BOARD OF TRUSTEES

Quality Committee

Wednesday, November 30, 2022
1:00 P.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. Andrea Caracostis**	**1 min**
II.	**Approval of the Minutes of Previous Meeting** • Quality Committee Meeting – October 4, 2022	**Dr. Andrea Caracostis**	**2 min**
III.	**Harris Health Safety Message: Clostridium Difficile (C-diff)** ***– Dr. Steven Brass***		**5 min**
IV.	**Presentation and Discussion Regarding Emergency Care Research Institute (ECRI) Top 10 Patient Safety Concerns 2022** ***– Ms. Debbie Garbade***		**10 min**
V.	**Presentation and Discussion Regarding Gastrointestinal Service Line** ***– Dr. Brooks Cash, Dr. R. J. Sealock, Dr. Fred Sutton and Ms. Amineh Kostov***		**10 min**
VI.	**Consideration of Approval of the 2023-2024 Harris Health Utilization Review Plan** ***– Dr. John Foringer***		**10 min**
VII.	**Executive Session**	**Dr. Andrea Caracostis**	**50 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 Report in Connection with the Evaluation of the Quality of Medical and Healthcare Services ***– Dr. Steven Brass and Dr. Yashwant Chathampally***		*(45 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 *(5 min)*

VIII. Reconvene **Dr. Andrea Caracostis** **1 min**

IX. Adjournment **Dr. Andrea Caracostis** **1 min**

HARRIS HEALTH SYSTEM
MINUTES OF THE BOARD OF TRUSTEES
QUALITY COMMITTEE MEETING
Tuesday, October 4, 2022
8:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Dr. Andrea Caracostis, Chair, called the meeting to order at 8:00 a.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 – August 16, 2022		**Moved by Ms. Alicia Reyes, seconded by Dr. Arthur Bracey, and unanimously approved the minutes of the previous meeting.**
III. Harris Health Safety Message: Antibiotics Before Surgery	Dr. Steven Brass, Executive Vice President & Chief Medical Executive, delivered a Minute for Medicine video series centered on Antibiotics Before Surgery. A copy of the presentation is available in the permanent record.	**As presented.**
IV. Presentation and Discussion Regarding Health Equity and Social Determinants of Health	Dr. Esperanza (Hope) Galvan, Interim Senior Vice President, Chief Health Officer, and Ms. Karen Tseng, Special Advisor to the CEO, Population Health, led the discussion regarding Health Equity and Social Determinants of Health. Ms. Tseng provided a brief overview of the drivers of health disparities as well as health equity related to Harris Health strategic plan. She addressed priority actions and initial focus areas for improving health equity and social determinants of health (SDoH). Ms. Tseng stated that through population health's partnership with The University of Texas School of Public Health (UTSPH), Harris Health has geocoded its patient data enabling: 1) new geospatial analytic capabilities and 2) deeper excavation of SDoH factors and its relationship to health disparities. Additionally, Ms. Tseng shared that the analytics plan allows Harris Health to better understand the extent of disparities in diabetes and maternal health outcomes across its patients as well as which factors are driving those disparities. Discussion ensued regarding expanding Harris Health's community health centers,	**As presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	institutional health partnerships within the community as well as care coordination. A copy of the presentation is available in the permanent record.	
V. Executive Session	At 8:21 a.m., Dr. Caracostis stated that the Quality Committee of the Board of Trustees would go into Executive Session 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 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	*The Quality Committee of the Board of Trustees recommends implementing the Proposed FY2023 Quality metrics and targets supporting the scorecard Pursuant to the Executive Session Presentation.*	**Moved by Dr. Ewan Johnson, seconded by Ms. Alicia Reyes, and unanimously accepted that the committee recommends that the Board approve item V.A.**
B. 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.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
C. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA, Other Federal and State Healthcare Program Requirements and an Update on the Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session		**No action taken.**
VI. Reconvene	At 9:28 a.m., Dr. Caracostis reconvened the meeting in open session; she noted that a quorum was present. The Quality Committee of the Board of Trustees took action on Item "A" of the Executive Session agenda.	
VII. Adjournment	Moved by Ms. Alicia Reyes, seconded by Dr. Arthur Bracey, and unanimously approved to adjourn the meeting. There being no further business, the meeting adjourned at 9:29 a.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 October 4, 2022.

Respectfully submitted,

Andrea Caracostis, M.D., MPH, Chair

Recorded by Cherry Pierson

Tuesday, October 4, 2022

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

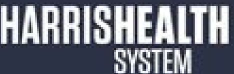
Note: For Zoom meeting attendance, if you joined as a group and would like to be counted as present, please submit an email to: BoardofTrustees@harrishealth.org before close of business the day of the meeting.

QUALITY COMMITTEE BOARD MEMBERS PRESENT	QUALITY COMMITTEE BOARD MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Andrea Caracostis (Chair)		
Dr. Arthur W. Bracey (Ex-Officio)		
Dr. Ewan Johnson		
Ms. Alicia Reyes		

EXECUTIVE LEADERSHIP
Dr. Esmaeil Porsa, President & Chief Executive Officer
Ms. Amy Smith, Senior Vice President, Transitions & Post-Acute Care
Mr. Anthony Williams, Vice President, Compliance Officer
Ms. Carolynn Jones, Executive Vice President & Chief Compliance and Risk Officer
Ms. Debbi Garbade, Vice President, Patient Safety & Risk Management, Quality & Safety Office
Dr. Esperanza Hope Galvan, Interim Senior Vice President, Chief Health Officer
Dr. Glorimar Medina-Rivera, Executive Vice President, Ben Taub Hospital
Dr. Hemant Roy, Vice Chair, Harris Health System & Ben Taub Hospital
Dr. Jackie Brock, Executive Vice President & Chief Nursing Executive
Dr. Jason Chung, Associate Chief Medical Officer & Senior Vice President, Medical Affairs and Utilization
Dr. Jennifer Small, Executive Vice President, Ambulatory Care Services
Dr. John Foringer, Chair, Medical Executive Board
Dr. Joseph Kunisch, Vice President, Quality Programs
Mr. Louis Smith, Senior Executive Vice President & Chief Operating Officer
Ms. Maria Cowles, Senior Vice President, Chief of Staff
Dr. Martha Mims, Vice Chair, Medical Executive Board
Dr. Matasha Russell, Chief Medical Officer, Ambulatory Care Services
Ms. Monica Carbajal, Vice President, Contract Administration
Ms. Olga Llamas Rodriguez, Vice President, Community Engagement & Corporate Communications
Dr. Otis Reggie Egins, Chief Medical Officer, Correctional Health

Ms. Patricia Darnauer, Executive Vice President, Lyndon B. Johnson Hospital
Ms. Sara Thomas, Vice President Legal Affairs/Managing Attorney, Harris County Attorney's Office
Dr. Sandeep Markan, Chief of Staff, Ben Taub Hospital
Dr. Steven Brass, Executive Vice President & Chief Medical Executive
Dr. Tien Ko, Chief of Staff, Lyndon B. Johnson Hospital
Dr. Yashwant Chathampally, Associate Chief Medical Officer & Senior Vice President, Quality and Patient Safety

