BOARD OF TRUSTEES

Public Meeting Agenda

HARRISHEALTH SYSTEM

Thursday, December 12, 2024
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, TX 77401
The meeting may be viewed online: 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**	**2 min**
II.	**Approval of the Minutes of Previous Meeting** • Board Meeting – October 24, 2024 • HRSA Special Call Board – November 14, 2024	**Dr. Andrea Caracostis**	**1 min**
III.	**Announcements / Special Presentations**	**Dr. Andrea Caracostis**	**15 min**
	A. CEO Report Including Special Announcements ***– Dr. Esmaeil Porsa***		*(10 min)*
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements		*(5 min)*
IV.	**Public Comment**	**Dr. Andrea Caracostis**	**3 min**
V.	**Executive Session**	**Dr. Andrea Caracostis**	**40 min**
	A. Consultation with Attorney Regarding Collaborative Opportunities from The University of Texas M.D. Anderson Cancer Center, Pursuant to Tex. Gov't Code Ann. §§551.071, 551.085 and Possible Action Upon Return to Open Session ***– Ms. Sara Thomas, Dr. Esmaeil Porsa and Mr. Louis Smith***		*(10 min)*
	B. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code Ann. §§160.007 and 151.002 to Receive Peer Review and/or Medical Committee Report, Including Report of the Medical Executive Board in Connection with the Evaluation of the Quality of Medical and Healthcare Services, and also the Harris Health Quality, Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting with Possible Action Regarding this Matter Upon Return to Open Session ***– Dr. Andrea Caracostis, Dr. Steven Brass and Dr. Yashwant Chathampally***		*(10 min)*

C.	Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of Harris Health Medical Staff **– *Dr. Martha Mims and Dr. Bradford Scott***		*(10 min)*
D.	Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, Including Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071 to Receive Peer Review and/or Medical Committee Report with Possible Action Upon Return to Open Session **– *Dr. Otis Egins***		*(10 min)*
VI.	**Reconvene to Open Meeting**	**Dr. Andrea Caracostis**	**2 min**
VII.	**General Action Item(s)**	**Dr. Andrea Caracostis**	**20 min**
A.	General Action Item(s) Related to Quality: Medical Staff		
1.	Consideration of Approval of Credentialing Changes for Members of Harris Health Medical Staff **– *Dr. Martha Mims***		*(2 min)*
2.	Consideration of Approval of Changes to the Internal Medicine Gastroenterology Clinical Privileges **– *Dr. Martha Mims***		*(2 min)*
3.	Consideration of Approval of the 2025-2026 Harris Health Utilization Review Plan **– *Dr. Martha Mims***		*(2 min)*
4.	Review and Discussion Regarding the Harris Health Staffing Advisory Committee's Semi-Annual Evaluation of the Nurse Staffing Plan and Aggregate Staffing Variance **– *Dr. Jackie Brock***		*(10 min)*
B.	General Action Item(s) Related to Quality: Correctional Health Medical Staff		
1.	Consideration of Approval of Credentialing Changes for Members of Harris Health Correctional Health Medical Staff **– *Dr. Otis Egins***		*(2 min)*
2.	Consideration of Approval of the Harris Health Correctional Health Medical Staff Bylaws **– *Dr. Otis Egins***		*(2 min)*
VIII.	**New Items for Board Consideration**	**Dr. Andrea Caracostis**	**25 min**
A.	Board Officer Elections for the Positions of Chair, Vice Chair and Secretary for the 2025 Calendar Year	**Dr. Andrea Caracostis**	*(15 min)*
B.	Consideration of Approval of the Appointment of 2025 Committees and Membership	**Dr. Andrea Caracostis**	*(5 min)*
C.	Consideration of Approval of the Tentative Harris Health 2025 Board of Trustees Calendar	**Dr. Andrea Caracostis**	*(5 min)*
IX.	**Strategic Discussion**	**Dr. Andrea Caracostis**	**50 min**
A.	Harris Health Strategic Plan Initiatives		
1.	Presentation Regarding the Harris Health 2021-2025 Strategic Plan Update **– *Ms. Maria Cowles***		*(30 min)*

2. Presentation Regarding Governance Structure of the Patient and Family Advisory Council (PFAC) **– *Dr. Jennifer Small and Mr. David Riddle*** *(10 min)*

B. November Committee Reports: *(10 min)*

- Governance Committee **– *Dr. Cody Pyke***
- Quality Committee **– *Dr. Andrea Caracostis***
- Budget & Finance Committee **– *Mr. Jim Robinson***
- Compliance & Audit Committee **– *Ms. Carol Paret***
- Joint Conference Committee **– *Dr. Andrea Caracostis***

X. Consent Agenda Items **Dr. Andrea Caracostis** **5 min**

A. Consent Purchasing Recommendations

1. Consideration of Approval of Purchasing Recommendations (Items A1 through A8 of the Purchasing Matrix) **– *Ms. Paige McInnis and Mr. Jack Adger, Harris County Purchasing Office***

   (See Attached Expenditure Summary: December 12, 2024)

B. Consent Committee Recommendations

1. Consideration of Acceptance of the Harris Health Fourth Quarter Fiscal Year 2024 Investment Report **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

2. Consideration of Acceptance of the Harris Health Third Quarter Calendar Year 2024 Pension Plan Report **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

3. Consideration of Acceptance of the Harris Health September 2024 Financial Report Subject to Audit **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

4. Consideration of Approval of the Harris Health Fiscal Year 2025 Internal Audit Charter **– *Mr. Mike Post, Harris County Auditor and Ms. Sharon Brantley Smith, Chief Assistant County Auditor***
   [Compliance & Audit Committee]

C. Consent Grant Recommendations

1. Consideration of Approval of Grant Recommendation (Item C1 of the Grant Matrix) **– *Dr. Jennifer Small***

   (See Attached Expenditure Summary: December 12, 2024)

D. Consent Contract Recommendations

1. Consideration of Approval of Contract Recommendation (Item D1 of the Contract Matrix) **– *Mr. Louis Smith and Mr. Aown Syed***

   (See Attached Expenditure Summary: December 12, 2024)

E. New Consent Items for Board Approval

1. Consideration of Approval of the Harris Health Investment Policy **– *Ms. Victoria Nikitin***

2. Consideration of Acceptance of the Harris Health October 2024 Financial Report Subject to Audit ***– Ms. Victoria Nikitin***

F. Consent Reports and Updates to the Board

1. Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health ***– Mr. R. King Hillier***

{End of Consent Agenda}

XI. Item(s) Related to the Health Care for the Homeless Program — **Dr. Andrea Caracostis** — **15 min**

A. Review and Acceptance of the Following Reports for the Health Care for the Homeless Program (HCHP) as Required by the United States Department of Health and Human Services, which Provides Funding to the Harris County Hospital District d/b/a/Harris Health to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act ***– Dr. Jennifer Small and Ms. Tracey Burdine*** *(13 min)*

- HCHP December 2024 Operational Update

B. Consideration of Approval of the HCHP Budget Summary Report ***– Dr. Jennifer Small and Ms. Tracey Burdine*** *(1 min)*

C. Consideration of Approval of the HCHP H80 Notice of Grant Award ***– Dr. Jennifer Small and Ms. Tracey Burdine*** *(1 min)*

XII. Executive Session — **Dr. Andrea Caracostis** — **56 min**

E. Consultation with Attorney Regarding Opioid Litigation, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action for Approval to Participate in the Settlement with Kroger in the Texas Opioid Multi-District Litigation Upon Return to Open Session ***– Ms. Ebon Swofford*** *(5 min)*

F. Consultation with Attorney Regarding Settlement of Claims Brought by or on Behalf of David Clark, Pursuant to Tex. Gov't Code Ann. §551.071 and Possible Action Upon Return to Open Session ***– Ms. Ebon Swofford and Mr. Michael Fritz*** *(10 min)*

G. Consideration of Approval of the Committee Reviewed Reports, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Health & Safety Code Ann. §161.032, Tex. Gov't Code Ann. §§418.183, 551.089, and 551.085 Upon Return to Open Session: *(1 min)*

[Budget & Finance Committee]

- Subsidy Payments to Community Health Choice, Inc. for the Health Insurance Marketplace Non-Federal Premium Payments to Eligible Harris Health Patients for Calendar Year 2025 ***– Ms. Victoria Nikitin***
- 2025 Operating and Capital Budget for Community Health Choice Texas, Inc. and Community Health Choice, Inc. ***– Ms. Lisa Wright, CEO and Ms. Anna Mateja, CFO, Community Health Choice***

[Compliance & Audit Committee]

- Harris Health Fiscal Year 2025 Internal Audit Plan ***– Ms. Sharon Brantley Smith, Chief Assistant County Auditor***
- Fiscal Year 2025 Harris Health Compliance and Internal Quality Audit Plans ***– Ms. Carolynn Jones***

H. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. 2025 Insurance Renewals, Pursuant to Tex. Gov't Code Ann. §551.085, Including Consideration of Approval of the Community Health Choice 2025 Insurance Renewals Upon Return to Open Session ***– Ms. Lisa Wright, CEO and Ms. Anna Mateja, CFO, Community Health Choice*** *(10 min)*

I. Consultation with Attorney Regarding Civil Action No. 4:23-CV-03198; Sarah Borchgrevink, Representative of the Estate of Matthew Ryan Shelton, Deceased, and Marianna Ruth Thomson, Statutory Wrongful Death Beneficiary of Matthew Ryan Shelton, Deceased v. Harris County, Texas; Harris County Hospital District, et al., In the U.S. District Court, Southern District of Texas, Houston Division, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Ebon Swofford and Mr. Michael Fritz*** *(10 min)*

J. Consultation with Attorney on Interlocal Agreement with Harris County for Correctional Healthcare Services and Consideration of Approval of Second Amendment to Interlocal Agreement between Harris County and Harris County Hospital District D/B/A Harris Health for Correctional Healthcare Upon Return to Open Session ***– Ms. Sara Thomas*** *(10 min)*

K. Consultation with Attorney Regarding Governance Structure of the Patient and Family Advisory Council (PFAC) and Council-at-Large, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Sara Thomas*** *(10 min)*

XIII.	**Reconvene**	**Dr. Andrea Caracostis**	**5 min**
XIV.	**Adjournment**	**Dr. Andrea Caracostis**	**1 min**

MINUTES OF THE HARRIS HEALTH SYSTEM BOARD OF TRUSTEES
Board Meeting
Thursday, October 24, 2024
9:00 a.m.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 9:36 a.m. by Dr. Caracostis, Chair. It was noted that a quorum was present and the attendance was recorded. Dr. Caracostis stated while some of Board members are in the room with us today, 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.	**A copy of the attendance is appended to the archived minutes.**
II. Approval of the Minutes of Previous Meeting	• Board Meeting – September 26, 2024	**Motion No. 24.10-146** **Moved by Ms. Sima Ladjevardian, seconded by Ms. Carol Paret, and unanimously passed that the Board approve the minutes of the September 26, 2024 Board meeting. Motion carried.**

III. Announcements/ Special Presentations	**A. CEO Report Including Special Announcements**
	
	Dr. Esmaeil Porsa, President and Chief Executive Officer (CEO), presented the CEO Report and provided the following updates:
	• A total of 180 nurses from Harris Health were recognized with the Good Samaritan Excellence in Nursing awards:
	  ○ Gold Award: Jessica Sennett, DNP, RN
	  ○ Silver Award: Rizalina Bonuel, PhD, RN
	• On October 16th, Harris Health, in partnership with the American Heart Association (AHA), hosted one of the largest Hands-Only CPR training events in observance of World Restart a Heart Day.
	• On October 16th, Harris Health celebrated its first joint UT Health at Lyndon B. Johnson (LBJ) Research Day, where faculty, residents, and employees showcased their research and quality improvement efforts, with Dr. Caracostis, Trustee, in attendance.
	• Ms. Maria Cowles, Executive Vice President, Chief Strategy Officer, was honored with the Women Who Mean Business award by the Houston Business Journal.
		As Presented.

