151.002 and §160.007.

PRIVILEGE/CONFIDENTIALITY OF QUALITY MANUAL ACTIVITIES

The Quality Governance Council and all Quality Ceommittees/Councils (Quality Committee/Council) that support and/or serve at the direction of the QGC ~~as well as all Quality Manual Committees and Councils, (Quality Committee/Council) described in the Quality Manual all function as~~ are "medical committees" and/or "medical peer review committees" pursuant to state law. ~~The~~All ~~Quality Committee/Council's~~ records, reports, data aggregations, presentations, documents of any kind as well as all ~~and~~ proceedings of these committees are, therefore, confidential, legally privileged, and protected from disclosure pursuant to Chapter 161 of the Texas Health and Safety Code and Chapters 151 and 160 of the Texas Occupations Code. ~~every under certain circumstances.~~

~~The function that the Quality Committee/Council performs determines the protected status of its activities. Information is protected by the privilege if it is sought out or brought to the attention of the medical committee and/or medical peer review committee for purposes of an investigation, review, or other deliberative proceeding. Medical peer review activities include the evaluation of medical and health care services, including the evaluation of the qualifications of professional health care practitioners and of patient care provided by those practitioners. These review activities include evaluating the merits of complaints involving health care practitioners, and~~

~~determinations or recommendations regarding those complaints. The medical peer review privilege applies to records and proceedings of the committee, and oral and written communications made to a medical peer review committee when engaged in medical peer review activities. Medical committee activities also include the evaluation of medical and health care services. The medical committee privilege protection extends to the minutes of meetings, correspondence between committee members relating to the deliberative process, and any final committee product, such as any recommendation or determination.~~

In order to protect the confidential nature of the quality and peer review activities conducted by the Quality Committee/Council, their records and proceedings must be used only in the exercise of proper medical committee and/or medical peer review functions to be protected as described herein. Therefore, Quality Committee/Council meetings must be limited to only the Quality Committee/Council members and invited guests who need to attend the meetings. Quality Committees/Councils must meet in executive session when discussing and evaluating the qualifications and professional conduct of professional health care practitioners and patient care provided by those practitioners. At the beginning of each meeting, the Quality Committee/Council members and invited guests must be advised that the records and proceedings must be held in strict confidence and not used or disclosed other than in Quality Committee/Council meetings, without prior approval from the Quality Committee/Council Chair. Documents prepared by or considered by Quality Committees/Councils in these meetings must clearly indicate that they are not to be copied, are solely for use by the Quality Committee/Council, and are privileged and confidential.

The records and proceedings of Harris Health departments *that support* the quality and peer review functions of Quality Committees/Councils, such as the Patient Safety/Risk Management and Quality Programs & Accreditation departments are also confidential, legally privileged, and protected from disclosure if ~~every, if the records are~~ prepared by or at the direction of the Quality Committees/Councils, and ~~are~~ not kept in the ordinary course of business. ~~Routine administrative records prepared by Harris Health System in the ordinary course of business are not legally privileged or protected from discovery. Documents that are gratuitously submitted to the Quality Committee/Council, or which have been created without Quality Committee/Council impetus and purpose, are also not protected~~. All work performed pursuant to this Quality Manual must also comply with state and federal (HIPAA) privacy laws, as well as Harris Health policies and procedures.

XIV. ANNUAL EVALUATION

A. The annual evaluation of the Harris Health System ~~Executive~~ Balanced ~~Quality~~ Scorecard, including the inpatient and ACS data, will be part of the organization's strategic planning process and the plan will reflect Harris Health System's strategic goals and the recommendations. Each year, the QGC will evaluate the effectiveness of the prior year's goals, including analysis of goal achievement and accomplishments. Based on this evaluation, emerging trends and requirements in the healthcare environment, internal quality information, and identified areas for improvement, the QGC will establish priorities for improvement that drive patient quality, safety, and PI initiatives The outcomes of this process is a plan that supports Harris Health System's strategic goals and high-level improvement priorities that create a set of aligned improvement initiatives for the next year. The final determination of the BSC will be approved by the Quality Board of Trustee Committee

B. The Harris Health System Quality Manual with be reviewed on an annual basis, with periodic reviews and updated as appropriate.