OTHERS PRESENT	
Antoinette "Toni" Cotton	Jerald Summers
Cherry Pierson	Karen Tseng
Daniel Smith	Matthew Schlueter
Derek Curtis	Nicholas Bell
Ebon Swofford	Paul Lopez
Elizabeth Ruff	Randy Manarang
Elizabeth Winn	Tai Nguyen
Jennifer Zarate	



Wednesday, November 30, 2022

Harris Health Safety Message

- Video: Harris Health Minute for Medicine – C-diff (Clostridium Difficile)

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HRO Safety Message

Steven Brass, MD, MPH, MBA
EVP, Chief Medical Executive

Board of Trustees Quality Committee
November 30, 2022

SAFETY MESSAGE

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: Link to video

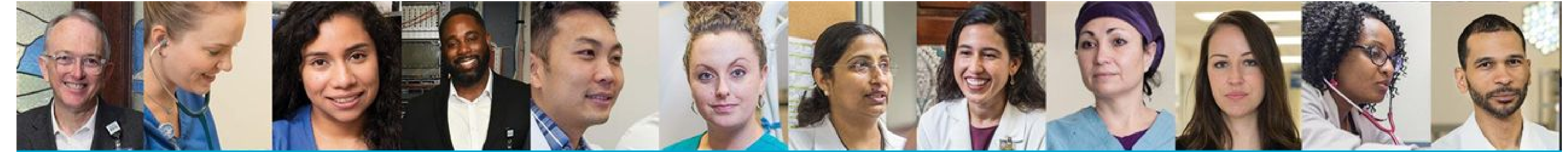
- 4-HarrisHealth_MinuteForMedicine_02_C-diff (Clostridium Difficile)
- https://youtu.be/o_nNZeA-44U

BOARD OF TRUSTEES

Quality Committee

Wednesday, November 30, 2022

Presentation and Discussion Regarding Emergency Care Research Institute (ECRI) Top 10 Patient Safety Concerns 2022



ECRI Top 10 Patient Safety Concerns 2022

a Failure Modes and Effects Analysis (FMEA) Report

Debbi Garbade MSN, RN, CPPS, CPHRM, CPHQ, CPSO

Vice President Pt. Safety & Risk Management

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Emergency Care Research Institute (ECRI)

- ECRI is the global authority on patient safety and technology
  - World's largest database of patient safety event data
  - Forensic equipment investigations
  - Independent medical device evaluations

- Mission: Advancing effective, evidence based healthcare globally

This annual Top 10 list helps organizations identify imminent patient safety challenges.

To select the Top 10, ECRI and our affiliate, the Institute for Safe Medication Practices (ISMP), analyzed a wide scope of data, including scientific literature, patient safety events or concerns reported to or investigated by ECRI or ISMP, client research requests and queries, and other internal and external data sources.

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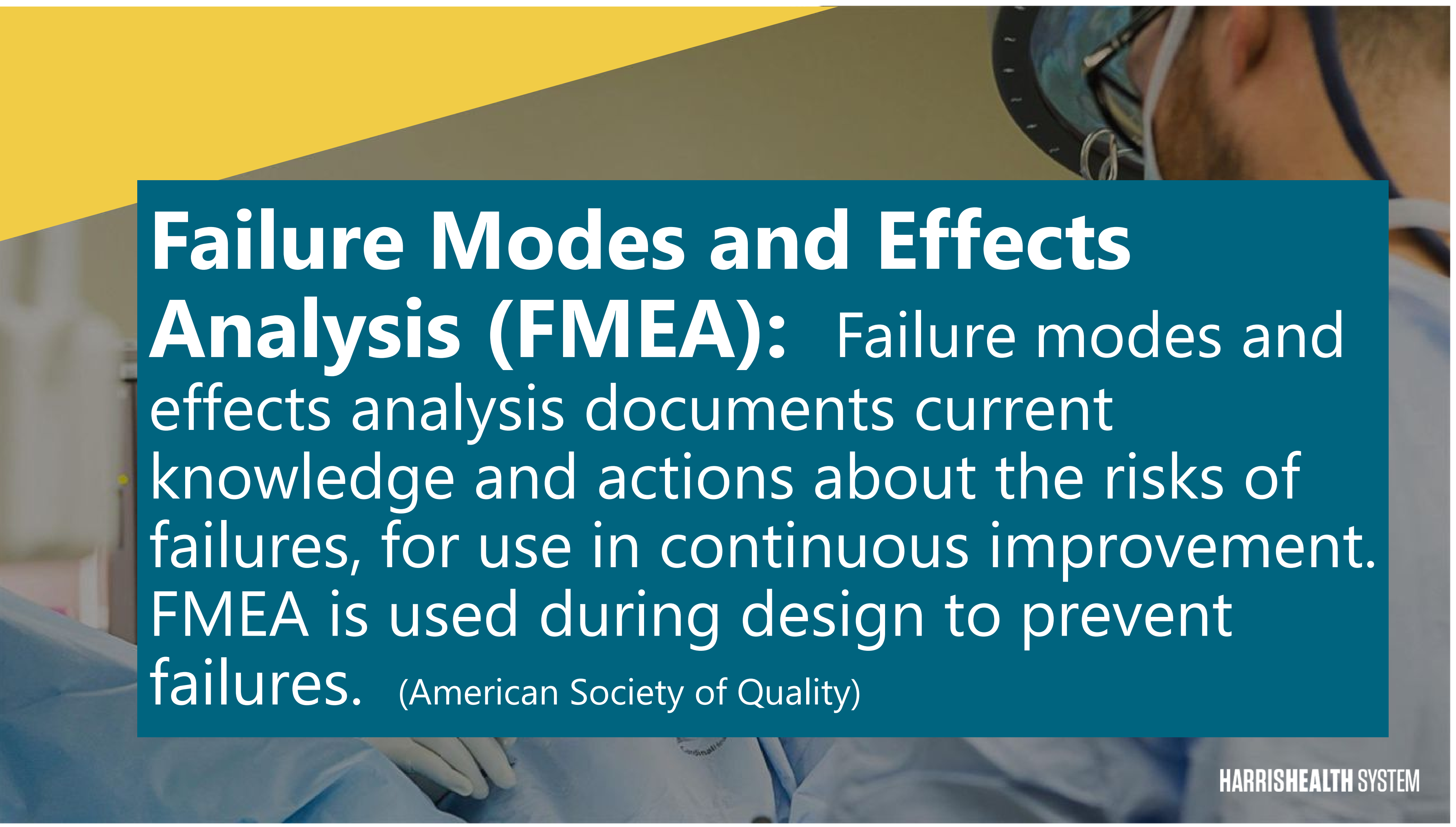
Failure Modes and Effects Analysis (FMEA): Failure modes and effects analysis documents current knowledge and actions about the risks of failures, for use in continuous improvement. FMEA is used during design to prevent failures. (American Society of Quality)
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ECRI Top 10 Patient Safety Concerns 2022

ECRI assessed organizations across the country and created this list to identify imminent patient safety challenges

1. Staffing Shortages
2. COVID-19 effects on healthcare workers' mental health
3. Bias and racism in addressing patient safety
4. Vaccine coverage gaps and errors
5. Cognitive biases and diagnostic error
6. Non-ventilator healthcare-associated pneumonia
7. Human factors in operationalizing telehealth
8. International supply chain disruptions
9. Products subject to emergency use authorization
10. Telemetry monitoring

A Special Thanks…

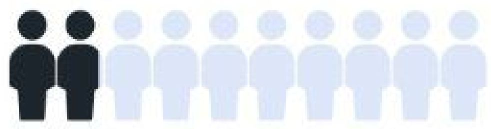
To all of the Harris Health leaders that assisted with this FMEA and provided information on the amazing programs they have in place to address these important safety concerns

Keith Manis – Human Resources, Talent and Acquisition Strategic Plan
Michelle Hunnicutt – Wellness, 2023 Wellness Program Report
Leslie Ferrell – Telehealth, Program Report
Doug Creamer – Supply Chain, Donations and EUA Report
Jobi Martinez – Diversity, Equity, and Inclusion; 2023 Plan
Scott Stanley – ACS Patient Safety, Vaccine and Immunization Report
System Telemetry Workgroup – Evelyne Laka, Telemetry Workgroup Updates

Staffing

The Problem

Even before the COVID-19 pandemic, there was a persistent shortage of clinical and nonclinical staff across the continuum. Staffing shortages have continued to increase throughout the pandemic.