	• On October 17th, Harris Health held its annual Pink Out event to recognize its breast cancer program and celebrate several breast cancer survivors, with Dr. Caracostis serving as the master of ceremonies. • This month, Harris Health hosted two community town hall meetings in Precincts 1 and 3. The Precinct 4 town hall meeting is scheduled for Wednesday, November 20th, at the Bayland Community Center. The Precinct 2 town hall meeting took place in September. • Harris Health participated in the 2nd Annual Uplift Her Wellness Day, offering mammography screenings, eligibility assistance, CPR education, and health education. • Ms. Sima Ladjevardian, Trustee, was named this year's awardee of the Habitat for Humanity Building Dreams Award for her leadership and contribution to providing affordable housing, which is essential for the health and well-being of our community members. • Upcoming events include the Houston Heart Walk on October 26th and Harris Health's 3rd Annual Celebrate You event, featuring Field Day activities, on Saturday, November 9th.	
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements There were no announcements made by the Board members.	**As Presented.**
IV. Public Comment	Ms. Cynthia Cole, Executive Director, Local #1550 – AFSCME, American Federation of State, County, and Municipal Employees, addressed the Board, advocating for fair treatment, wages, and safe working environments for employees.	**As Presented.**
V. Executive Session	At 9:47 a.m., Dr. Caracostis stated that the Board would enter into Executive Session for Items V. 'A through C' as permitted by law under Tex. Health & Safety Code Ann. §161.032, Tex. Occ. Code. Ann. §§ 151.002, 160.007 and Tex. Gov't Code Ann. §551.071.	
	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, Including Report of the Medical Executive Board in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including the Harris Health Quality, Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting and Possible Action Regarding this Matter Upon Return to Open Session	**No Action Taken.**
	B. Medical Executive Board Report .and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of Harris Health Medical Staff	**No Action Taken.**

	C. Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, Including Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071 to Receive Peer Review and/or Medical Committee Report with Possible Action Upon Return to Open Session	**No Action Taken.**
VI. Reconvene to Open Meeting	At 10:20 a.m., Dr. Caracostis reconvened the meeting in open session; she noted that a quorum was present, and that no action was taken in Executive Session.	
VII. General Action Item(s)		
	A. General Action Item(s) Related to Quality: Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health System Medical Staff Dr. Martha Mims, Chair, Medical Executive Board, presented the credentialing changes for members of the Harris Health System Medical Staff. For October 2024, there were thirty – three (33) initial appointments, 270 reappointments, twelve (12) change/add privileges, thirty - one (31) resignations, eighteen (18) temporary privileges and eight (8) urgent patient care need privileges. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.10-147** **Moved by Ms. Ingrid Robinson, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda item VII.A.1. Motion carried.**
	B. General Action Item(s) Related to Quality: Correctional Health Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health System Correctional Health Medical Staff Dr. Otis Egins, Chief Medical Officer, Harris Health Correctional Health, presented the credentialing changes for members of the Harris Health System Correctional Health Medical Staff. For October 2024, there were two (2) initial appointments, seven (7) reappointments and three (3) resignations. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.10-148** **Moved by Ms. Carol Paret, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda item VII.B.1. Motion carried.**
VIII. New Items for Board Consideration		
	A. Approval of the Appointment of Mr. Jim Robinson as a Member of the Board of Trustees Compliance and Audit Committee	**Motion No. 24.10-149** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Ingrid Robinson, and unanimously passed that the Board approve agenda item VIII.A. Motion carried.**

	B. Approval of the Appointment of Ms. Libby Viera-Bland as a Member of the Board of Trustees Diversity Equity and Inclusion Committee and the Ambulatory Surgical Center at LBJ Governing Body	**Motion No. 24.10-150** **Moved by Ms. Sima Ladjevardian, seconded by Ms. Ingrid Robinson, and unanimously passed that the Board approve agenda item VIII.B. Motion carried.**
IX. Strategic Discussion		
	A. Harris Health Strategic Plan Initiatives	
	1. Presentation Regarding the Harris Health 2021-2025 Strategic Plan Update	**Agenda Item Tabled.**
	2. Review and Consideration of Approval Regarding the Naming and Launch of the Sheila Jackson Lee Center for Accelerating Health Equity Dr. Chethan Bachireddy, Senior Vice President, Chief Health Officer, presented a resolution regarding the naming and launch of the Sheila Jackson Lee Center for Accelerating Health Equity, honoring the tireless work and legacy of the late U.S. Congresswoman Sheila Jackson Lee.	**Motion No. 24.10-151** **Moved by Ms. Sima Ladjevardian, seconded by Ms. Ingrid Robinson, and unanimously passed that the Board approve agenda item IX.A.2. Motion carried.**
	B. October Committee Reports **Quality Committee** Dr. Caracostis reported that the monthly High Reliability Organization (HRO) Video "Clostridioides difficile (C. diff)" was displayed in Open Session at the Quality Committee meeting on October 8, 2024. She emphasized that Harris Health's commitment to the safety of employees and patients is unwavering and continues to evolve as conditions evolve. She also highlighted opportunities for future improvements in workplace safety and violence prevention, including reaching people through videos, website communications, emails, flyers, and monthly committee meetings. **Diversity, Equity and Inclusion (DEI) Committee** Ms. Ingrid Robinson shared that the Diversity, Equity & Inclusion Committee met on October 11, 2024, covering the following topics: • Dr. Chethan Bachireddy, Senior Vice President, Chief Health Officer, delivered a presentation regarding Partnering with Patients and Communities to Advance Access to Care. Dr. Bachireddy highlighted the Settegast Community Action Plan activities, the patient orientation initiative, and the medical home for the primary care program. He also covered community outreach and partner engagement efforts, including health fairs, ongoing training for community partners, and articles published in newspapers.	**As Presented.**

	• Dr. Jobi Martinez, Vice President, Chief Diversity Officer, provided an overview of the 2023 Employee Engagement Survey, an analysis of DEI Employee Engagement findings, a review of employee engagement resources and initiatives for 2024, and discussed the statistical significance of the findings. • The Committee also discussed the proposed 2025 DEI reporting schedule.	
X. Consent Agenda Items		
	A. Consent Purchasing Recommendations	
	1. Approval of Purchasing Recommendations (Items A1 through A3 of the Purchasing Matrix) A copy of the purchasing agenda is available in the permanent record.	**Motion No. 24.10-152** **Moved by Ms. Ingrid Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item X.A.1. Motion carried.**
	2. Approval of the Harris Health Premier Spend Report for Quarter 3 of Fiscal Year 2024	**For Information Only.**
	B. Consent Committee Recommendations Ms. Ingrid Robinson requested to have consent agenda item X.B.1. brought forward for discussion.	
	1. Approval of the 2025 DEI Reporting Schedule It was noted that the DEI Committee discussed the proposed 2025 DEI reporting schedule, emphasizing the recommended months with no changes to the dates.	**Motion No. 24.10-154** **Moved by Ms. Ingrid Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda items X.B.1. Motion carried.** ***Note: this item was taken out of order after the vote on agenda items X.C-D.***
	C. Consent Grant Recommendations	
	1. Approval of Grant Recommendations (Items C1 of the Grant Matrix)	**Motion No. 24.10-153** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.C-D. Motion carried.**
	D. New Consent Items for Board Approval	

	1. Approval of the Re-Appointment of Dr. Sandeep Markan as Chief of Staff for Ben Taub Hospital	**Motion No. 24.10-153** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.C-D. Motion carried.**
	2. Approval of a Second Amendment to the Interlocal Subrecipient Agreement Between Harris County and Harris Health for Funds to Support Expansion of Harris Health's Food Rx and Food Farmacy Program	**Motion No. 24.10-153** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.C-D. Motion carried.**
	3. Approval of a Second Amendment to the Population Health Collaboration Agreement between The University of Texas MD Anderson Cancer Center and Harris Health	**Motion No. 24.10-153** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.C-D. Motion carried.**
	4. Approval to Amend the Lease with Houston Business Development, Inc. for the Dental Center located at 5220-5250 Griggs Rd., Houston, Texas 77021	**Motion No. 24.10-153** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.C-D. Motion carried.**
	E. Consent Reports and Updates to the Board	
	1. Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health System ***{End of Consent Agenda}***	**For Information Only.**

XI. Item(s) Related to the Health Care for the Homeless Program		
	A. Review and Acceptance of the Following Reports for the Health Care for the Homeless Program (HCHP) as Required by the United States Department of Health and Human Services, which Provides Funding to the Harris County Hospital District d/b/a/Harris Health System to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act • HCHP October 2024 Operational Update • HCHP Consumer Advisory Report • HCHP Revised Legislative Mandate Policy • HCHP HIV Prevention Funding • HCHP Quality Management Report Ms. Tracy Burdine, Director of the Health Care for the Homeless Program, presented the October 2024 Operational Update, which included information on the Productivity Report, Consumer Advisory Report, Revised Legislative Mandate Policy, HIV Prevention Funding, Community Engagement, and the Quality Management Report. She reported that HCHP has provided care to 5,324 unduplicated patients and conducted a total of 20,654 visits year – to – date. In September of 2024, HCHP served 1,194 unduplicated patients, with 766 receiving family practice services. Ms. Burdine shared that despite challenges with provider vacancies, HCHP saw a 6% increase in services compared to the previous year. Additionally, Ms. Burdine reported that a total of 2,250 visits were completed in the month of September. Ms. Burdine presented the following highlights of Council activities from May 2024 to July 2024: • The council was informed about the HRSA Behavioral Health Service Expansion notice of funding opportunity and approved the grant application. • The council was informed about the HRSA Service Area Competition notice of funding opportunity and approved the grant application. • The council reviewed and approved revisions to the 2024 Quality Management Plan. • The council was informed about the operations and locations of services for the new mobile units. Ms. Burdine provided an overview of the revisions to the HCHP Legislative Mandate policy, including changes in verbiage and updates to the funding acknowledgement. She also discussed the HIV Epidemic Grant Funding, outlining the award date, funding amount, and the services offered. HCHP community engagement efforts include outreach, educational awareness, and primary care services provided to the community from June to October 2024.	**Motion No. 24.10-155** **Moved by Ms. Libby Viera - Bland, seconded by Dr. Cody Pyke, and unanimously passed that the Board approve agenda item XI.A for the HCHP October 2024 Operational Update. Motion carried.**

	Dr. LaResa Ridge, Medical Director for the Health Care for the Homeless Program, presented the Q2 Quality Management Report. She reported that HCHP has met Health Resources and Services Administration (HRSA) benchmarks as well as its own internal benchmarks for 11 out of 14 quality standards. The three (3) standards with the most room for improvement are childhood immunization status, depression remission at 12 months, and diabetes A1c >9. Action plans have been implemented to assess the effectiveness of these measures. A copy of the presentation is available in the permanent record.	
	B. Approval of the HCHP Consumer Advisory Report	**Motion No. 24.10-156** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.B. Motion carried.**
	C. Approval of the HCHP Revised Legislative Mandate Policy	**Motion No. 24.10-157** **Moved by Dr. Cody Pyke, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.C. Motion carried.**
	D. Approval of the HCHP HIV Prevention Funding	**Motion No. 24.10-158** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.D. Motion carried.**
	E. Approval of the HCHP Quality Management Report	**Motion No. 24.10-159** **Moved by Dr. Cody Pyke, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.E. Motion carried.**

XII. Executive Session	At 10:54 a.m., Dr. Andrea Caracostis stated that the Board would enter into Executive Session for Items XII. 'D through I' as permitted by law under Tex. Health & Safety Code Ann. §161.032, Tex. Gov't Code Ann. §§551.071 and 551.085.	
	D. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Organizational Update and the Year-to-Date August 2024 Financial Performance, Pursuant to Tex. Gov't Code Ann. §551.085	**No Action Taken.**
	E. Discussion Regarding Expansion of Clinical Service Lines, Pursuant to Tex. Gov't Code Ann. §551.072 and Tex. Gov't Code Ann. §551.085	**No Action Taken.**
	F. Consultation with Attorney Regarding Settlement of Claim with Johnston, LLC, Pursuant to Tex. Gov't Code Ann. §551.071 and Possible Action Upon Return to Open Session *Harris Health, by and through its Board of Trustees, hereby authorizes settlement of a claim between Harris Health and Johnston, LLC payable to Harris Health in the amounts of $75,800 for the Ben Taub Observation Project and $39,400 for the Ben Taub Neuropsychiatric Center Level 3 & 4 Project. President/CEO of Harris Health or his designee is authorized to execute any agreement, release, or any other necessary documents to affect this settlement.*	**Motion No. 24.10-160** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda item XII.F. Motion carried.**
	G. 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, Including Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032	**No Action Taken.**
	H. Consultation with Attorney Regarding Jail Interlocal Agreement, Pursuant to Tex. Gov't Code §551.071	**No Action Taken.**
	I. Consultation with Attorney Regarding Council-at-Large Bylaws, Pursuant to Tex. Gov't Code §551.071	**No Action Taken.**
XIII. Reconvene	At 12:13 p.m., Dr. Andrea Caracostis reconvened the meeting in open session; she noted that a quorum was present, and that no action was taken in Executive Session. Dr. Caracostis stated that the Board will now take action on items XII. 'F' of the Executive Session agenda.	
XIV. Adjournment	There being no further business to come before the Board, the meeting adjourned at 12:14 p.m.	