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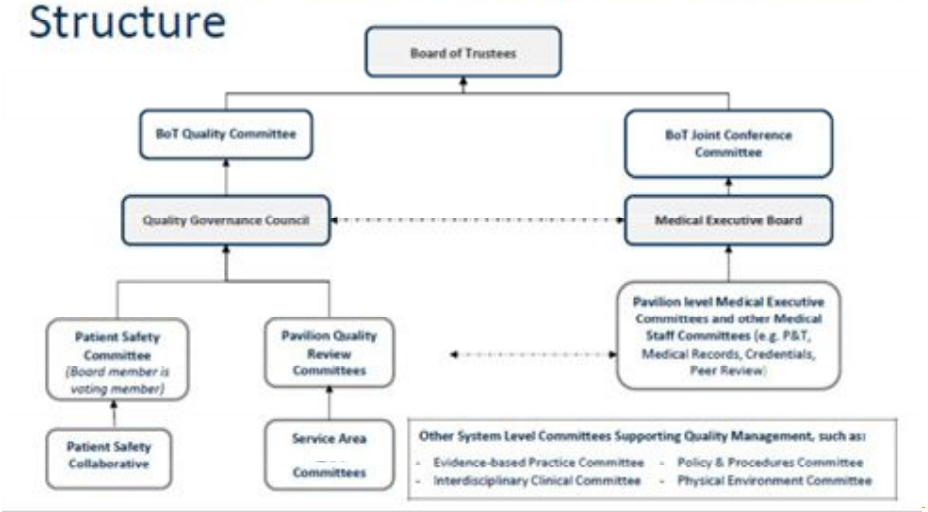
Appendix A

Quality and Patient Safety Organizational Chart

HARRISHEALTH SYSTEM

Quality and Patient Safety Organizational Structure



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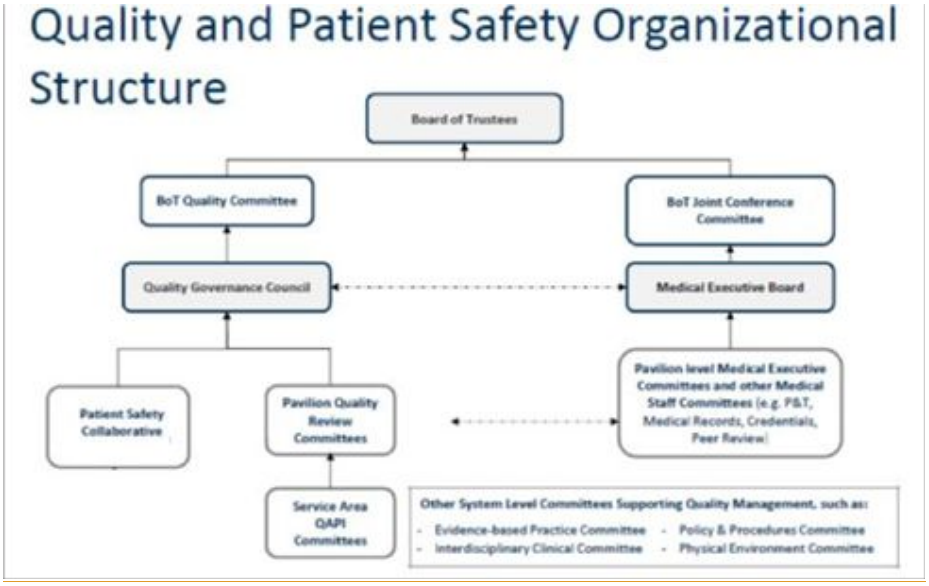
Quality and Patient Safety Organizational Structure
Board of Trustees
BoT Quality Committee
BoT Joint Conference Committee
Quality Governance Council
Medical Executive Board
Patient Safety Collaborative
Pavilion Quality Review Committees
Pavilion level Medical Executive Committees and other Medical Staff Committees (e.g. P&T, Medical Records, Credentials, Peer Review)
Service Area QAPI Committees
Other System Level Committees Supporting Quality Management, such as:
- Evidence-based Practice Committee
- Interdisciplinary Clinical Committee
- Policy & Procedures Committee
- Physical Environment Committee