In 2020, hospital registered nurse (RN) turnover was **18.7%.**

Source: NSI Nursing Solutions, Inc.

A high proportion of nurses are at or near traditional retirement age, raising concerns that nursing shortages will greatly increase in the coming years:

- The median age of RNs in 2020 was **52 years**.
- Nearly 20% of RNs are **65 years or older**.
- The median age of licensed practical or
- vocational nurses in 2020 was **53**.

Nursing schools are unlikely to be able to supply enough nurses to replace retiring nurses, much less alleviate existing gaps. In 2019, **80,407 qualified nursing school applicants were turned away** due to insufficient resources (faculty, clinical sites, classroom space, clinical preceptors, and budget).

Source: AACN

Over a ten-year period (2016 to 2026), nursing assistants will be the top staffing need in long-term care.

- There will be **678,300 job openings**.
- But **368,100 workers** will move to another occupation.

Source: McKnight's

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STEM

Action Planning -- Staffing

- Employer Branding
- Innovative recruitment solutions
- Targeted recruitment campaigns
- Engaging the local community/labor market
- Talent acquisition program development
- Internal career mobility – “Inside First” approach to talent acquisition

2021-2025 Talent Acquisition – Recruitment and Retention Strategic Plan

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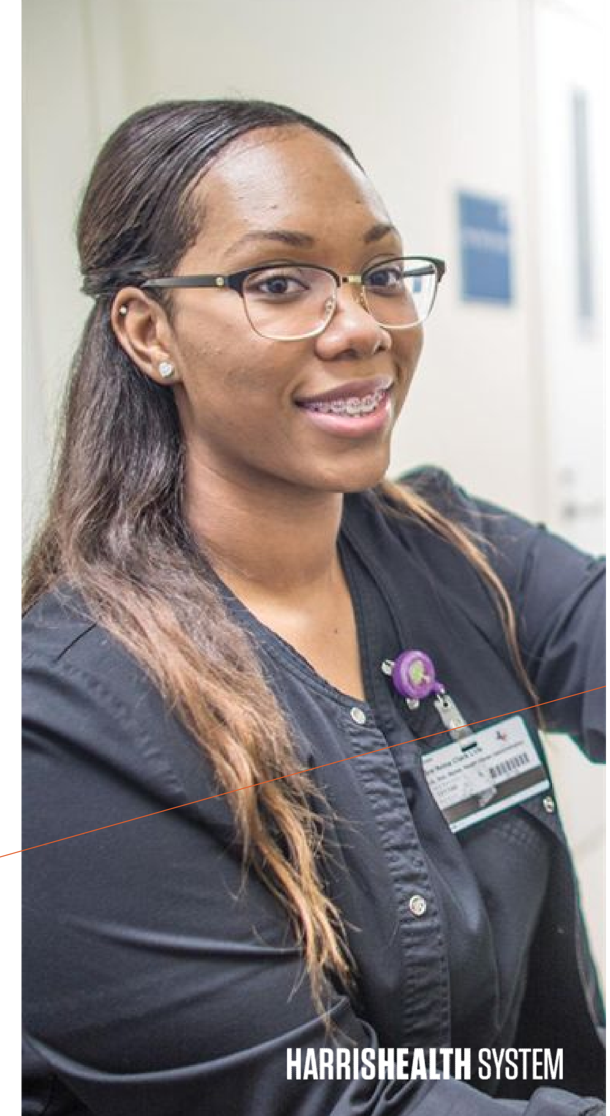

COVID-19 effects on healthcare workers' mental health

Related to this survey, recommendations for the following were offered:

Set an organizational tone of personal connection

- Be available to staff
- Avoid ineffective communication

Support practitioner wellness effectively

- Provide wellness programming
- Engage professional development specialists to offer mindfulness practices

A survey of nurses published in February 2021 found the following:

35% experienced poor quality sleep.

28% demonstrated heightened anxiety during unexpected events.

25% experienced unintended negative memories.

13% reported trauma.

25% working in critical care units reported high levels of emotional exhaustion.

24% working in dedicated COVID-19 units reported high levels of emotional exhaustion.

In addition:

Only **39%** demonstrated posttraumatic growth (positive psychological change following stressful circumstances).

What we've done

- During COVID Surges
  - Resource newsletter to guide employees to programs that they may qualify for
  - Confidential and free EAP
  - Live Webinars on topics like stress management

- Employee wellness
  - Newsletters
  - Fitness Centers
  - Partner with Cigna to promote healthy lifestyles
    - Multiple different types of offerings designed to meet the different needs of our employees
  - Implemented the Self Care for Healthcare program for all nurses

In the numbers:

Voted America's Healthiest Employer 2022

- Increase of 60,823 Wellness Program units of service (more employees were participating)
- 128.62% of employees and spouses completed at least one program
- 96.34% of employees and spouses completed their annual physical
- 89.72% of employees believe that Harris Health System cares about their health and well-being, a 3.43% increase from the prior year

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Bias and Racism in addressing patient safety

Although patients from racial and ethnic minority groups are more likely to experience an adverse event while in the hospital, providers are **significantly less likely to report harmful events for patients from minority groups** than for white patients.

In one study, the odds of reporting patient safety events in African American patients were only **0.65 times** the odds of reporting in white patients.

Sources: Thomas et al.; Thurtle et al.