I certify that the foregoing are the Minutes of the Harris Health System Board of Trustees Meeting held on October 24, 2024.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Carol Paret, BS, Secretary

Minutes transcribed by Cherry A. Pierson, MBA

HARRISHEALTH

Thursday, October 24, 2024
Harris Health Board of Trustees Board Meeting Attendance

BOARD MEMBERS PRESENT	BOARD MEMBERS ABSENT
Afsheen Davis	
Dr. Andrea Caracostis *(Chair)*	
Carol Paret *(Secretary)*	
Dr. Cody Pyke *(Vice Chair)*	
Ingrid Robinson	
Jim Robinson	
Libby Viera-Bland	
Sima Ladjevardian	

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Alexander Barrie	Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*
Amineh Kostov	Emily Solis
Dr. Amy Smith	Dr. Esmaeil Porsa *(Harris Health System, President & CEO)*
Anna Mateja *(Community Health Choice, CFO)*	Esperanza "Hope" Galvan
Anna Robertson *(APN Student)*	Dr. Glorimar Medina
Anthony Williams	Holly Gummert *(Harris County Attorney's Office)*
Berrlyn Nelson	Jack Adger *(Harris County Purchasing Office)*
Boa Choi	Dr. Jackie Brock
Carolynn Jones	Jeffrey Baker
Cherry Pierson	Dr. Jennifer Small
Dr. Chethan Bachireddy	Jennifer Zarate
Cole Rasmussen	Jerry Summers
Cynthia Cole *(Public Speaker: AFSME 1550)*	Jessey Thomas
Daniel Smith	John Matcek
David Riddle	Dr. Joseph Kunisch
Debbie Boswell	Kiki Teal
Derek Curtis	Dr. Kunal Sharma
Ebon Swofford *(Harris County Attorney's Office)*	Dr. LaResa Ridge

Virtual Attendee Notice: *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.*

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Lindsey “Katie” Rutherford *(Harris County Attorney’s Office)*	Patrick Casey
Lisa Wright *(Community Health Choice, CEO)*	R. King Hillier
Louis Smith	Randy Manarang
Maria Cowles	Sam Karim
Dr. Martha Mims	Dr. Sandeep Markan
Matthew Schlueter	Sara Thomas *(Harris County’s Attorney’s Office)*
Micah Rodriguez	Sarah Worth
Michael Fritz *(Harris County Attorney’s Office)*	Shawn DeCosta
Michael Hill	Dr. Steven Brass
Dr. Michael Nnadi	Taylor McMillan
Monica Carbajal	Tekhesia Phillips
Nicholas J. Bell	Teong Chai
Dr. O. Reggie Egins	Dr. Tien Ko
Olga Rodriguez	Tiffani Dusang
Omar Reid	Tracey Burdine
Paige Chilholm *(PNP Student)*	Victoria Nikitin
Patricia Darnauer	

Virtual Attendee Notice: *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.*

MINUTES OF THE HARRIS HEALTH SYSTEM BOARD OF TRUSTEES
HRSA Special Called Board Meeting
Thursday, November 14, 2024
8:30 a.m.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 8:30 a.m. by Ms. Carol Paret, Presiding Officer. It was noted that a quorum was present and the attendance was recorded. Ms. Paret stated while some of Board members are in the room with us today, 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.	**A copy of the attendance is appended to the archived minutes.**
II. Public Comment	There were no public speakers registered to appear before the Board.	**As Presented.**
III. Announcements/ Special Presentations	**A. Board Member Announcements Regarding Board Member Advocacy and Community Engagements** • New Member of the Harris Health Board of Trustees Ms. Paret warmly welcomed Mr. Paul Puente as a new member of the Board. Mr. Puente was appointed by the Commissioner of Precinct 2 and Harris County Commissioners' Court in October 2024. Mr. Puente serves as the Executive Secretary of the Houston Gulf Coast Building and Construction Trades Council, and represents construction unions across a 20-county jurisdiction. Elected in January 2013, Mr. Puente oversees 18 unions, 15 crafts, and 13 apprenticeship programs, each with a Joint Apprenticeship Training Committee (JATC). A journeyman wireman electrician and member of The International Brotherhood of Electrical Workers (IBEW) Local Union 716, Mr. Puente began his electrical career in 1990, earning a degree in Electrical Technology from San Jacinto College. He's also an organizer and assistant business manager for his local union. Mr. Puente is a proud family man with his wife, Janie, their six children, and two grandchildren. He is active in numerous organizations, including the Harris County AFL-CIO, Houston Business Roundtable, Labor Council for Latin American Advancement (LCLAA), the Maritime Trades Department, and serves as Labor Liaison for Congressman Al Green. He also holds leadership roles in the Building Trades MC3, Port of Houston Small Business Advisory Board, and other key local initiatives.	**As Presented.**

XI. Item(s) Related to the Health Care for the Homeless Program		
	A. Review and Acceptance of the Following Reports for the Health Care for the Homeless Program (HCHP) as Required by the United States Department of Health and Human Services, which Provides Funding to the Harris County Hospital District d/b/a/ Harris Health to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act • HCHP November 2024 Operational Update, Including a Presentation Regarding the Health Resources and Services Administration (HRSA) Annual Compliance Training HCHP Consumer Advisory Report Dr. Nelson Gonzalez, Grants Project Manager for the Health Care for the Homeless Program, presented the November 2024 Operational Update, which covered the HCHP Bylaws Annual Review and the HRSA Compliance Annual Training. He reported that the HCHP Bylaws are reviewed annually and updated as needed, and currently, no changes are recommended. Dr. Gonzalez provided an overview of Health Care for the Homeless services and the Federally Qualified Health Centers (FQHCs), highlighting the nineteen (19) Key Health Center Requirements. Discussion ensued regarding the needs assessment and its findings, collaborative relationships with other organizations that serve the homeless population, and the HCHP budget, specifically in relation to funding from HRSA versus patient income. Dr. Andrea Caracostis inquired about the Prospective Payment System (PPS) rate for the homeless program. Ms. Tracy Burdine, Director, Health Care for the Homeless Program, stated that that the program is collaborating with their Accreditation and Compliance team to assign a PPS rate to its FQHCs. A copy of the presentation is available in the permanent record.	**Motion No. 24.11-161** **Moved by Ms. Ingrid Robinson, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda item XI.A. Motion carried.**
	B. Approval of HCHP Bylaws	**Motion No. 24.11-162** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.B. Motion carried.**
XII. Adjournment	There being no further business to come before the Board, the meeting adjourned at 8:57 a.m.	

I certify that the foregoing are the Minutes of the Harris Health System Board of Trustees HRSA Special Called Meeting held on November 14, 2024.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Carol Paret, BS, Secretary

Minutes transcribed by Cherry A. Pierson, MBA

Thursday, November 14, 2024
Harris Health Board of Trustees HRSA Special Call Board Meeting Attendance

BOARD MEMBERS PRESENT	BOARD MEMBERS ABSENT
Dr. Andrea Caracostis *(Chair)*	Afsheen Davis
Carol Paret *(Secretary)*	Dr. Cody Pyke *(Vice Chair)*
Ingrid Robinson	
Jim Robinson	
Libby Viera-Bland	
Paul Puente	
Sima Ladjevardian	

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Alexander Barrie	Micah Rodriguez
Anthony Williams	Michael Hill
Carolynn Jones	Dr. Michael Nnadi
Cherry Pierson	Dr. Nelson Gonzalez
Daniel Smith	Nicholas J. Bell
Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*	Olga Rodriguez
Dr. Esmaeil Porsa *(Harris Health System, President & CEO)*	Omar Reid
Dr. Jackie Brock	Randy Manarang
Dr. Jennifer Small	Samuel De Leon
Jennifer Zarate	Dr. Sandeep Markan
Jerry Summers	Sara Thomas *(Harris County's Attorney's Office)*
John Matcek	Shawn DeCosta
Louis Smith	Dr. Steven Brass
Maria Cowles	Dr. Tien Ko
Dr. Matasha Russell	Tracey Burdine

Virtual Attendee Notice: *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.*

HARRISHEALTH

Public Comment Request and Registration Process

Pursuant to Texas Government Code §551.007, members of the public are invited to attend the regular meetings of the Harris Health Board of Trustees and may address the Board during the **Public Comment** segment regarding an official agenda item that the Board will discuss, review, or take action upon, or regarding a subject related to healthcare or patient care rendered at Harris Health. Public Comment will occur prior to the consideration of all agenda items. If you have signed up to attend as a Public Speaker virtually, a meeting link will be provided. Note: Public Speakers will be removed from the meeting after speaking and have the option to join the meeting live via **http://harrishealthtx.swagit.com/live**.

How to Request to Address the Board of Trustees
Members of the public must register in advance to speak at the Harris Health Board of Trustees meetings. To register, members of the public must contact the Board of Trustees Office during core business hours, Monday through Friday between 8:00 a.m. to 5:00 p.m. Members of the public must submit the registration no later than 4:00 p.m. on the day before the scheduled meeting and may only register in one of the following manners:

1. Providing the requested information located in the "Speak to the Board" tile found at: https://www.harrishealth.org/about-us-hh/board/Pages/public-comment-request-and-registration-process.aspx.
2. Printing and completing the downloadable registration form found at: https://www.harrishealth.org/about-us-hh/board/Pages/public-comment-request-and-registration-process.aspx.
   2a. A hard-copy may be scanned and emailed to BoardofTrustees@harrishealth.org.
   2b. Mailing the completed registration form to 4800 Fournace Pl., Ste. E618, Bellaire, TX 77401.
3. Contacting staff at (346) 426-1524.

Prior to submitting a request to address the Harris Health Board of Trustees, please take a moment to review the rules to be observed during the Public Comment Period.

Rules During Public Comment Period
The presiding officer of the Board of Trustees or the Board Secretary shall keep the time for speakers.

Three Minutes
A speaker, whose subject matter, as submitted, relates to an identifiable item of business on the agenda, will be requested by the presiding officer to come to the podium where they will be provided three (3) minutes to speak. A speaker, whose subject matter, as submitted, does not relate to an identifiable item of business on the agenda, will also be provided three (3) minutes to speak. A member of the public who addresses the body through a translator will be given at least twice the amount of time as a member of the public who does not require the assistance of a translator.

Thursday, December 12, 2024

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

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

- Pages 24-25 Were Intentionally Left Blank -

Thursday, December 12, 2024

Executive Session

Medical Executive Board Report and Credentialing Discussion, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007 and Tex. Health & Safety Code Ann. §161.032 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of Harris Health Medical Staff.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

- Pages 27-44 Were Intentionally Left Blank -

Thursday, December 12, 2024

Executive Session

Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, Including Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §151.002, Tex. Occ. Code Ann. §160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071 to Receive Peer Review and/or Medical Committee Report with Possible Action Upon Return to Open Session.

O. Reggie Egins

O. Reggie Egins, MD, CCHP-P
Chief Medical Officer of Correctional Health

- Pages 46-47 Were Intentionally Left Blank -

Thursday, December 12, 2024

Consideration of Approval Regarding Credentialing Changes for Members of the Harris Health Medical Staff

The Harris Health Medical Executive Board approved the attached credentialing changes for the members of the Harris Health Medical Staff on November 12, 2024.

The Harris Health Medical Executive Board requests the approval of the Board of Trustees.

Thank you.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

Board of Trustees

December 2024 Medical Staff Credentials Report

HARRISHEALTH SYSTEM

Medical Staff Initial Appointments: 38

BCM Medical Staff Initial Appointments - 15
UT Medical Staff Initial Appointments - 22
HCHD Medical Staff Initial Appointments - 1

Medical Staff Reappointments: 0

BCM Medical Staff Reappointments
UT Medical Staff Reappointments
HCHD Medical Staff Reappointments

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Changes in Clinical Privileges: 0

BCM/UT/HCHD Medical Staff Resignations: 65

Other Business

For Information

Temporary Privileges Awaiting Board Approval - 22
Urgent Patient Care Need Privileges Awaiting Board Approval - 4

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Files for Discussion: 2

Medical Staff Initial Appointment Files for Discussion - 2
Medical Staff Reappointment Files for Discussion - 0

Thursday, December 12, 2024

Consideration of Approval of Changes to the Internal Medicine Gastroenterology Clinical Privileges

A revision was made to the Internal Medicine Gastroenterology Clinical Privileges for Endoscopic Submucosal Dissection (ESD) and Peroral Endoscopic Myotomy (POEM). The Chiefs of Service at BT and LBJ have reviewed and are in agreement with the revisions being presented.

The Medical Executive Board has approved the revisions to the Internal Medicine Gastroenterology Clinical Privileges and requests the approval of the Board of Trustees.