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Appendix B

Quality Reporting Procedure

1) Process owners will be responsible for monitoring Key Performance Indicators (KPI) for their area including areas identified for Opportunities For Improvement (OFI)
2) KPIs will focus on patient impacting quality metrics. Operational metrics will only be included when required by accrediting organization (DNV)
3) For presentations, only KPIs that are below system goals AND not demonstrating an improving trend line will be reported verbally along with ~~corrective action~~ quality improvement plan and/or process improvement initiatives along with any barriers identified. All other metrics will be added to the consent agenda items as approved by Committee Chair
4) Presentations will be limited to no more than five slides and five minute time limit in order to be succinct and efficient for time management
5) KPI process owners will determine if performance data can be stratified by each pavilion or is specific only to one pavilion. KPI performance specific to each pavilion will be reported out at the corresponding pavilion Quality Reporting Committee (QRC).
6) System aggregated KPI metrics will be reported out at the Quality Governance Committee (QGC) using the same criteria stated in line 3. Any entity demonstrating an improving trend and/or are meeting system improvement goals will be added to the consent agenda items with approval of Committee Chair.
7) All required reporting entities will report their KPI metrics performance and ~~corrective action~~ quality improvement plans and/ process improvement initiatives on a standard time interval as established by the Quality Program Leadership to assure that all regulatory requirements are met.
8) Any reporting entity is required to report out on their assigned month(s). If KPI metrics are not available, reporting entity will report out updates on their progress of developing KPI metrics and/or dashboards or barriers hindering their progression. Any requests to delay report outs must be approved by Committee Chair and added to the consent agenda to be captured in the meeting minutes.

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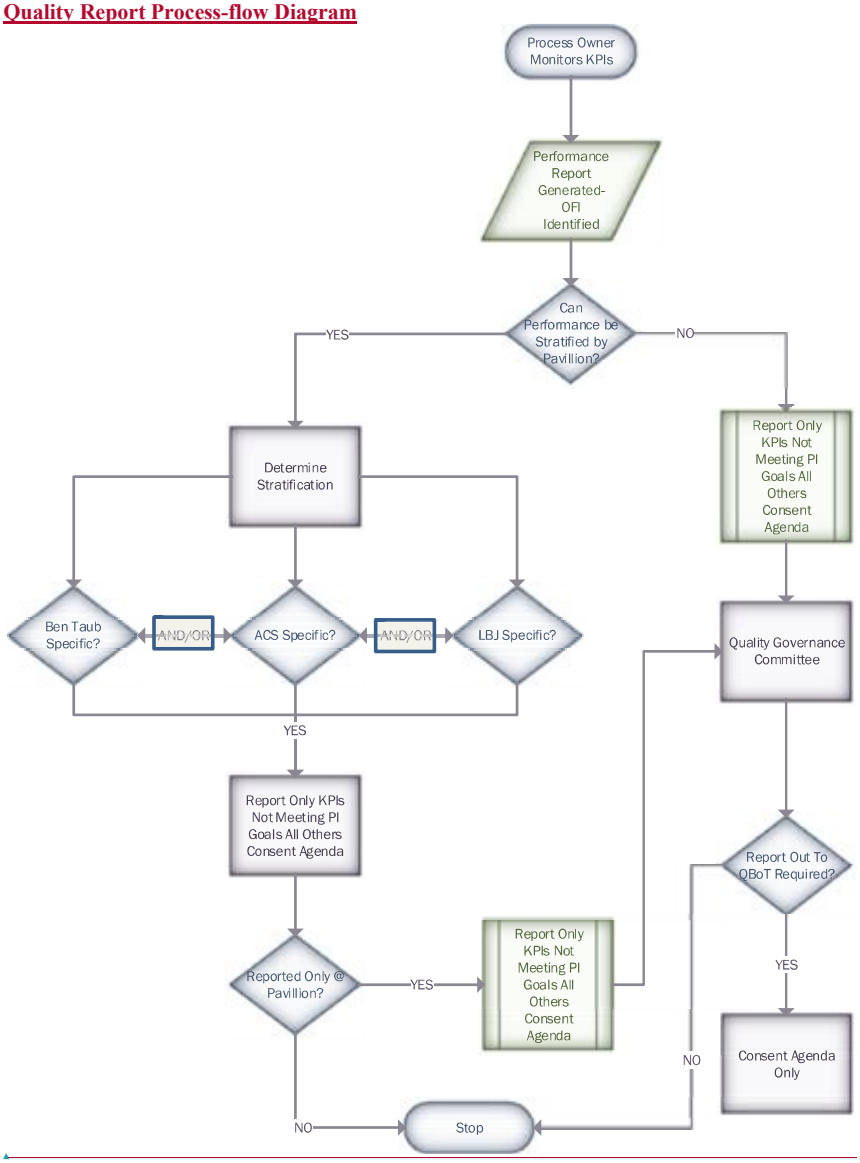
Quality Report Process-flow Diagram