Action Recommendations

Recognize that racism may be present in the organization

Train leaders on health equity and cultural competence

Assess health equity and cultural competence

Take allegations of racism, bias, or discrimination seriously

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Harris Health Interventions

- Hired Dr. Jobi Martinez as VP & Chief Diversity Officer
- Executive Advisory Council for DEI
- Patient and Family Advisory Council
- Bias Sync (a 9 month bias intervention and mitigation micro learning program)
- Health Equity Committee
- Population Health Resources & Programs
- DEI Metric Framing Training
- Interpretation Services
- Health Equity & Cultural Competence Training
- Bilingual Fluency Spanish Evaluation & Language Access Training for Clinical Interpreters

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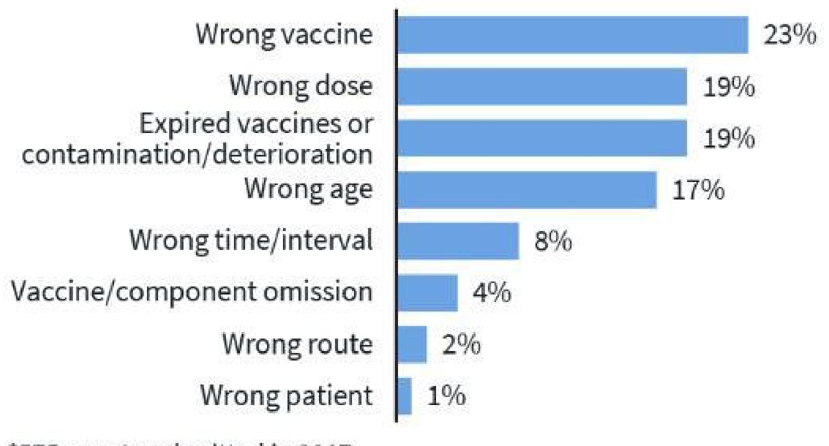
Vaccine Coverage Gaps and Errors



*575 events submitted in 2017

Source: ISMP "Part I"

Vaccine errors can lead to:

- Inadequate immune protection
- Increased cost to providers
- Reduced confidence in healthcare

Here at Harris Health

- Pharmacy developed a new process for identifying Beyond Use Date (BUD numbers)
- New nursing processes were designed to "Quarantine" vaccines very near to expiration times
- Standardized labeling and colored bin storage process in place to clearly designate different vaccines from each other in their storage area

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Cognitive biases and diagnostic error

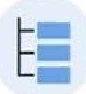
Four Common Clinician Biases

Anchoring bias: The clinician adheres to their initial impression in the face of conflicting evidence.

Confirmation bias: Information is "cherry picked" to support the diagnosis.

The affect heuristic: Actions are driven by emotions; this often manifests as strong feelings regarding a patient after an encounter.

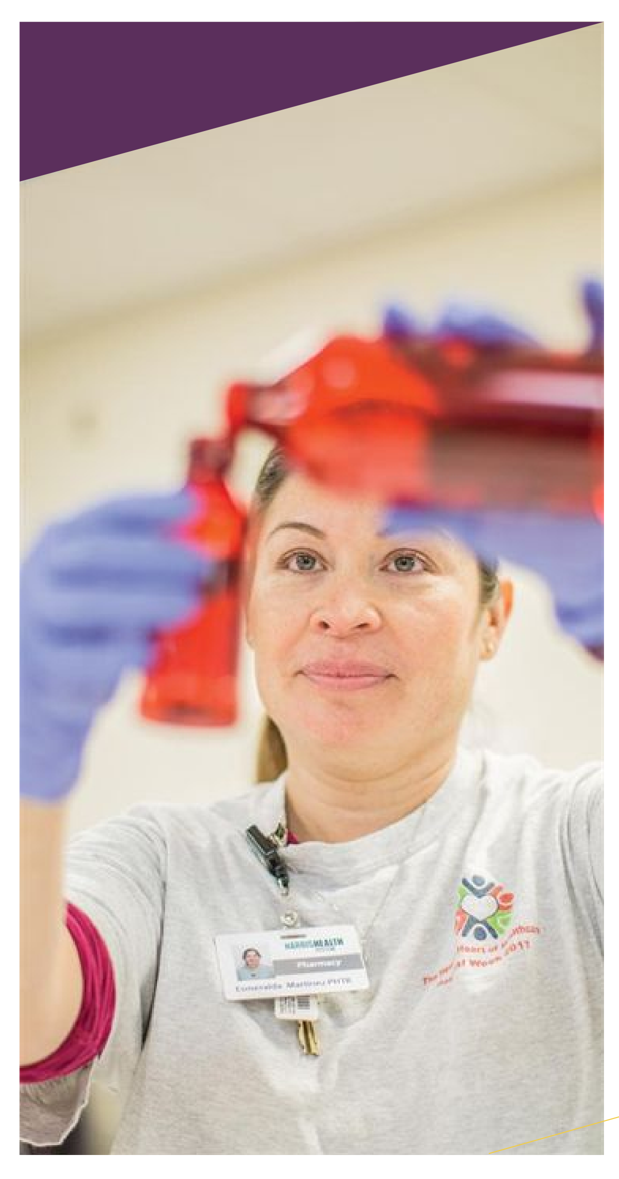
Outcomes bias: Clinical results always follow prior decisions, preventing clinicians from considering feedback to improve their care delivery.



Source: Doherty et al.

Delayed diagnosis for patients with respiratory symptoms who may be suspected of COVID even when the test is negative – delay in care of their actual problem

- Recognize cognitive biases and effect on diagnosis
- Develop organizational understanding of the depth to which cognitive bias affects patient outcomes
- Simulation training
- Incorporate critical thinking methodologies to increase clinician objectivity
- Limit patient descriptors such as "frequent flyer" or "drug-seeking"



How we are working to eliminate it

- Simulation training for different disciplines is being expanded in multiple areas of safety concern (hands on drills to practice responses, diagnostic reflex testing when positive results are found, etc.)
- Plans for Patient Safety Department interactive education offerings related to cognitive bias and delivery of tools (Pt Safety Toolbox) to assist in identifying these types of bias

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Non-ventilator healthcare-associated pneumonia

NV-HAP Bundle

- **Comprehensive oral care**
- **Maintenance of mobility**
- **Reduction of aspiration risks**
- **Elevation of health of bed**
- **Swallow assessments for dysphagia**
- **Adequate nutrition**
- **Stress ulcer prophylaxis**
- **Glycemic control**
- **Oral/nasogastric feeding tube assessments**
- **Age-appropriate immunizations**

NV-HAP is a preventable event that is underreported as a healthcare complication. About **1 in every 100 hospitalized patients** experiences NV-HAP, with mortality rates ranging from **15%-30% for hospitalized patients** and **13%-41% for nursing home residents**.

The impact of NV-HAP on hospital utilization:

— length-of-stay extended by up to 15 days

— intensive care unit (ICU) admission required in up to 46% of non-ICU cases

— increased antibiotic use

— readmissions within 30 days in up to 20% of survivors

Sources: Munro et al.; Stamm et al.

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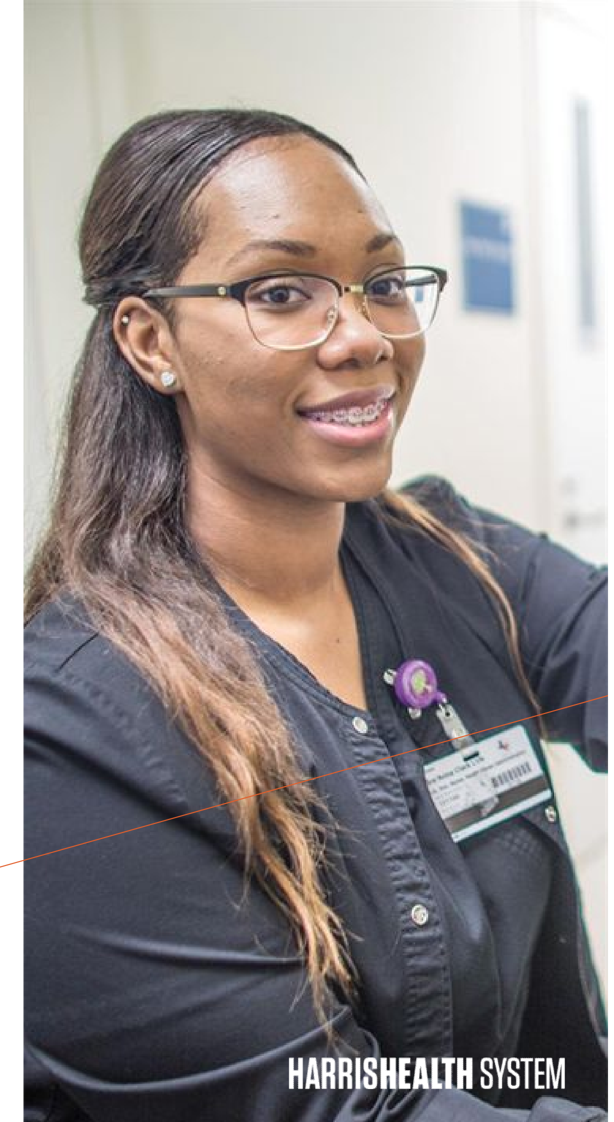
Prevention…