Type of Change	Subject	Comments/Notes
Removal	Criteria	• Advanced Endoscopy fellowship with hands on training on Endoscopic Submucosal Dissection • A letter of recommendation from the applicant's residency or fellowship Program Director that included Endoscopic Submucosal Dissection procedure training or from the physician's proctor • A letter of recommendation from the applicant's residency or fellowship Program Director that included Peroral Endoscopic Myotomy (POEM) procedure training or from the physician's proctor

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:
☐ **Ben Taub;** ☐ **LBJ;** ☐ **ACS;**_____
Print ACS Clinic Name

QUALIFICATIONS FOR ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD)

Definition: A procedure to remove early tumors of the Gastrointestinal tract by creating submucosal space and dissecting the tumor under direct visualization utilizing special needles/knifes created specifically for this technique.

Criteria (Initial): MD or DO fully credentialed with clinical privileges

- Completion of an ACGME or AOA accredited Residency training program in Internal Medicine.

AND

- Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology.

AND

1. Completion of Endoscopic Submucosal Dissection course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (**5**) cases is required.

OR

2. Completing a minimum of three (**3**) hands-on Endoscopic Submucosal Dissection courses; At least one of three (**3**) courses should include live animal model training; Courses should be recognized by a national or international gastrointestinal society.

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least five (5) successful Endoscopic Submucosal Dissection procedures during the past 24-months based on results of ongoing performance data review (OPDR) and outcomes

☐ **ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) PRIVILEGES REQUESTED**

Applicant Name: _____

Please Choose Pavilion for Requested Privileges:
☐ **Ben Taub;** ☐ **LBJ;** ☐ **ACS;**_____
Print ACS Clinic Name

QUALIFICATIONS FOR PERORAL ENDOSCOPIC MYOTOMY (POEM)

Description: An evolving family of procedures that utilize a natural orifice and a specialized endoscope to access a surgical site to perform a procedure that was traditionally performed using laparoscopic / thoracoscopic or open technique.

Criteria (Initial): MD or DO fully credentialed with clinical privileges

- Completion of an ACGME or AOA accredited Fellowship training program in Gastroenterology

AND

1. Completion of Peroral Endoscopic Myotomy (POEM) course recognized by a national or international gastrointestinal society, followed by supervision by a credentialed practitioner for a minimum of five (5) cases

OR

2. Completion of a minimum of three (3) hands-on Peroral Endoscopic Myotomy (POEM) or Endoscopic Submucosal Dissection (ESD) courses; At least one (1) of the three (3) courses should include live animal model training on Peroral Endoscopic Myotomy (POEM); Courses should be recognized by a national or international gastrointestinal society.

OR

3. Applicant must provide documentation of provision of five (5) cases representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year)

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least five (**5**) successful Peroral Endoscopic Myotomy (POEM) procedures during the past 24-months based on results of ongoing performance data review (OPDR) and outcomes

☐ **PERORAL ENDOSCOPIC MYOTOMY (POEM) PRIVILEGES REQUESTED**

Thursday, December 12, 2024

Consideration of Approval of the 2025-2026 Harris Health Utilization Review Plan

Biennial Review of the Harris Health Utilization Review Plan

As required by the CMS Conditions of Participation and the Medical Staff Bylaws, the 2025-2026 Utilization Review Plan is presented for approval.

Dr. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

HARRIS HEALTH

Ben Taub Hospital
Lyndon B. Johnson Hospital
Ambulatory Care Services

UTILIZATION REVIEW PLAN 2025-2026

I. INTRODUCTION

The Utilization Review (UR) Plan of the Harris Health 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 Acentra Health (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 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.

6. 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.
7. 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.
8. 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.
9. 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.
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 monthly 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

Other than certain statistical information provided and discussed in the System Utilization Review Committee that is publicly reported to the Harris Health Board of Trustees, the Utilization Review Committee is a medical committee as defined by the Texas Health and Safety Code and the Texas Occupations Code and as such the records and proceedings of the Utilization Review Committee are confidential, legally privileged, and protected from disclosure pursuant to state and federal confidentiality statutes and laws. See Article XIV of the Medical Staff Bylaws for more information.

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 Board of Trustees.

B. A copy of any amendment or revision, properly signed dated by the Chair of the Harris Health 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 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	__	__
IM/MOON Compliance Report	Evaluate compliance of CMS required documentation for Medicare beneficiaries	Bi-annual	X	__	__
Outsourced Care Management	Evaluation of coordinated care and services provided by outside contracted vendors/agencies, denial reasons, frequency of denials, turnaround time of evaluation case requests	Quarterly	X	__	__

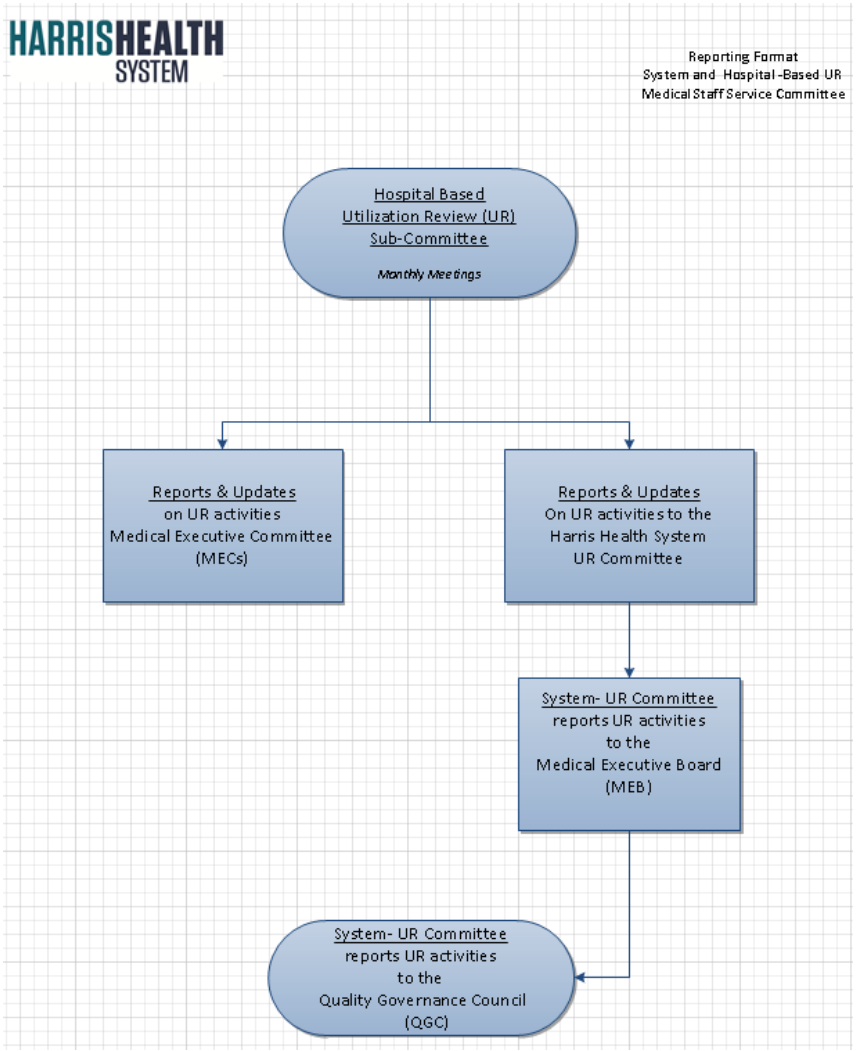
ACS: Virtual Care Data	Evaluation of telemedicine data statistics to address alternative modalities for outpatient appointments	Quarterly	X	__	__
ACS: Transition of Care Report	Evaluate the effectiveness of post-acute Transition of Care referral process in patients who are problem prone and/or have a 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 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	Quarterly	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	Annually	X	__	__

Vitamin D deficiencies in ACS clinics	PI Project to analyze the risk/benefits of measuring Vitamin D levels	Annually	X	__	__
Inpatient CDI Statistics Report - Working MS-DRG	Overview on effectiveness of CDI Program on, review rate, query rate, response rate, response time and revenue impact for each pavilion	Monthly	__	X	X
Avoidable Delay w/Action Plan	Assess top reasons for hospital delays with action plan to address impact to hospital	Monthly	__	X	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
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

System UR Committee meeting
Medical Executive Board
Board Quality Subcommittee
Board of Trustees

Appendix B



Revised: 10-23-2024

Thursday, December 12, 2024

Staffing Advisory Committee's Semi-Annual Evaluation of the Nurse Staffing Plan & Aggregate Staffing Variance

In accordance with Harris Health policy and Department of State Health Services, Title 25, Texas Administrative Code, §133.41(f) and (o); the Staffing Advisory Committee reports semi-annually to the Board of Managers its evaluation of the effectiveness of the official nursing services staffing plan and aggregate staffing variance.

This report is being presented for informational purposes only.

Jackie Brock, RN, DNP
Executive Vice President & Chief Nurse Executive

Harris Health Board of Trustees
Staffing Advisory Committee Re-evaluation of the FY24 Nurse Staffing Plans
Summary
Board Date: December 12, 2024

I. Overview

Annually, Harris Health Nursing Services plan for adequate numbers of nurses and support staff for each nursing service provided. The staffing plan is based on historical data; projections for future program development and expansion; and the Staffing Advisory Committee's input into the needs of patients, the unit and nursing staff. The plan takes into account patient census, scope of services provided on the unit; severity of illness and intensity of care; geographical layout of the unit; skill mix; and competency and experience of the nurses.

II. FY 2024 Staffing Plans

The table below shows our RN to patient ratios. These ratios are consistent with community and national standards. The unlicensed assistive personnel ratios vary based on census, the patient population served, and the needs of the patients.

Patient Care Area	Charge Nurse	RN to Patient Ratio	Unlicensed Personnel	Clerical
Intensive Care	1	1:1-2	1:5-10	1
Coronary Care	1	1:1-2	1:5-10	1
Intermediate Care	1	1:3-4	1:5-10	1
Specialty Care	1	1:3-4	1:5-10	1
Medical/Surgical	1	1:5	1:5-10	1
Labor & Delivery	1	1:1-2	1	1
Perinatal Special Care		1:3		
Postpartum Couplets	1	1:3-4 couplets	1	1
Level III Nursery: Neonatal ICU	1	1:2		1
Level II Nursery	1	1:3-4		1
Psychiatry	1	1:6	1:5-6	
IMU/Med Surg/Tele Units	1	1:4-5	1:5-10	1
Operating Services	This area follows The Association of Perioperative Registered Nurses (AORN) Staffing Guidelines			

III. Evaluation of the Nurse Staffing Plans – September/October 2024

A. Ben Taub Hospital

Evaluators	Total Surveyed	% Strongly agree or agree	% Disagree or strongly disagree*
Nurse Clinician Members	16	95%	5% - Disagreed
			0 – Strongly disagreed

B. Lyndon B. Johnson Hospital

Evaluators	Total Surveyed	% Strongly agree or agree	% Disagree or strongly disagree*
Nurse Clinician Members	13	93%	7% - Disagreed
			0 – Strongly disagreed

*Ben Taub Hospital: The statements with the highest level of disagreement were:

1) "There is a general sense of adequate staffing", and
2) "The staffing plan takes into account relevant patient characteristics (age, functional ability, severity of illness, etc.)."

*LBJ Hospital: The statements with the highest level of disagreement were:

1) "The staffing plan takes into account relevant unit characteristics (volume, scope of services, intensity of patient care, etc.)", and
2) "The staffing plan takes into account relevant patient characteristics (age, functional ability, severity of illness, etc.)."

IV. Year-to-Date Aggregate RN Staffing Variance (Clinical Areas)

(As of August 2024)

	Actual RN FTEs Worked	Budgeted RN FTEs Flexed	RN FTE Variance
BT – Nursing Services	751.62	735.64	15.98
LBJ – Nursing Services	530.23	481.30	48.93

V. Patient Care Outcomes

In review of fall data from April 2023 to March 2024, the Committee conducted a correlation analysis between patient falls and hours per patient day. The units included in the review had patient fall scores that were above the National Database of Nursing Quality Indicators (NDNQI) mean for at least 6 of the 12 months. Results: There were no significant correlation between the two variables.

In review of central line-associated blood stream infection (CLABSI) data from the same time period, no unit had a CLABSI score that was above the NDNQI mean for at least 6 of the 12 months.

Thank you.

Thursday, December 12, 2024

Consideration of Approval of Credentialing Changes for Members of the Harris Health Correctional Health Medical Staff

The Harris Health Correctional Health Medical Executive Committee approved the attached credentialing changes for the members of the Harris Health Medical Staff on October 28, 2024.

The Harris Health Correctional Health Medical Executive Committee requests the approval of the Board of Trustees.