Field Code Changed

Consent Agenda Guidance:

1. **Purpose**
   - improves the efficiency and effectiveness of committee meetings
   - provides an efficient process to acknowledge receipt of reports or approve regular, non-controversial, routine issues that come before the committee, or matters where no debate, discussion or explanation is expected or required
   - helps to manage time, as the committee addresses all items listed within or under the consent agenda as a single item with one vote

2. **Description**
   A consent agenda groups routine items and reports which require no discussion or debate into one agenda item called the consent agenda. These items may include KPI reports and/or summary reports including informational only reports. The consent agenda practice allows the committee voting members to approve or acknowledge receipt of all items listed under the consent agenda that are unanimously agreed to with one vote instead of filing multiple motions.

3. **Content of Consent Agenda**
   All materials and items proposed in the consent agenda shall be clearly identified as such in the meeting packages. All committee members must receive and review the consent agenda items prior to the meeting, with the expectation that no discussion will take place during the committee meeting.

4. **Consent agenda items may include:** Key Performance Indicator reports that require no discussion. This is based on a demonstrated performance that either meets predetermined goals and/or clear evidence that trend lines indicated positive movement towards reaching goals.

5. **Approval of Consent Agenda**
   The consent agenda will be approved by the committee at the beginning of each meeting.

   - Committee members may request that matters be added, deleted or that the order of items be moved and the committee chair shall make a decision on each request. Any decision may be subject to challenge and reversed by the committee.

   - Any item may be moved out of the consent agenda section at the request of any committee member, before approval of the agenda. A member may request to move an item to further discuss it, inquire about it, or vote against it. No motion or vote of the committee is required to a request to move an item out of the consent agenda.

   - When a committee member requests that an item be moved out of the consent agenda section, the committee chair shall decide where to place that item on the agenda.

   - When only one item on the consent agenda list does not qualify as a consent agenda item or is requested to be moved, that item shall be moved out of the consent agenda and the rest of the items shall remain on the consent agenda.