- An initial assessment is underway to determine the extent of the problem with our patient population
- The Patient Safety Department is planning to partner with nursing and infection prevention to implement a Med/Surg aspiration pneumonia prevention program
  - Aspiration Bundle
  - Screening for immunizations and risks
  - Mobility initiatives



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Human factors in operationalizing telehealth

User Satisfaction

Another survey asked for which of the following services U.S. adults (n=1,700) would be willing to use telehealth and found the following:

Common illnesses/infections: 69%

Follow-up visits: 66%

Talk therapy: 49%

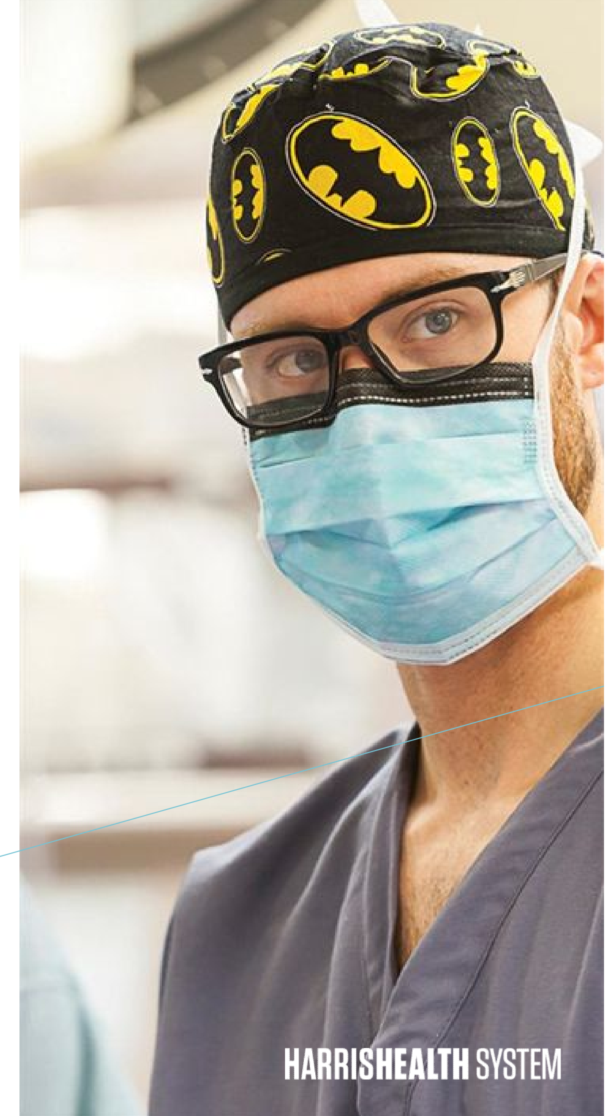
Management for a chronic condition: 44%

Physical therapy: 18%

Source: SingleCare

Harris Health Successes!

- MyHealth Patient Portal
  - On-site events at clinics to provide in-person support and answer questions (personnel fluent in Spanish and Vietnamese present)
    - Download, account creation and activation
    - Features and benefits
  - New patient facing videos and print user guide with FAQ (available in 3 languages)
- EC and SDC Telehealth offered to patients calling into Ask My Nurse line
  - **81% EC visit avoided** by taking care of the patient swiftly and virtually with our providers
    - Program has won awards, been featured in the Harvard Business Review and is in the process of being expanded
- Remote Patient Monitoring for Hypertension CDM had 564 patients enrolled
  - Branded HealthyConnect
  - **92% reported Patient satisfaction**
- eConsults (provider to provider)
  - Volume increasing every month and conditions expanding in many specialties to keep more low-acuity patients in their medical home vs. on the wait list for a referral appointment
  - **Faster care to patients in their comfort zone**



International supply chain disruptions

Areas of concern:

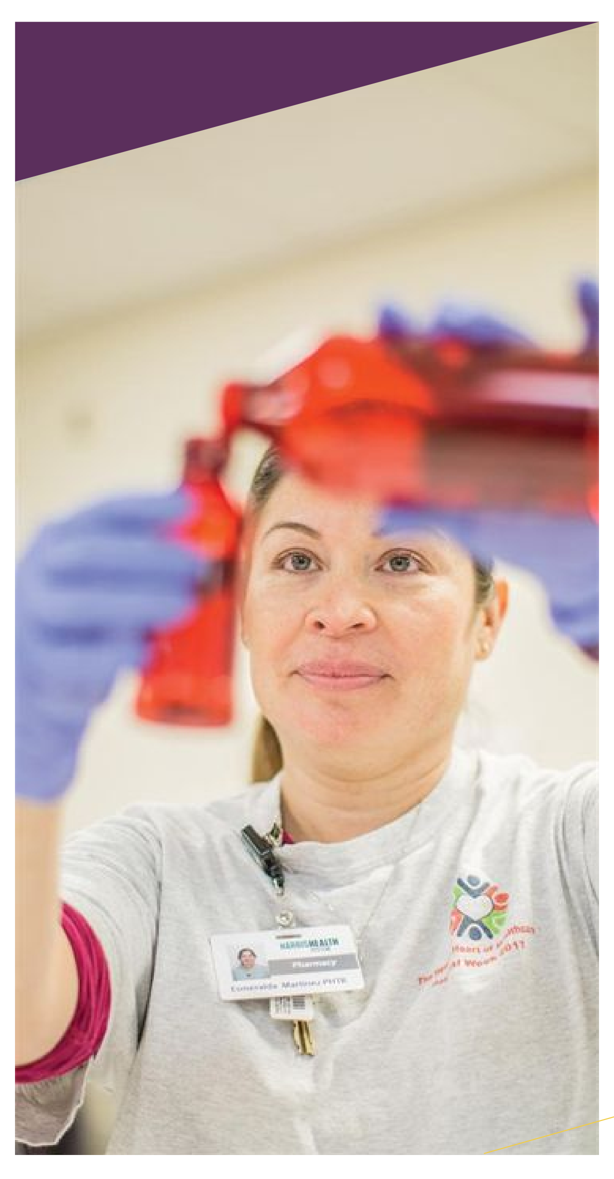
1. Manufacturers are having difficulty accessing raw materials
2. Delivery disruptions have impacted the availability of shipping containers, unloading space, trucking capacity, and delivery workers