O. Reggie Egins

O. Reggie Egins, MD, CCHP-P
Chief Medical Officer of Correctional Health

Board of Trustees

HARRISHEALTH SYSTEM

December 2024 Correctional Health Credentials Report

Medical Staff Initial Appointments: 3

Medical Staff Reappointments: 0

Medical Staff Resignations: 0

Medical Staff Files for Discussion: 0

Thursday, December 12, 2024

Consideration of Approval of the Harris Health Correctional Health Medical Staff Bylaws

The Harris Health Correctional Health MEC and Medical Staff have approved the attached Correctional Health Medical Staff Bylaws. The Correctional Health MEC and Dr. Otis Egins, Correctional Health MEC Chair, requests the approval of the Board of Trustees.

A summary of changes are below:

- **Preamble (Page 5)** – Clarified language to make it applicable to Correctional Health
- **Definitions (Page 6)** – Added definition of Chief Medical Officer; updated definition of Completed Application
- **Article I, Name (Page 9)** – Clarified language to make it applicable to Correctional Health
- **Article III, Section 2 - Qualifications for Membership (Page 10)** – Clarified language related to DEA and liability insurance
- **Article III, Section 2 - Qualifications for Membership (Page 10)** – Added language to describe the process for individuals to request a waiver of one or more qualifications for membership if he/she is "unusually qualified", as defined in this section
- **Article VI, Section 2 - Qualifications for Membership (Page 16)** – Clarified language related to DEA
- **Article VI, Section 9 – Temporary Privileges (Page 20)** – Language was revised to further clarify temporary privilege process and requirements
- **Article VII, Section 1 – Corrective Action – Procedure (Page 22)** - Language was added to reflect new state law requirement that any final adverse action that impacts the clinical privileges of a physician for more than fourteen (14) days must be reported to the Texas Medical Board
- **Article VII, Section 4 – Administrative Suspension (Page 24)** - Language added to clarify instances that qualify as an administrative suspension, including the addition of an administrative suspension for failure to complete annual mandatory education
- **Article IX, Section 2 – Chief Medical Officer, Responsibilities (Page 36)** – Clarified language related to responsibilities
- **Article X, Sections 1 – Medical Executive Committee (Page 38-39)** – Language added to include peer review duties.

HARRISHEALTH

CORRECTIONAL HEALTH MEDICAL STAFF BYLAWS

October, 2024

Table of Contents

BYLAWS OF THE

HARRIS HEALTH ~~SYSTEM~~

CORRECTIONAL HEALTH MEDICAL STAFF

PREAMBLE

WHEREAS, ~~the~~ Harris County ("County") owns detention facilities ("Detention Facilities") which are under the supervision and control of the Sheriff of Harris County ("Sheriff"); and

WHEREAS, the Sheriff is charged by law with the responsibility for obtaining and providing adequate medical care for detainees of the County's Detention Facilities (each such facility generally referred to as the "Jail"); and

WHEREAS, the Sheriff desires to outsource the provision and supervision of medical and mental health care (generically, "health care") to a qualified care provider; and

WHEREAS, the Harris County Hospital District d//b/a Harris Health System ("Harris Health") " is a hospital district established pursuant to Article IX, Section 4 of the Texas Constitution and Tex. Health & Safety Code §§281.001 et seq., as amended with responsibility for furnishing medical and hospital care for indigent and needy persons residing in Harris County~~has experience evaluating whether health care services are being provided in a safe and effective manner~~; and

WHEREAS, in compliance with the Interlocal Cooperation Act, the ~~Sheriff~~ County and Harris Health have entered into an Interlocal Cooperation Agreement ("the Agreement") for Harris Health to provide certain medical care to Jail detainees; and

~~**WHEREAS,** the Agreement obligates Harris Health to provide certain medical care to Jail detainees; and~~

WHEREAS, subject to oversight by the Harris Health Board of Trustees ("Governing Body"), the Harris Health Correctional Health Medical Executive Committee ("Medical Executive Committee") is responsible for determining, implementing, and monitoring policies governing the medical care to Jail detainees, including the quality and safety of the medical care in the Jail, and holding the medical staff accountable to fulfill Harris Health's obligations to the Jail detainees; and

WHEREAS, the Medical Executive Committee has approved these Harris Health Correctional Health Medical Staff Bylaws ("Bylaws").

THEREFORE, the Practitioners and Advanced Practice Professionals practicing in the Jail shall carry out the functions delegated to the Medical Staff by the Governing Body in compliance with these Bylaws.

DEFINITIONS

Whenever the context requires, words of masculine gender used herein shall include the feminine and the neuter, and words used in the singular shall include the plural.

1. The term **"ADVANCED PRACTICE PROFESSIONAL" (APP)** shall be defined as an individual who holds a state license in their profession as well as other educational credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Optometrist (OD), or Nurse Practitioner (NP).

2. The term **"CHIEF MEDICAL OFFICER"** shall mean the Chief Medical Officer for Correctional Health.

~~2.~~3. The term **"CLEAN APPLICATION"** shall mean a completed application in which all aspects of the application are complete; all references have been returned with all questions fully answered as either superior or good; the applicant has not been a party to any malpractice cases, adverse actions involving medical staff membership, clinical privileges or licensure/certification requiring further investigation; and all training, licensure, National Practitioner Data Bank, and OIG database information has been verified, with the results of such verification found to be acceptable. The term "Clean Application" may also be applied to an application from a Medical Staff member requesting new clinical privileges.

~~3.~~4. The term **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the permission granted by the Governing Body to a Practitioner to provide those diagnostic, therapeutic, or medical services which the Practitioner has been approved to render.

~~4.~~5. The term **"COMPLETED APPLICATION"** shall mean a signed Texas State Standardized Application in which all questions have been answered, current copy of licensure (State, DEA, DPS), peer reference letters, delineation of clinical privileges or job description, current appropriate professional liability insurance if applicable, National Practitioner Data Bank, OIG, Board Status, hospital affiliations, and verification of any other relevant information from other professional organizations according to the Bylaws and Credentialing Procedures Manual. Additionally, all information and documentation has been provided, and all verifications solicited by the Medical Executive Committee have been received and require no further investigation. A completed application may be determined to be incomplete, based upon the review of Harris Health's Medical Staff Services, the Chief Medical Officer, or the Medical Executive Committee.

~~5.~~6. The term "**CREDENTIALING PROCEDURES MANUAL"** shall mean the policy containing additional details related to the credentialing process of Correctional Health, as further detailed in these Bylaws.

~~6.~~7. The term **"DAYS"** shall mean calendar days, including Saturdays, Sundays, and holidays unless otherwise specified herein. Days are counted beginning on the day following the transmittal or receipt of a notice or other required correspondence.

~~7.~~8. The term **"DENTIST"** means an individual with a D.D.S. or equivalent degree licensed or authorized to practice dentistry by the State of Texas.

~~8.~~9. The term **"EXECUTIVE SESSION"** means any meeting or portion of any meeting, of any section, department, or committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is

presented or discussed.

~~9.~~10. The term **"EX-OFFICIO"** shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, refers to a position without voting rights.

~~10.~~11. The term **"FEDERAL HEALTH CARE PROGRAM"** shall mean any plan or program that provides health benefits whether through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP)/Tricare/CHAMPUS and the veterans' programs.

~~11.~~12. The term **"GOOD STANDING"** means that, at the time of his or her most recent appointment, this individual was deemed to have met the following requirements: satisfactory clinical competence, satisfactory technical skill/judgment, satisfactory results of Quality Assurance activity, satisfactory adherence to these Bylaws, satisfactory medical records completion, satisfactory physical mental health completion, satisfactory relationships to peers and status.

~~12.~~13. The term **"GOVERNING BODY"** means the Harris Health ~~System~~ Board of Trustees.

~~13.~~14. The term **"INELIGIBLE PERSON"** means any individual or entity that: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal and/or state health care programs or in federal and/or state procurement or non-procurement programs (this includes persons who are on the List of Excluded Individuals or Entities of the Inspector General, List of Parties Excluded from Federal Programs by the General Services Administration or the Medicaid Sanction List); or (ii) has been convicted of a criminal offense related to the provision of a health care program that falls within the ambit of 42 U.S.C. §1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

~~14.~~15. The term **"MEDICAL EXECUTIVE COMMITTEE"** means the committee with authority to exercise Correctional Health-wide functions on behalf of the Medical Staff.

~~15.~~16. The term **"MEDICAL STAFF"** means all physicians and dentists who are appointed to the Medical Staff to provide healthcare services at Harris Health Correctional Health and who either (i) hold a faculty appointment at the University of Houston College of Medicine; or (ii) are employed by or have a contractual relationship with University of Houston College of Medicine or Harris Health.

~~16.~~17. The term "**PEER**" shall mean an individual who practices in the same profession as the Practitioner under review. The level of subject-matter expertise required to provide meaningful evaluation of a Practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. The Medical Executive Committee shall determine the degree of subject matter expertise required on a case-by-case basis.

~~17.~~18. The term "**PEER REVIEW**" shall mean the evaluation of medical and healthcare services, including evaluation of the qualifications and professional conduct of professional healthcare practitioners and of patient care provided by those Practitioners. The Practitioner is evaluated based on generally recognized standards of care. The Medical Executive Committee conducts a peer review with input from one or more Practitioner colleagues (peers).

~~18.~~19. The term **"PHYSICIAN"** means an individual with an M.D., D.O. or equivalent degree currently licensed to practice medicine in the State of Texas.

~~19.~~20. The term **"PRACTITIONER"** means, unless otherwise expressly limited, any Physician or Dentist holding a current license to practice in the State of Texas.

~~20.~~21. The term **"SPECIAL NOTICE"** shall mean written notification sent by certified or registered mail, return receipt requested, or by personal or e-mail delivery with a receipt of delivery or attempted delivery obtained.

~~21.~~22. The term **"STATE"** shall mean the State of Texas.

~~22.~~23. The term **"STATE BOARD"** shall mean, as applicable, the Texas Medical Board, the State Board of Dental Examiners, or such other licensing board that may license individuals who have clinical privileges at Correctional Health.

ARTICLE I — NAME

The name of this organization governed by these Bylaws shall be the Medical Staff of Harris Health ~~System~~ Correctional Health (hereinafter referred to as "Correctional Health").

ARTICLE II — PURPOSE

The purposes of this organization are:

1. To provide the best possible care for all Jail detainees;
2. To ensure a high level of professional performance of all Medical Staff members authorized to practice in Correctional Health through appropriate delineation of the clinical privileges that each Medical Staff member may exercise and through an ongoing review and evaluation of each Medical Staff member's performance;
3. To provide an appropriate educational setting for Medical Staff members that will maintain medical and scientific standards that will lead to continuous advancement in professional knowledge and skill;
4. To initiate and maintain these Bylaws for self-governance of the Medical Staff;
5. To provide a means for communication and conflict resolution regarding issues that are of concern to the Medical Staff.

ARTICLE III — MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of Correctional Health is a privilege which shall be extended, without discrimination as to race, color, sex, religion, disability, national origin, or age only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, and does not in any way imply or preclude employment status by Harris Health. Membership on the Medical Staff shall confer only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

Section 2. Qualifications for Membership

a. Only individuals who have no health problems that could affect his or her ability to perform the privileges requested and can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others so as to assure the Medical Staff and Governing Body that patients treated by them will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

b. Only individuals who have and continue to maintain current unrestricted privileges, in Good Standing, at Harris Health Correctional Health.

c. Only individuals who have current licenses and certificates. Medical Staff members must have unrestricted licenses and certificates, with no past adverse licensure actions(s) (~~e.g.~~e.g., probation, suspension, revocation). Past adverse licensure action(s) do not include action(s) taken for administrative reasons, such as failure to timely pay licensure fees. Required licenses and certificates include:

- State of Texas license to practice medicine, osteopathy, or dentistry;

- United States Controlled Substances Registration Certificate (DEA) as applicable, with exceptions approved by the Medical Executive Committee;
- National Provider Identifier (NPI); and
- Professional liability insurance covering the exercise of all requested privileges, except for Practitioners or APPs employed by Harris Health~~, whose liability is governed by the Texas Tort Claims Act~~.

d. Only Practitioners who have no record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any other healthcare facility for reasons related to professional competence or conduct.

e. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in Correctional Health merely by virtue of the fact that he or she is duly licensed to practice medicine, osteopathy, or dentistry in this State or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or presently has, such privileges at another healthcare facility.

f. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he or she will strictly abide with all provisions of these Bylaws.

g. The Practitioner will remain in Good Standing so long as he or she is a member of the Medical Staff.

h. The Practitioner is required to be eligible to participate in federal and/or State healthcare programs. The Practitioner may not currently be an Ineligible Person and shall not become an Ineligible Person during any term of membership. The Practitioner must also have no record of conviction of Medicare, Medicaid or insurance fraud and abuse.