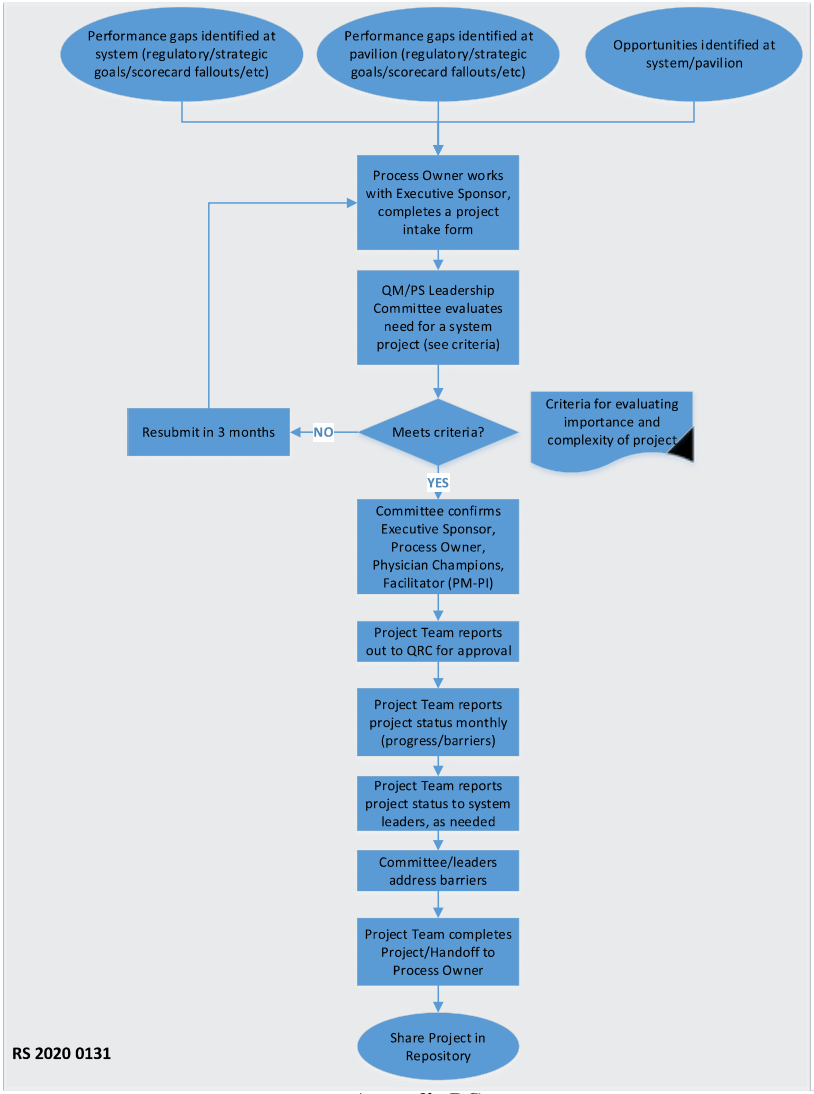
- Approval of the consent agenda by the committee constitutes approval of each of the items listed under the consent agenda portion of the meeting. No separate vote to approve each consent agenda item is required.

6. **Motion to Approve Consent Agenda**
   When the requested changes have been made to the consent agenda:
   - Chairperson reads items listed under consent agenda.
   - Chairperson asks "would any committee member like to remove any of the items from the consent agenda", if no requests are made, then states: "If there is no objection, these items will be adopted".
   - The chairperson calls for a motion to accept the consent agenda and a vote is taken and recorded.

7. **Minutes**
   Minutes of the meeting will include the full text copy of approved resolutions, recommendations or reports received under the consent agenda portion of the meeting to ensure a record is kept for future reference.

Appendix C~~B~~

System Performance Improvement Process



Appendix D~~C~~

Service Area ~~QAPI~~ Committee Charter

Commented [MS24]: I edited to include exec. Sponsor on the front end, QRC approval-as defined earlier in this document- and that committee confirms-not assigns- the exec. Sponsor, physician champion, and process owner

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The Quality Governance Council (QGC) under the direction of the Board of Trustees Quality Committee (BQC) of the Harris Health System (the "System") has authorized the formation of a Service Area ~~QAPI~~ Committee (the "Committee") and approved the following charter to set forth the purpose, structure, authority, and duties and responsibilities of the Committee and the members thereof. In accordance to the National Integrated Accreditation for Healthcare Organizations (NIAHO) QM.7 Standard Requirements, Service Area Committees will function as outlined below.

I. Purpose:

As a core driver of its activities and responsibilities, the Committee will promote the System's dedication to:

- Delivery of safe, high quality health care across the System to the patients and community that the System serves;
- Full compliance with applicable Federal, state and county laws and regulations, and adherence to professionally recognized standards of care; and
- An enterprise-wide culture of safety and just behavior (Just and Accountable Culture).