- Prioritize critical supplies
- Monitor drug shortages
- Establish and maintain communication with local, state, and federal government agencies to determine which stockpiles are accessible
- Reexamine sole-source agreements

Examples of healthcare equipment shipping delays

	Prepandemic	September 2021
Portable plastic toilets	No delay	Up to 4 months
Heart defibrillators	2 weeks	Up to 3 months
Examination tables	6 weeks	Up to 5 months

Source: Aeppel



Supply Chain leveraging the TMC power

- Webex calls with all TMC hospitals for almost 2 years during the COVID surges to discuss needs
  - Able to leverage group purchasing power
- Safety huddles to discuss supply chain shortages and develop communication and action plans
- Pharmacy communications regarding medications or supplies in short supply or unable to be obtained

Total dollar amount for donated masks, gloves, and gowns

TOTAL NUMBER OF ITEMS	740,793	TOTAL FMV (Fair Market Value)	$765,895.05

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Products subject to emergency use authorization

EUAs allow **temporary** use of:

- Unapproved products
- Unapproved applications of approved products

EUAs:

- May be revised or revoked at any time
- Terminate when the emergency ends or FDA approves the product

In some circumstances, using a product after the EUA ends may risk **regulatory compliance problems** or **loss of federal liability protections.**

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1. Inventory all EUA products and documents
2. Monitor EUA status
3. Keep providers informed about which products have EUA and safety/efficacy risks
4. For revised EUAs, replace product documents with new versions
5. Inform providers of EUA revocations and ensure those products are taken out of service

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Supply Chain/Pharmacy Monitored all EUA products

- #1 EUA product was the COVID Vaccine
- The CDC/FDA relaxed mask related requirements for all masks, including KN95 and N95 Respirators with EUAs early during COVID.
- Harris Health reprocessed our Cardinal/Makrite N95 Masks using UV and Steris reprocessing methods for approximately 6 months
- Disposable Isolation Gowns, nitrile exam gloves, we utilized Texas Medical Center (TMC) 'Co-Op'
- Product substitutions were fast-tracked for review/approval at our Value Analysis Committee/Production Standardization Committee

- In spite of supply chain difficulties all throughout the COVID Pandemic, Harris Health maintained extraordinary patient outcomes while keeping our employees safe!

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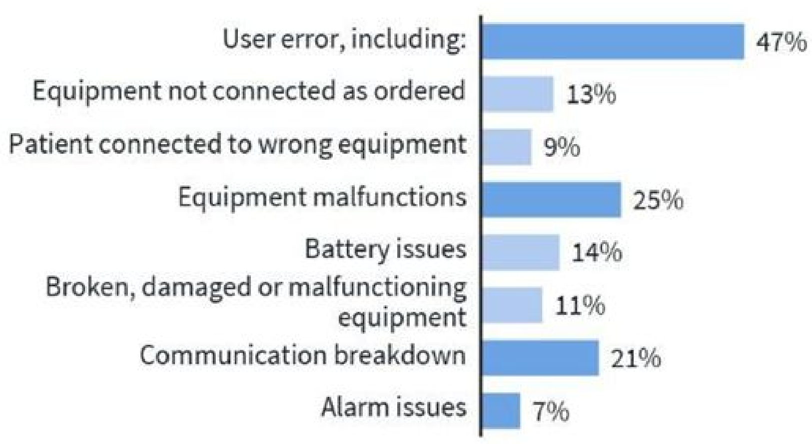
Telemetry Monitoring

The Pennsylvania Patient Safety Reporting System identified 558 TM-related cardiac events submitted between 2014 and 2018, finding:



Source: Kukielka

Common problems:

Alarm fatigue

Poor safety culture **between departments**

Infrastructure breakdowns leading to information **dropouts/lost communication** (e.g., malfunction/low battery at telepack, access points, or central monitoring unit [CMU])

Lack of effective **emergency backup** plans during outages

Extended downtime due to **confusion in roles and responsibilities** between information technology and clinical engineering

Cybersecurity vulnerabilities (e.g., interrupting data transmission or data fidelity)

Communication complications (e.g., extended turnaround time, missing data) between newly merged or acquired organizations using **different hardware/software** to communicate with a CMU

Source: ECRI

Telemetry Interventions

- Opened a designated EC monitored telemetry station in the BT EC on 8/30/22
- System Telemetry Sub-committee completed gap analysis
  - Recommendations on volumes
  - Staffing
  - Process redesign
- Vendor came to do assessment of alarm settings and advised on preventing alarm fatigue through modifications
- Coordinate results from safety culture survey with findings from rounds to improve communication between techs and nurses

HARRISHEALTH SYSTEM

BOARD OF TRUSTEES

Quality Committee

Wednesday, November 30, 2022

Presentation and Discussion Regarding Gastrointestinal Service Line

Gastrointestinal (GI) Service Line

Dr. Brooks Cash, Interim Medical Director, GI, UT

Dr. R. J. Sealock, GI, BCM

Dr. Fred Sutton, Interim Medical Director, GI, BCM

Amineh Kostov, VP, System Service Lines

November 30, 2022

Board of Trustees Quality Committee

Accomplishments

- Physicians from UTHealth and Baylor College of Medicine received a combined grant from the American Society of Gastrointestinal Endoscopy (ASGE), Medtronic, and Amazon Web Services to provide three GI Genius Artificial Intelligence Modules which are designed to enhance the detection of neoplastic lesions during colonoscopy at LBJ and Ben Taub Hospital
- For the second year in a row, LBJ GI was awarded the American College of Gastroenterology Scopy Award for Colorectal Cancer Screening Awareness

GI Service Line Year in Review

- Developed Abnormal Liver Panel to improve GI referral process for Primary Care
- Engaged in Performance Excellence Project for Colo-Rectal Cancer Screening
- Kick-off meeting and demonstration of Epic Lumens (endoscopy module)
- Consistently completed high volumes of eConsults for HHS providers in a timely fashion

GI Service Line Measures

- Meeting all Bowel Prep, Adenoma Detection Rate, Cecum Withdrawal Time, Cecal Intubation Rate, and Hand Hygiene Measures

Academic Year 2023 Goals

Pillar	Owner	Goal
Development of one clinical pathway	**GI Service Line in collaboration with Primary Care Physician Champion(s).**	**Develop referral guidelines to define criteria for OMS Vendor(s) and internal GI lab to guide PCP Providers when entering referral for colonoscopy.**
Development of one standard of care	**GI Service Line**	**Develop colon cancer screening algorithm for primary care physicians to determine patient appropriate procedure of FIT vs. Screening colonoscopy.**
Development of one clinical pathway	**GI Service Line in Collaboration with Outsourced Medical Services**	**Develop workflow for patients who decline service by outside vendor to return to Harris Health.**

Wednesday, November 30, 2022

Consideration of Approval of the 2023-2024 Harris Health Utilization Review Plan

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Biennial Review of the Harris Health Utilization Review Plan

As required by the CMS Conditions of Participation and the Medical Staff Bylaws, the 2023-2024 Utilization Review Plan is presented for approval. Updates to the Utilization Review Plan for 2023-2024 include; change to the effective dates of the updated UR Plan to 2023-2024; changed Case Management to Care Management throughout the document; Appendix A lists the ongoing Utilization Review (UR) initiatives and has been updated to reflect the current system and pavilion-based UR areas of focus, DSRIP report out has been removed; Revision of Appendix C to include updated Extended Stay workflows involving Care Management, the Physician Advisor's and Utilization Management.