(1) A Practitioner is required to disclose immediately any debarment, exclusion, or other event that makes the person an Ineligible Person.

(2) An Ineligible Person is immediately disqualified for membership to the Medical Staff or the granting of clinical privileges or practice prerogatives.

i. A Practitioner or APP who does not meet one or more of the qualifications for membership described above may request special consideration by the Medical Executive Committee to waive one or more of the qualifications for membership if the Practitioner is determined unusually qualified as set forth in this subsection. ~~The Medical Executive Committee's determination not to waive one or more of the qualifications for membership is not a denial of the Practitioner or APP's application for Medical Staff membership, is not reportable to the National Practitioner Databank, and does not entitle the Applicant to the fair hearing rights as described in these Bylaws.~~

In order to be deemed "unusually qualified," Practitioners applying under this exception must (i) receive written recommendations by the Chief Medical Officer~~applicable Chief of Service and Chief of Staff~~, (ii) document sufficient post-training experience in the applicant's primary field at the time of application, and (iii) be a recognized leader or innovator in his or her field, as evidenced by documented research, publications, and/or unique procedural ability not otherwise available or for which there is an unexpected and non-preventable shortage on the current Medical Staff. It is anticipated that approvals of applications under this exception will be rare and are subject to approval by the ~~Credentials Committee,~~ Medical Executive Committee~~Board~~, and the Governing Body.

At the application for reappointment, the P~~p~~ractitioner granted privileges under this section must submit a progress report. The Practitioner's progress report shall be confirmed by the

~~Chief of Service and Chief of Staff~~ Chief Medical Officer, demonstrating the exception continues to be warranted by the ongoing exercise of the privileges for which the exception was granted.

The Medical Executive Committee's determination not to waive one or more of the qualifications for membership is not a denial of the Practitioner or APP's application for Medical Staff membership, is not reportable to the National Practitioner Databank, and does not entitle the Applicant to the fair hearing rights as described in these Bylaws.

Section 3. Basic Responsibilities of Medical Staff Membership

The following responsibilities shall govern the professional conduct of Medical Staff members and failure to meet these responsibilities shall be cause for suspension of privileges or dismissal from the Medical Staff:

a. The principal objective of the Medical Staff is to render service to humanity with full respect for the dignity of each person. Medical Staff members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service, devotion and continuity of care. Medical Staff members are responsible for the quality of the medical care provided to patients.

b. Medical Staff members should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional qualifications.

c. Medical Staff members should observe all laws, uphold the dignity and honor of their profession and accept self-imposed disciplines. They should report without hesitation, illegal or unethical conduct by other Medical Staff members and self-report their own illegal or unethical conduct. Reports should be made to the Chief Medical Officer, who will report the information to Medical Staff Services.

d. Medical Staff members should self-report any physical, behavioral or mental impairment that could affect his or her ability to perform his or her clinical privileges, or treatment for the impairment that occurs at any point during his or her Medical Staff membership. Reports should be made to the Chief Medical Officer, who will report the information to Medical Staff Services.

e. In an emergency, Medical Staff members should render services to the best of their abilities. Having undertaken the care of a patient, a Medical Staff member may not neglect him or her.

f. Medical Staff members should not solicit patients.

g. Medical Staff members should not dispense of their services under terms or conditions that tend to interfere with or impair the free and complete exercise of their professional judgment and skill or tend to cause a deterioration of the quality of their care.

h. Medical Staff members should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of service may be enhanced thereby.

i. Medical Staff members may not reveal the confidences entrusted to them in the course of professional attendance unless they are required to do so by law or unless it becomes necessary in order to protect the welfare of an individual or of the community.

j. Medical Staff members must abide by these Bylaws and applicable policies and procedures.

k. Medical Staff members must participate cooperatively in quality review and peer evaluation activities, both as a committee member and in conjunction with evaluation of his or her own performance or professional qualifications.

l. Medical Staff members must prepare and complete medical records in a timely fashion for all patients to whom the member provides care in Correctional Health.

m. Medical Staff members are accountable to the Governing Body.

Section 4. Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the Medical Executive Committee.

b. Initial appointments shall be acted upon following submittal of a Completed Application.

c. All appointments to the Medical Staff shall be for a period of not more than three (3) years.

d. Appointment or reappointment to the Medical Staff confers on the appointee only such clinical privileges as have been approved by the Governing Body.

e. Each application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of a Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by these Bylaws, to accept committee assignments and to accept staff assignments in Correctional Health. All Medical Staff members shall carry an appropriate level of professional liability insurance as determined by the Governing Body.

f. Appointments and reappointments to the Medical Staff shall always conform to applicable State and Federal laws.

Section 5. Leave of Absence

a. Requesting a Leave of Absence. A Practitioner may submit a written request to Medical Staff Services for a leave of absence 30 days prior to the requested leave, unless related to a Medical Leave of Absence. Upon favorable recommendation by the Chief Medical Officer, the Medical Executive Committee may consider a voluntary leave of absence for up to one (1) year. An additional one (1) year may be granted for good cause in accordance with policy. During the period of the leave, the Practitioner shall not exercise clinical privileges at Correctional Health, and the Practitioner's rights and responsibilities shall be inactive. All medical records must be completed prior to granting a leave of absence unless circumstances would not make this feasible.

b. Termination of Leave. At least 45 days prior to the termination of the leave of absence, or at any earlier time, the Practitioner may request reinstatement of privileges by submitting a written notice to Medical Staff Services along with a summary of relevant activities during the leave. The Practitioner's request, activity summary and verification, if applicable, shall be presented to the Chief Medical Officer. The Chief Medical Officer will review the documentation and provide a recommendation to the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be subject to quality review as determined by the Medical Executive Committee following recommendation by the Chief Medical Officer. If the Ppractitioner is scheduled for reappointment during the approved leave, the Ppractitioner's application for reappointment must be finalized in accordance with these Bylaws prior to the practitioner's return.

c. Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall not give rise to the right to a fair hearing. A request for Medical Staff membership received from a Ppractitioner subsequent to termination shall be submitted and processed in the manner specified for applications for initial appointments.

d. Medical Leave of Absence. Following recommendation by the Chief Medical Officer, the Medical Executive Committee shall determine the circumstances under which a particular practitioner shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. Unless accompanied by a reportable restriction of privileges, the leave shall be deemed a voluntary medical leave of absence and will not be reported to the National Practitioner Data Bank.

e. Military Leave of Absence. Requests for leave of absence to fulfill military service obligations shall be granted upon appropriate notice to Medical Staff Services and will be provided to the Medical Executive Committee for information only.

ARTICLE IV — CATEGORIES OF THE MEDICAL STAFF

Section 1. Medical Staff

The Medical Staff shall be divided into the following categories: Active Staff and Moonlighters.

Section 2. Active Staff

a. Service. All Active Staff shall be appointed to a specific service.

b. Qualifications. The Active Staff shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 2;

(2) Hold faculty appointment at the University of Houston College of Medicine or are employed by or have a contractual relationship with the University of Houston College of Medicine or Harris Health; and

(3) If the member is a physician, has successfully completed an ACGME- or AOA-accredited residency-training program in their specialty. If the member is a dentist, has successfully completed an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation.

c. Prerogatives. Except as otherwise provided, the prerogatives of an Active Staff member shall be:

(1) Exercise of Clinical Privileges granted to the member pursuant to Article VI;

(2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any service or committee of which such person is a member;

(3) Hold any staff or service office for which the member is qualified; and

(4) Serve as a voting member on any committee to which such person is duly appointed or elected.

Section 3. Moonlighters

a. Service. All Moonlighters shall be appointed to either the Emergency Medicine, Family Medicine, Internal Medicine, or Psychiatry service.

b. Qualifications. Moonlighters shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 2;

(2) Be employed by or have a contractual relationship with Harris Health; and

(3) Has successfully completed at least one (1) year of an ACGME- or AOA- accredited residency-training program with continued enrollment in the program.

c. Prerogatives. Except as otherwise provided, the prerogatives of a Moonlighter shall be:

(1) Exercise of Clinical Privileges granted to the member pursuant to Article VI;

(2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any service or committee of which such person is a member;

ARTICLE V — ADVANCED PRACTICE PROFESSIONALS

Section 1. Membership

Advanced Practice Professionals are not members of the Medical Staff, but are granted clinical privileges to provide clinical services to Jail detainees.

Section 2. Qualifications

APPs include those non-Medical Staff members whose license or certificate permits, and these Bylaws authorize, to permit the individual provision of patient care services without direction or supervision within the scope of the APP's individually delineated clinical privileges. APPs must:

(1) Meet all applicable standards related to licensure, training and education, clinical competence and health status as described in these Bylaws and applicable policies and procedures;

(2) Be assessed, credentialed, and monitored through existing Correctional Health credentialing, quality assessment, and performance improvement functions;

(3) Maintain an active and current credential file and hold delineated clinical privileges approved by the Medical Executive Committee and Governing Body;

(4) Complete all proctoring requirements as may be established by the Medical Executive Committee; and

(5) Not assume primary patient care responsibilities.

APPs include those categories of individuals identified in the Definitions Section of these Bylaws.

Section 3. Prerogatives

(1) By virtue of their training, experience and professional licensure, APPs are allowed to function within the scope of their licensure and delineated clinical privileges but may not assume primary patient care responsibilities. All APPs shall be under the supervision of a sponsoring physician, who is member of the Medical Staff, who is responsible for delineating the applicant's clinical privileges. If the sponsoring physician's Medical Staff membership is terminated, then the APP's ability to perform clinical services shall be suspended for a period of up to ninety (90) days or until an alternative supervising physician can be secured. If the suspension lasts longer than ninety (90) days or if there is any change in the APP's privileges, then the APP shall complete the initial application procedure. Each APP must notify Medical Staff Services immediately upon loss of required sponsorship or supervision.

(2) APPs holding clinical privileges shall have their privileges or practice prerogatives reviewed and approved through the same mechanism described in these Bylaws unless otherwise determined by the Medical Executive Committee.

(3) The clinical privileges and/or practice prerogatives which may be granted to specific APPs shall be defined by the Medical Staff. Such prerogatives may include:

(a) The provision of specific patient care services pursuant to established protocols, either independently or under the supervision or direction of a physician or other member of the Medical Staff. The provision of such patient care services must be consistent with the APP's licensure or certification and delineated clinical privileges or job description;

(b) Participation by request on Medical Staff and/or administrative committees or teams; and

(c) Attendance by request at Medical Staff and/or administrative meetings.

(4) Participating in quality assessment and performance improvement activities as requested by the Medical Executive Committee, or any other committee of the Medical Staff or Governing Body. Failure of an APP to participate in quality assessment or performance improvement activities when requested by the Medical Staff or Governing Body shall result in responsive action, including the possible revocation or suspension of all privileges or practice prerogatives.

Section 4. Review

Nothing in these Bylaws shall be interpreted to entitle APPs to the fair hearing rights as described in these Bylaws. An APP shall, however, have the right to challenge any action that would adversely affect the APP's ability to provide patient care services in Correctional Health. Under such circumstances, the following procedures shall apply:

(1) Notice. Special Notice of the adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has thirty (30) days in which to request a hearing. If the APP does not request a hearing within thirty (30) days, the APP shall have waived the right to a hearing.

(2) Hearing Panel. The Chief Medical Officer shall appoint a hearing panel that will include at least three members. The panel members shall include the Chief Medical Officer, another member of the Medical Staff, and if possible, a peer of the APP, except that any peer review of a nurse shall meet the panel requirements of the Texas Nursing Practice Act. None of the panel members shall have had a role in the adverse recommendation or action.

(3) Rights. The APP subject to the adverse recommendation or action shall have the right to present information but cannot have legal representation or call witnesses.

(4) Hearing Panel Determination. Following presentation of information and panel deliberation, the panel shall make a determination:

i. A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

ii. A determination adverse to the APP shall result in notice to the APP of a right to appeal the decision to the Chairperson of the Governing Body.

(5) Final Decision. The decision of the Chairperson of the Governing Body shall be the final appeal and represent the final action in the matter.

ARTICLE VI – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. Failure of a Practitioner to produce required information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided. Initial applicants who fail to produce all appropriate information and/or documents as requested may withdraw their application prior to review by the Medical Executive Committee.