II. Duties and Responsibilities :

The Committee's responsibilities include:

- Promoting a culture focused on safety and just behavior, including non-retaliation.
- Overseeing and evaluating the structure, operations and effectiveness of the Service Area ~~QAPI~~ initiatives and activities in support of the System Quality Program and in coordination with the Chief Quality and Safety Officer (CQSO).
- Reporting data and information specific to the Service Area according to established criteria and requirements to the QGC (e.g., data fallouts) and any other designated Quality Program resource/committee for proper analysis and identification of trends for prioritization of quality improvement efforts. ~~and/or corrective measures.~~
- Evaluating key and support activities and processes related to the Service Area's provision of care and/or other services to determine relevant and appropriate measures/metrics to monitor the effectiveness and quality of the services provided (Service Area Dashboard).
- Reviewing and evaluating identified measures/metrics on a regular basis to identify opportunities for improvement and changes that will lead to improvement.
- Reviewing and analyzing safety event data related to the Service Area on a regular basis for trends and/or other areas of focus~~/corrective measures.~~ for quality improvement
- Promoting and participating in auditing and monitoring activities related to the Service Area conducted by internal or external resources as part of the Quality Program, and ensuring appropriate ~~corrective actions~~quality and process ~~are~~improvements are developed and implemented timely in response to the findings.

  Selecting and conducting performance improvement (PI) initiatives/projects utilizing the PI Project Selection and Completion Process.
- Reviewing and evaluating quality and PI initiatives/projects, innovations, ~~corrective action~~ quality improvement plans, and risk reduction activities initiated in response to data fallouts,

safety events and/or other negative trends to determine the effectiveness of those activities to address the identified issues/goals.

- Performing, at least annually, a review and evaluation of the Service Area Dashboard for any necessary revisions to established measures/metrics and benchmarks.
- Maintaining oversight of survey readiness for the Service Area, including staying abreast of significant developments relating to regulatory requirements and standards and expectations of accrediting bodies in coordination with the Accreditation/Regulatory Affairs Department.
- Assessing periodically, and no less than annually, the Service Area's oversight of its quality and safety~~QAPI~~ plan as evidenced by its operation in conformance with all Charter requirements and reporting such to the QGC.
- Maintain departmental quality and safety documents as a portion of their respective operational manual as required for survey readiness.

III. Membership

The Committee will be composed of:

- Service Area Executive Sponsor
- Service Area System Lead – Committee Chair
- Service Area Medical Director, as applicable
- Service Area Nursing Representative(s), as applicable
- Service Area Pavilion Representative(s)
- ~~Designated Director of Quality~~
- Risk and Patient Safety Representative
- Infection Prevention Representative, as applicable
- Support Services Representative(s)

IV. Meetings, Minutes and Committee Action

The Committee will meet regularly and no less than ten (10) times per year unless the Committee determines otherwise. At every meeting, the Chair will designate a secretary to take and maintain minutes.

Minutes of the meetings shall include discussions, decisions and action plans of the committee and will be prepared after every meeting. The Committee shall follow the Robert's Rules of Order including voting process for approvals.

Meetings should be conducted in person whenever possible. All Committee members are expected to attend each meeting. A quorum representing a majority of the Committee members must be present to transact business.

V. Amendments

This Charter may be amended or revised only upon approval by the QGC. The Service Area System Lead shall be responsible for timely advising the QGC of any proposed amendments or revisions to this Charter.

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers and Stakeholders, etc.)
06/14/2016	Original 1.0	Reviewed 06/14/16	Approved by Harris Health System Quality Governance Council
07/14/2016		Reviewed 07/04/16	Approved by Harris Health System Board of Managers
11/08/2016	2.0	Revised 11/08/16	Approved by Harris Health System Quality Governance Council
01/25/2017		Reviewed 01/25/2017	Approved by Harris Health System Board of Managers
02/22/2018		Reviewed 02/22/2018	Approved by Harris Health System Board of Trustees
3/13/2019		Reviewed 3/13/2019	Approved by Harris Health System Quality Governance Council
3/13/2019		Reviewed 04/11/2019	Approved by Harris Health System Board of Trustees
3/10/2020		Reviewed 3/12/2020	Approved by Harris Health System Quality Governance Council
3/10/2020		Reviewed 3/14/2020	Approved by Harris Health System Board of Trustees
12/29/2021			
4/28/2023	3.0	Updated with minor changes in scope and added ECCSR structure	

BOARD OF TRUSTEES

Quality Committee

HARRISHEALTH SYSTEM

Tuesday, September 12, 2023

Executive Session

Report Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occupations Code Ann. §160.007, and Tex. Occupations Code Ann. §151.002, to Receive Peer Review and/or Medical Committee Reports in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including the Harris Health System Quality and Safety Performance Measures.

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