HARRIS HEALTH SYSTEM

Ben Taub Hospital
Lyndon B. Johnson Hospital
Ambulatory Care Services

UTILIZATION REVIEW PLAN 2023-2024

I. INTRODUCTION

The Utilization Review (UR) Plan of the Harris Health System has been developed by UR staff in collaboration with Medical Staff leaders.

II. PURPOSE OF THE UTILIZATION REVIEW COMMITTEE

The System Utilization Review Committee is established within the Medical Staff Bylaws with the following objectives:

A. To ensure the maintenance of high-quality patient care.

B. To assure that inpatient/outpatient services provided are medically necessary.

C. To increase effective utilization of inpatient/outpatient services through analysis and an evidenced-based approach involving studies of patterns of care within the hospital and Ambulatory Care Services.

D. To establish and carry out a program of utilization review for patients in accordance with applicable requirements and regulations (i.e., Prospective Payment System {PPS}; Prospective Payment System Exempt Units):

1. Review of medical services to determine whether the services were reasonable and medically necessary, were furnished in the appropriate setting, and were of a quality that meet professionally recognized standards of care;
2. Review of cases involving preadmission and pre-procedure review requirements established by the Centers of Medicare and Medicaid Services (CMS);
3. Review of cases in support of Hospital Payment Monitoring Programs and determinations made by Kepro, the Quality Improvement Organization (QIO) for Texas.

III. ORGANIZATION OF UTILIZATION REVIEW COMMITTEE & HOSPITAL-BASED UR SUBCOMMITTEES

A. The System Utilization Review Committee is a standing committee of the Medical Staff, as well as other professional personnel, as established in accordance with the Medical Staff Bylaws.

1. The Chair and Medical Staff members are appointed by the Chair of the Medical Executive Board. Membership on the committee is composed of at least four (4) members of active medical staff, including the Chief Medical Executive and Chief Executive Officer or designee. Terms of appointment will be according to the Harris Health System Medical Staff Bylaws.
2. Members of Administrative Staff and departmental representatives will be appointed by the Chair of the System UR Committee or Hospital-Based UR Subcommittees. The appointees may include at least one representative for each Hospital and Ambulatory Care Services from the following:
   a) Administration
   b) Utilization Management
   c) Quality & Patient Safety
   d) Care Management
   e) Nursing
   f) Health Information Management
   g) Patient Financial Services
   h) Decision Support Services
   i) Patient Access/Registration
   j) Corporate Compliance
   k) Business Development & Strategic Planning
3. No member of the committee's utilization review staff shall participate in the review of a case that he/she is professionally involved in the care of the patient.

B. The Hospital-Based UR Sub-Committees are an established forum in which to provide a platform for the development and enhancement of clinical operations related to utilization management. These sub-committees will provide recommendations, reports, and information back to the System UR Committee in order to assist in the evaluation of systems, services or provider specific performance across system sites. See Appendix A for a listing of current UR initiatives.

IV. UTILIZATION REVIEW COMMITTEE OR SUBCOMMITTEE MEETINGS

A. The System Utilization Review Committee or Hospital-Based UR Sub-Committees shall meet quarterly, at a minimum, or as deemed necessary by the UR chair. At least 50% of the voting members of Utilization Review Committee or Hospital-Based UR Subcommittee must be present for the Committee to conduct business. In addition, the Utilization Review Committee must have at least one representative from The University of Texas Health Science Center at Houston and one representative from Baylor College of Medicine. The Utilization Review Chair may call a special meeting when necessary.

Minutes and records of all Utilization Review Committee or Hospital-Based UR Sub-Committee meetings will be maintained by Medical Staff Services.

V. GENERAL PROCEDURES FOR REVIEW

All patients may be subject to review without regard to payment source with respect to medical necessity of:

A. Admissions or Continued Stay Review

1. Review of admissions or continued stay may be performed before, at, or after, hospital admission.
2. Reviews may be conducted on a sample basis.
3. The determination that an admission or continued stay is not medically necessary:
   a) May be made by one physician member of the System-UR committee if the attending practitioner or practitioners responsible for the care of the patient, concur with the determination or fail to present their views when afforded the opportunity; and
   b) Must be made by at least two physician members of the System-UR committee in all other cases.
4. Before making a determination that an admission or continued stay is not medically necessary, a physician from the System-UR committee must consult the attending practitioner or practitioners responsible for the care of the patient and afford the practitioner or practitioners the opportunity to present their views.
5. If the attending physician contests the System UR committee’s findings, or if they present additional information relating to the patient’s need for extended stay, at

least one additional physician member of the System UR committee must review the case. If the two physician members determine that the patient's stay is not medically necessary or appropriate after considering all the evidence, their determination becomes final.

5. If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given after the determination, to the hospital administrator, the patient(or next of kin), the attending practitioner or practitioners responsible for the care of the patient, and the single State agency (in the case of Medicaid) no later than 2 days after such final determination and in no event later than 3 working days after the end of the assigned extended stay period.
6. If, after referral of a questioned case to the committee or subgroup thereof, the physician reviewer determines that an admission or extended stay is justified, the attending physician shall be so notified and an appropriate date for subsequent extended stay review will be selected and noted on the patient's record.
6. Initial screenings and review activities will be performed by non-physician reviewers of the Care Management department. When someone other than a doctor of medicine or osteopathy makes an initial finding that the written criteria for extended stay are not met, the case must be referred to the committee, or subgroup thereof which contains at least one physician. In no case will a non-physician make a final determination that a patient's stay is not medically necessary or appropriate.
7. A nationally recognized medical necessity screening tool will be utilized in the review process.

B. Extended Stay Reviews

1. The System UR Committee will review all cases reasonably assumed to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis. A case review escalation process is followed in order to identify the outliers. See Addendum B.
2. The System-UR Committee will make the periodic reviews no later than seven (7) days after the outlier threshold of thirty (30) days and reports quarterly at the UR Committee meeting.

C. Review of Professional Services

1. The UR Committee will review professional services identified to be of resource concern to determine medical necessity and to promote the most efficient use of available Harris Health facilities and services. Cases for review will include those designated as outlier cases based on extraordinarily high costs.

2. “Professional services” includes services provided by practitioners, including both physicians and non-physician practitioners. Professional Services review topics are established by the System Utilization Review Committee and may include the availability and use of necessary services (underused, overuse, appropriate use), timeliness of scheduling of services (operating room, diagnostic procedures), and the appropriate utilization of therapeutic procedures.

3. Current Professional Services Reviews are listed in Appendix A.

VI. PRIVILEGE/CONFIDENTIALITY OF UTILIZATION REVIEW ACTIVITIES

While certain statistical information provided and discussed in the System Utilization Review Committee is publicly reported to the Harris Health System Board of Trustees, the Utilization Review Committees also functions as a “medical committee” and/or “medical peer review committee” pursuant to state law. Other than the information publicly reported to the Board of Trustees, the Utilization Review Committees records and proceedings are confidential, legally privileged, and protected from discovery based on the function 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 System or Hospital-Based Utilization Review Sub-Committees, its 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, System or Hospital-Based Utilization Review Sub-Committee meetings must be limited to only the Committee members and invited guests who need to attend the meetings. The Committees 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 Committees 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 Committees meetings, without prior approval from the Committees Chair. Documents prepared by or considered by the Committees in these meetings must clearly indicate that they are not to be copied, are solely for use by the Committees, and are privileged and confidential.