Section 2. Application for Appointment

a. All applications for appointment to the Medical Staff shall be signed by the applicant, and shall be submitted on a form prescribed by the State of Texas. The application shall include the following detailed information:

- evidence of current licensure;
- evidence of current United States Controlled Substances Registration Certificate (DEA) as applicable;
- evidence of current National Provider Identifier (NPI);
- evidence of appropriate professional liability insurance, as determined by the Governing Body;
- privileges requested;
- Evidence of appropriate Basic Life Support (BLS) Certificate.
- relevant training and/or experience;
- current competence;
- physical and mental health status attestation;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary decrease of privileges at any other hospital or institution;
- suspension or revocation of membership in any local, state or national medical society;
- suspension or revocation of license to practice any profession in any jurisdiction
- any claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, including consent to the release of information from the present and past malpractice insurance carrier(s);
- loss of clinical privileges;
- a clear, legible copy of a government-issued photo identification, e.g., valid driver's license or passport;

- three professional peer references; and
- evidence of continuing medical education satisfactory to the Medical Executive Committee.

b. The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

c. Upon the receipt of a Completed Application, Medical Staff Services shall verify the applicant's information on behalf of the Medical Executive Committee, including consulting with primary sources of information about the applicant's credentials. It is the applicant's responsibility to resolve any problems Harris Health may have in obtaining information from primary sources. Verifications of licensure, controlled substances registrations, and professional liability claims history, as well as queries of the National Practitioner Data Bank and queries to ensure the applicant is not an Ineligible Person shall be completed. Verification may be made by a letter or computer printout obtained from the primary source, verbally, if documented, or electronically if transmitted directly from the primary source to Harris Health. For new applicants, information about the applicant's membership status and/or work history shall be obtained from all organizations where the applicant currently has membership or privileges and/or is employed, and where the applicant has held membership or has been granted clinical privileges and/or has been employed during the previous five (5) years. Associated details on the credentialing process are set forth in Harris Health's Credentialing Procedures Manual.

d. The application and verifications shall be forwarded to Medical Staff Services for review. After review by Medical Staff Services for completeness, the application and all supporting materials shall be transmitted to the Medical Executive Committee for evaluation.

e. By applying for appointment to the Medical Staff, applicants thereby signify their willingness to appear for interviews in regard to the application; authorize Harris Health and/or the Medical Executive Committee, to consult with members of Medical Staffs of other health care organizations with which the applicant has been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on the applicant's competence, character and ethical qualification; consent to the inspection of all records and documents that, in the opinion of the Medical Executive Committee, may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as moral and ethical qualifications for staff membership; releases from any liability all representatives of Harris Health and the Medical Executive Committee for their acts performed in good faith and without malice in connection with evaluation of the applicant and his or her credentials; and releases from any liability all individuals and organizations who provide information to Harris Health and/or the Medical Executive Committee in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

f. Each applicant shall sign and return a statement that he or she has received and read these Medical Staff Bylaws and that he or she agrees to be bound by the terms thereof relating to consideration of the application and, if the applicant is appointed, to all terms thereof.

Section 3. Appointment Process

a. Medical Staff Services shall transmit Completed Applications to the Medical Executive Committee at its next regularly scheduled meeting following completion of verifications tasks and receipt of all relevant materials.

b. Within one hundred and twenty days (120) days after receipt of the Completed Application, the Medical Executive Committee shall report its review and recommendation to the Governing Body. Prior to making this report, the Medical Executive Committee shall examine the evidence of the character, professional competence, physical and mental health status, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant, and from any other sources available to the committee, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested.

c. Within sixty (60) days of receipt of the recommendation from the Medical Executive Committee, the Governing Body shall determine whether to accept or reject the recommendation. The Governing Body may only make a decision contrary to the recommendation of the Medical Executive Committee if the applicant meets all of the requirements for Medical Staff membership and the Medical Executive Committee's recommendation is unreasonable or not based on sound judgment. If the Governing Body makes a decision contrary to the recommendation of the Medical Executive Committee, the Governing Body must document its rationale for doing so.

d. A decision by the Governing Body to accept a recommendation resulting in an applicant's appointment to the Medical Staff shall be considered a final action. Within twenty (20) days of the Governing Body's final action, the Medical Executive Committee shall provide notice of all appointments approved by the Governing Body by Special Notice to each new Medical Staff member. All such notices shall include a delineation of approved privileges and appointment dates.

e. The time periods specified in Section 3(b) and (c) above are for guidance only and do not create any right for the applicant to have his or her application processed within those time periods.

f. When the recommendation of the Governing Body is adverse to the applicant, either in respect to appointment or clinical privileges, the Chief Medical Officer shall notify the applicant by Special Notice within fifteen (15) days, as described in these Bylaws. No such adverse recommendation shall be forwarded to the Governing Body until after the applicant has exercised his or her right to a hearing as provided in these Bylaws. If the applicant fails to act within thirty (30) days of receipt of the Special Notice, the applicant will have waived his or her right to a hearing as provided in these Bylaws.

g. If, after the Medical Executive Committee has considered the report and recommendations of the hearing committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph "b" of this section. If such recommendation continues to be adverse, the Chief Medical Officer shall promptly so notify the applicant by Special Notice. The Chief Medical Officer shall so forward such recommendation and documentation to the Governing Body.

h. The Governing Body shall send notice of its final decision regarding any such review under these Bylaws through the Chief Medical Officer to the applicant.

Section 4. Reappointment Process

a. It is the responsibility of Active and Affiliate members and Advanced Practice Professionals to request reappointment to the Medical Staff in accordance with the "Reappointment and Renewal of Clinical Privileges Procedure" in the Credentialing Procedures Manual.

Reappointment to the Medical Staff shall be based on the applicant's maintaining qualifications for Medical Staff membership, as described in Section 2 of this Article, current competence, and consideration of the results of quality assessment activities as determined by the Medical Executive Committee. Failure to submit a completed reappointment application form with required supporting documentation no less than sixty (60) days prior to the expiration of the Practitioner's then current appointment shall constitute a resignation from the Medical Staff and all privileges will terminate upon expiration of said appointment. Such termination shall not give rise to the right to a hearing pursuant to these Bylaws. Reappointment shall occur every three (3) years. Medical Staff Services will transmit the necessary reapplication materials to the Practitioner not less than 120 days prior to the expiration date of their then current appointment.

All claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, either final or pending, since the last appointment or reappointment must be reported.

b. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall take into consideration the following characteristics:

- the practitioner's specific case record, including measures employed in quality assurance/performance improvement program
- professional competence and clinical judgment in the treatment of patients;
- ethics and conduct;
- relations with other Medical Staff members;
- general attitude toward patients, Correctional Health, and the public;
- documented physical and mental health status;
- evidence of continuing medical education that is related, at least in part, to the Practitioner or APP's clinical privileges;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of such licensure or registration;
- voluntary or involuntary termination of Medical Staff membership; and
- voluntary or involuntary decrease of privileges at any other hospital.

c. Thereafter, the procedure provided in Sections 2 and 3 of this Article relating to recommendations on applications for initial appointment shall be followed.

d. Members of the Medical Staff shall maintain current licensure and certifications, as described in these Bylaws. Members of the Medical Staff must notify the Chief Medical Officer and Medical Staff Services whenever their license to practice in any jurisdiction has been voluntarily/involuntarily limited, suspended, revoked, denied, or subjected to probationary conditions, or when proceedings toward any of those ends have been instituted. Those without current licensure and certifications will be subject to loss of privileges as described in these Bylaws.

e. The appointment of any Practitioner who fails to submit an application for reappointment, loses faculty appointment at University of Houston College of Medicine, or ceases to be employed by have a contractual relationship with University of Houston College of Medicine or Harris Health shall automatically expire at the end of his or her faculty appointment, employment, or contractual relationship. A Practitioner whose appointment has expired must

submit a new application, which shall be processed without preference as an application for initial appointment.

f. When the final action has been taken, the Chief Medical Officer shall give written notice of the reappointment decision to the Practitioner.

Section 5. Performance Data

a. Practitioner or APP specific performance data will be evaluated, analyzed, and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the Medical Staff.

b. Performance data will be routinely collected within the reappointment period or as required as a part of the peer review process and will include specific data elements approved by the Medical Executive Committee.

c. If the Practitioner or APP does not have sufficient performance data from his or her practice at Harris Health Correctional Health, the Practitioner or APP must submit performance data from other clinical locations where he or she practices.

d. The Medical Executive Committee will review summarized performance data as part of the reappointment process for each Practitioner or APP and make appropriate recommendations for any remedial or corrective action or refer the Practitioner or APP to peer review.

Section 6. Application for Clinical Privileges

Every initial application for staff appointment to the Medical Staff and each reappointment application must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, clinical training, experience, current competence, references, judgment, and other relevant information. The applicant shall have the burden of establishing his or her qualifications and competency to be granted the clinical privileges requested.

Section 7. Clinical Privileges

a. Every Medical Staff member practicing within Correctional Health by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, exercise only those clinical privileges specifically approved, ratified, and affirmed to him or her by the Governing Body.

b. Clinical privileges will be limited to those activities deemed the responsibility of the specialty area to which the applicant is appointed.

Section 8. Privileges in More Than One Specialty

Practitioners or APPs may be awarded clinical privileges in one or more specialty in accordance with their education, training, experience, and demonstrated competence.

Section 9. Temporary Privileges

a. Upon the basis of information then available, including information from staffing agencies providing applicants to Harris Health, which may reasonably be relied upon as to the competence and ethical standing of the applicant, the Medical Executive Committee may grant temporary clinical privileges to the new applicant. ~~Temporary privileges of the applicant shall persist for no more than 120 days and shall cease at the time of official action upon his or her application for Medical Staff membership.~~

b. **New Applicants**: Following receipt of a Clean Application from a new applicant, the

Medical Executive Committee may grant temporary Clinical Privileges to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the Chief Medical Officer. Temporary privileges of the applicant shall persist until the next meeting of the Governing Body (not to exceed 120 days) and shall cease at the time of official action upon his or her application for Medical Staff membership.

~~a.~~c. Note: New Applicants include individuals applying for clinical privileges for the first time, an individual currently holding clinical privileges who is requesting one or more additional privileges, and an individual who is in the reappointment process and is requesting one or more additional privileges.

~~b.~~d. Termination. Temporary clinical privileges may be terminated by the Chief Medical Officer.

~~c.~~e. Neither termination of temporary clinical privileges nor failure to grant them shall constitute a Final Hearing Review Action and neither is an Adverse Recommendation or Action.

Section 10 Emergency Clinical Privileges

In the case of an emergency, any current Medical Staff member, to the degree permitted by his or her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of a patient using the appropriate resources available, including the calling for any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which a patient is in immediate danger of serious permanent harm or loss of life, and any delay in administering treatment could add to that danger.

Section 11 Confidentiality of the Credentials File

A Medical Staff member or other individual exercising clinical privileges shall be granted access to his or her own credentials file, subject to the following provisions:

a. A request for access must be submitted in writing to the Chairperson of the Medical Executive Committee.

b. The individual may review, and receive a copy of, only those documents provided by or addressed personally to the individual. All other information, including peer review committee findings, letters of reference, proctoring reports, complaints, and other documents shall not be disclosed.

c. The review by the individual shall take place in Medical Staff Services during normal work hours with an officer or designee of the Medical Staff present.

ARTICLE VII - CORRECTIVE ACTION

Section 1. Procedure

a. Whenever the activities, professional conduct or health status of any Medical Staff member are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of Correctional Health, corrective action against such Medical Staff member may be requested by the Chief Medical Officer or by the Governing Body. All such requests shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Chief Medical Officer or designee must meet with the member to discuss the issues that are the basis for the request either prior to submission or no later than 72 hours after receipt of a copy of the request. In the event that the member who is the subject of the request for corrective action is the Chief Medical Officer, another voting member of the Medical Executive Committee must conduct the meeting. The party conducting the

meeting shall send a letter to the staff member immediately following the meeting confirming that the meeting was held and the matters discussed. The letter must be sent to the staff member via Special Notice procedures with a copy to Medical Staff Services.

b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Chairperson of the Medical Executive Committee shall immediately appoint an ad hoc committee to investigate the matter.

c. Within thirty (30) days after the ad hoc committee's receipt of the request for corrective action, it shall make a report of its investigation to the Medical Executive Committee. If in the reasonable view of the Medical Executive Committee more than thirty (30) days is needed to complete the investigation, the Medical Executive Committee shall grant an extension to the ad hoc committee. Prior to the making of a report, the Medical Staff member against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, the Medical Staff member shall be informed that the meeting shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the Chairperson of the Medical Executive Committee.

d. Within thirty (30) days following the receipt of the report of the ad hoc investigating committee, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Medical Staff member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.

e. The Medical Executive Committee shall take such action as deemed justified as a result of these investigations.

f. Any recommendations by the Medical Executive Committee to the Governing Body for reduction or revocation of clinical privileges, or expulsion from the Medical Staff shall entitle the affected Medical Staff member to the procedural rights provided in these Bylaws.