The records and proceedings of Harris Health departments that support the quality and peer review functions of the Utilization Review Committees, are also confidential, legally privileged, and protected from discovery, if the records are prepared by or at the direction of the Committees 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 Committees, or which have been created without Committees impetus and purpose, are also not protected.

VII. AMENDMENTS/REVISIONS TO THE UTILIZATION REVIEW PLAN

A. The System Utilization Review Committee may amend this plan with the approval of the Medical Staff and Harris Health System Board of Trustees.

B. A copy of any amendment or revision, properly signed dated by the Chair of the Harris Health System Board of Trustees and the Chair of the Medical Executive Board will be forwarded to Utilization Management and Medical Staff Service Departments.

C. Upon approval by the aforementioned parties, the amendment or revision will become part of the official Harris Health System UR Plan.

Appendix A

Title	*Defined*	*Report Frequency*	*System Committee*	*BT Subcommittee*	*LBJ Subcommittee*
UM Executive Scorecard Review	Overview of System performance metrics, strategic outcomes, and goals	Monthly	X	X	X
Medicaid RAC Audit Report & Action Plan Summary	Retrospective evaluation of primary payer of System [Medicaid inpatient potentially preventable readmissions (PPR)] due to high-cost dollars at risk with implementation of a reporting process and reimbursement action plan	Bi-annual	X	__	__
Radiology – Care Select	Evaluate effectiveness focused on improving the indication selection workflow in Epic; predicts the most relevant indications based on patient data, provider, order, and care setting	Quarterly	X	__	__
IM/MOON Compliance Report	Evaluate compliance of CMS required documentation for Medicare beneficiaries	Bi-annual	X	__	__

Outside Medical Services (OMS) Utilization Data	Evaluation of coordinated care and services provided by outside contracted vendors/agencies	Quarterly	X	__	__
ACS: Virtual Care Data	Evaluation of telemedicine data statistics to address alternative modalities for outpatient appointments	Quarterly	X	__	__
ACS: Transition of Care Report	Evaluate the effectiveness of post-acute Transition of Care referral process in patients who are problem prone and/or have a chronic high-risk diagnosis to appropriate physician and non-physician providers, promote self-management, adherence with treatment goals and decrease utilization	Quarterly	X	__	__
Medical Necessity GZ Modifier Pilot Program	Analysis of applying GZ Modifier (indicating medical necessity has not been met for specific tests, services, etc.) in funded cases (outpatient setting) to identify the impact on reimbursement and opportunities for improvement within the System	Bi-annual	X	__	__
ACS Taskforce: F/U Appointment w/PCP	Evaluation of data related to discharge process, variation and scheduling complexities related to follow-up appointment at time of discharge from hospital unit	Quarterly	X	__	__

Revised: 10-2022

Pro-calcitonin Utilization Ordering in EPIC	PI Project to address overutilization and cost impact of Pro-calcitonin lab ordering by providers	Quarterly	X	__	__
Inpatient CDI Statistics Report - Working MS-DRG	Overview on effectiveness of CDI Program on CMI, review rate, query rate, response rate, response time and revenue impact for each pavilion	Quarterly	__	X	X
Avoidable Delay w/Action Plan	Assess top reasons for hospital delays with action plan to address impact to hospital	Monthly	__	X	X
Care Management Order Volume	Assess volume and type of Care Management orders in acute care setting to identify opportunities for improvement in patient care flow	Quarterly	__	X	__
Patient Throughput Dashboard Summary	Overview of top Throughput metrics with fallouts and action plan to address inefficiencies	Monthly	__	X	X
Blood Bank – Blood Wastage Utilization	Evaluation of wastage data, identification of factors affecting product wastage and effectiveness of implemented interventions	Quarterly	__	X	X

Laboratory – Beaker Metric	Data analysis of high-cost lab tests for each pavilion which represents largest area of improvement opportunity for System	Quarterly	__	X	X
Radiology – Imaging Services Utilization	Overview of EC Radiology turn-around-times (TATs), identification of barriers and evaluation of action plan to address inefficiencies	Quarterly	__	X	X
Radiology – Imaging IR Delays	Evaluation of IR delays, barriers to hospital workflow, and implementation of action plan to improve cost savings	Quarterly	__	X	X
CDI – Clinical Validation Denial	Evaluation of high-risk clinical diagnoses with highest improvement opportunity in denial rate	Bi-annual	__	X	X
Physician Advisor Program Development - Focus Update	Evaluation of initiatives, contributions, and challenges to address inefficiencies in PA Program and in the System	Quarterly	__	X	X
PT/OT Consults Data	Overview of data collection regarding appropriateness of PT/OT consults with action plan to improve inefficiencies	Bi-annual	__	X	X

Radiology – PICC Team Productivity Tracking	Evaluation of new central line placement protocol, statistical data, and impact on improving efficiency	Quarterly	__	X	X
Top 3 DRG Project (formerly Top 10 DRG)	Identification, selection, and audit of top MS-DRG diagnoses at each pavilion with action plan to address opportunities for improvement	Annually - On Hold	__	X	X

System UR Committee meeting 11-4-22 – Approved
Medical Executive Board 11-8-22 – Approved
Board Quality Subcommittee 11-30-22

Appendix B

HARRISHEALTH SYSTEM

Reporting Format
System and Hospital-Based UR
Medical Staff Service Committee

Hospital Based Utilization Review (UR) Sub-Committee
Monthly Meetings

Reports & Updates
on UR activities
Medical Executive Committee (MECs)

Reports & Updates
On UR activities to the
Harris Health System
UR Committee

System- UR Committee
reports UR activities
to the
Medical Executive Board (MEB)

System- UR Committee
reports UR activities
to the
Quality Governance Council (QGC)

Appendix C: Extended Stay Reviews and Escalation Process – Care Management and Utilization Management

Inpatient Hospitalization

- Hospitalization Exceeds Expected Date of Discharge
- Update Expected Date of Discharge

Clinical Care Management

- Complete medical necessity review (MCG) per departmental policy. Refer to policy, Hospitalization and Medical Necessity Review, 4100
- Review Barriers to Discharge w/ Provider and/or Interdisciplinary Team
- Care Management will escalate to Physician Advisor (PA) for any barriers/delays
- Care Management will escalate to PA if Length of Stay (LOS)>10 days and Length of Stay (LOS) >30 days
- Document Variance type within MCG-Indicia
- Comorbid, Complication, Physiologic Delay
System Delay
Patient or Family/Social Support
Financial Resource Issue

Physician Advisor

- PA will complete Secondary Medical Review and document in EPIC in account notes and add billing indicator to account

Utilization Management

- Reviews weekly extended stay report > than 30 days for all patients. Distribute all accounts to PA for Secondary Medical Review

Wednesday, November 30, 2022

Executive Session Agenda Item

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 Report in Connection With the Evaluation of the Quality of Medical and Health Care Services, Including the Harris Health System Quality and Safety Performance Measures, and Possible Action Regarding This Matter Upon Return to Open Session

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