~~f.~~g. Any final adverse action taken after the procedural rights provided in Article ~~IX~~VIII have been exhausted (1) that adversely affects the Clinical Privileges of a Physician for a period longer than 14 days must be reported in writing to the Texas Medical Board; and (2) that adversely affects the Clinical Privileges of a Practitioner for a period lasting longer than 30 days must be reported to the National Practitioner Data Bank.

~~g.~~h. All decisions resulting from investigations of a Medical Staff member in a medical administrative position shall be reviewed by the Governing Body following the process as outlined in these Bylaws.

~~h.~~i. When the Medical Executive Committee or Governing Body has reason to question the physical and/or mental status of a Medical Staff member, the latter shall be required to submit an evaluation of their physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee and the affected physician as a prerequisite to further consideration of: (1) their application for appointment or reappointment, (2) their exercise of previously granted privileges, or (3) their maintenance of a Medical Staff appointment.

Section 2. Summary Suspension

Whenever there is a reasonable belief that a Member's conduct or condition requires that immediate action be taken to protect life or to reduce the likelihood of injury or damage to the health or safety of patients, workforce members, or others, summary action must be taken as to all or any portion of the Member's clinical privileges, and such action shall become effective immediately upon imposition.

The Chairperson of the Medical Executive Committee, the Medical Executive Committee itself, the Chief Medical Officer, Harris Health's Chief Medical Executive, or the Governing Body shall have the authority, whenever action must be taken immediately in the best interest of patient care, to suspend summarily all or any portion of the clinical privileges of a Medical Staff member, and such summary suspension shall become effective immediately upon imposition.

The Medical Staff member must be immediately notified by Special Notice from the Chief Medical Officer. A suspended member's patients must be assigned to another member by the applicable specialty, considering the wishes of the patient, where feasible, in choosing a substitute practitioner.

As soon as possible, but within ten (10) working days after a summary suspension is imposed, the Medical Executive Committee shall convene to review and consider the action taken. In its sole discretion, the Medical Executive Committee may provide the member the opportunity to meet with the Medical Executive Committee, which may recommend modification, continuation or termination of the terms of the suspension. A Medical Executive Committee recommendation to continue the extension or to take any other adverse action as defined in Article VII entitles the Medical Staff member, upon timely and proper request, to the procedural rights contained in Article VIII.

Section 3. Automatic Suspension

Occurrence of any of the following shall result in an automatic suspension as detailed. An automatic suspension is not considered a final action or an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article VIII of these Bylaws.

(1) Suspension, limitation or placement of a condition on a member's professional license by the state licensing board shall result in automatic suspension of the member's privileges until the Medical Executive Committee can assess whether the suspension, limitation, or condition will be adopted by the medical staff. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(2) Indictment of a member for a felony or indictment of any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services shall result in automatic suspension of the member's privileges. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(3) Failure of the member to maintain current required licensure and certifications, as described in Article III, Section ~~3~~2, shall result in automatic suspension of the member's privileges for up to thirty (30) days. The member's privileges will be reinstated once Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such actions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the actions as appropriate. Failure to satisfy this requirement in thirty (30) days will result in a voluntary resignation of the member's privileges and require the submission of an initial

credentialing application, which will be processed without preference. In certain circumstances, the Medical Executive Committee may approve an exception to this requirement.

~~(3) A member's delinquency in completion of medical records shall result in automatic suspension of the member's privileges and medical staff membership until Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such resolutions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the resolution as appropriate.~~

Section 4. Administrative Suspension

(1) Occurrence of any of the following shall result in an administrative suspension as detailed below. An administrative suspension is not considered a final action or an adverse recommendation or action and therefore, is not reportable or required to be disclosed in subsequent credentialing applications, but an administrative suspension may be considered in any investigation or proceeding pursuant to Article VIII of these Bylaws. Failure to satisfy requirements listed below in thirty (30) days after the administrative suspension will result in a voluntary resignation of the member's privileges and require the submission of an initial credentialing application, which will be processed without preference. In certain circumstances, the Chief Medical Officer, or designee, based on a recommendation from the Medical Executive Committee, may approve an exception to this requirement.

~~(1)~~(2) A member's delinquency in completion of medical records shall result in administrative suspension of the member's privileges and medical staff membership until Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such resolutions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the resolution as appropriate.

Section 5. Automatic Termination

Occurrence of any of the following shall result in an automatic termination as detailed. An Automatic termination is not considered an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article V~~I~~II of these Bylaws.

(1) Revocation of a physician's professional license by the Texas Medical Board shall cause all the member's clinical privileges and the medical staff membership to automatically terminate.

(2) Conviction of or a guilty or nolo contendere plea to (including deferred adjudication) for a felony or conviction of or a guilty or nolo contendere plea to any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services by a member shall result in automatic termination of the member's privileges and medical staff membership.

(3) A member's privileges and staff membership shall automatically terminate if the member becomes an Ineligible Person as that term is defined in these Bylaws.

(4) Loss of employment or contractual relationship with University of Houston College of Medicine or Harris Health, to provide clinical care in Correctional Health shall result in automatic termination of the Practitioner~~'s~~ or APP's privileges and staff membership. However, if the loss of employment is related to the member's professional competence or conduct, such action is considered an adverse action under Article VIII. ~~, Section 1.~~

(5) The privileges and medical staff membership of a member who is suspended four times in a twelve (12) month period for delinquency in completion of medical records shall automatically terminate upon the first day of the fourth suspension within twelve months.

(6) The privileges and medical staff membership of a member who remains suspended for six (6) continuous weeks for delinquency in completion of medical records shall automatically terminate upon the last day of the sixth week of continuous suspension.

(7) Failure to notify Medical Staff Services of the occurrence of any of the events listed in Article VII, Section 3 shall result in automatic termination of a member's privileges and medical staff membership.

a. Notice

The member must be immediately notified by Special Notice from the Chief Medical Officer.

Section ~~5~~6. Medical Administrative Positions

A Medical Staff member shall not lose staff privileges if his or her medical administrative position is terminated without following the hearing and appellate procedures as outlined in Article VIII.

ARTICLE VIII — PROCEDURAL RIGHTS OF REVIEW

Section 1. Events Giving Rise to Hearing Rights

a. Actions or Recommended Actions

Subject to the exceptions set forth in Section 1.c of this Article, the following actions or recommended actions, if deemed adverse under Section 1.b below, entitle the member (for purposes of this Article, the term "member" shall include an applicant to the Medical Staff whose application for Medical Staff appointment and clinical privileges has been denied) to a hearing upon timely and proper request as provided in Section 4:

(1) Denial of initial Medical Staff appointment;

(2) Denial of reappointment;

(3) Suspension of appointment, provided that summary suspension entitles the member to request a hearing only as specified in this section;

(4) Revocation of appointment;

(5) Denial or restriction of requested clinical privileges;

(6) Reduction in clinical privileges;

(7) Suspension of clinical privileges, provided that summary suspension entitles the member to request a hearing only as specified in this section,

(8) Revocation of clinical privileges;

(9) Individual application of, or individual changes in, mandatory consultation or supervision requirement; or

(10) Summary suspension of appointment or clinical privileges, if the recommendation of the Medical Executive Committee or action by the Governing Body is to continue the suspension or to take other action which would entitle the member to request a hearing under Section 4, provided that if the Medical Executive Committee initiates an investigation of the member in accordance with Article VII~~I~~, no hearing rights shall accrue until the Medical Executive Committee had acted upon the report of

the ad hoc committee.

b. When Deemed Adverse

Except as provided below, any action or recommended action listed in Section 1.a above is deemed adverse to the member only when it has been:

(1) recommended by the Medical Executive Committee; or

(2) taken by the Governing Body under circumstances where no prior right to request a hearing exists.

c. Exceptions to Hearing Rights

(1) Certain Actions or Recommended Actions: Notwithstanding any provision in these Bylaws, or in the Credentialing Procedures Manual to the contrary, the following actions or recommended actions do not entitle the member to a hearing:

(a) the issuance of a verbal warning or formal letter of reprimand; the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;

(b) the imposition of a probationary period involving review of cases;

(c) the imposition of a requirement for a proctor to be present at procedures performed by the member, provided that there is no requirement for the proctor to grant approval prior to provision of care;

(d) the removal of a Practitioner from a medical administrative office within the hospital unless a contract or employment arrangement provides otherwise; and

(e) any other action or recommended action not listed in Section 1.a above.

(2) Other Situations: An action or recommended action listed in Section 1.a above does not entitle the applicant or member to a hearing when it is:

(a) voluntarily imposed or accepted by the Practitioner;

(b) automatic pursuant to any provision of these Bylaws and related manuals;

(c) taken or recommended with respect to temporary privileges, unless the action must be reported to the National Practitioner Data Bank.

Section 2. Notice of Adverse Action

a. Correctional Health shall, within fifteen (15) days of receiving written notice of an adverse action or recommended action under Section 1.a, give the Practitioner Special Notice thereof. The notice shall:

(1) advise the Practitioner of the nature of and reasons for the proposed action and of his or her right to mediation or a hearing upon timely and proper request pursuant to Section 3 and/or Section 4 of this Article VIII~~IX~~;

(2) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for mediation or a hearing and that the request must satisfy the conditions of Section 3 and/or Section 4;

(3) state that failure to request mediation or a hearing within that time period and in the proper manner constitutes a waiver of rights to mediation or a hearing and to an

appellate review on the matter that is the subject of the notice;

(4) state that any higher authority required or permitted under this Article to act on the matter following a waiver is not bound by the adverse action or recommended action that the Practitioner has accepted by virtue of the waiver but may take whatever action, whether more or less severe, it deems warranted by the circumstances;

(5) state that upon receipt of his mediation or hearing request, the Practitioner will be notified of the date, time, and place of the hearing, and the grounds upon which the adverse recommendation or action is based; and

(6) provide a brief summary of the rights the Practitioner would have at a hearing, as set forth in Sections 12-14 of this Article.

Section 3. Request for Mediation

a. Within ten (10) days of receipt of the notice of adverse recommendations giving rise to hearing rights, an affected member may file a written request for mediation. The request must be delivered by Special Notice to the Chief Medical Officer and state the reason the member believes mediation is desirable. If a hearing has already been scheduled, mediation must be completed prior to the date of the hearing. If no hearing has been scheduled, the mediation must take place within 45 days of receipt of the request. Under no circumstances will a hearing be delayed beyond the originally scheduled date unless both parties agree to a continuance to a date certain.

b. The mediator shall be selected by the Chairperson of the Medical Executive Committee and must have the qualifications required by state law and experience in medical staff privileging and disputes.

c. The fee of the mediator shall be shared equally among the parties.

d. An individual shall be appointed by the Chairperson of the Medical Executive Committee to participate in the mediation and represent the Medical Executive Committee. The affected member and the representative of the Medical Executive Committee may each be accompanied in the mediation by counsel of their choice.

e. Under no circumstances may the mediation delay the filing of any report required by law, or result in an agreement to take any action not permitted by law. No agreement arising out of the mediation may permit or require the Medical Executive Committee, the Governing Body, or Harris Health to violate any legal requirement, accreditation requirement or any requirement of these Bylaws.

f. If no resolution is reached through the mediation, a hearing must be scheduled no later than forty-five (45) days following the mediation, unless otherwise agreed by the parties.

Section 4. Request for Hearing

The Practitioner shall have thirty (30) days after receiving the above notice to file a written request for a hearing. The request must be delivered to the Chief Medical Officer by Special Notice.

Section 5. Waiver by Failure to Request a Hearing

A member who fails to request a hearing within the time and in the manner specified in Section 4 above waives his or her right to any hearing and appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommended action triggering the Section 2 notice. The Chief Medical

Officer shall as soon as reasonably and ~~practicable~~ practicably send the member Special Notice of each action taken under any of the following Sections and shall notify the Chairperson of the Medical Executive Committee of each such action. The effect of a waiver is as follows:

a. Adverse Action by the Governing Body

A waiver constitutes acceptance of the adverse action, which immediately becomes the final decision of the Governing Body.

b. Adverse Recommendation by the Medical Executive Committee

A waiver constitutes acceptance of the adverse recommendation, which becomes effective immediately and remains so pending the decision of the Governing Body. The Governing Body shall consider the adverse recommendation as soon as practicable following the waiver but at least at its next regularly scheduled meeting. Its action has the following effect:

(1) If the Governing Body's action accords in all respects with the Medical Executive Committee recommendation, the Governing Body decision becomes effective immediately.

(2) If, on the basis of the same information and material considered by the Medical Executive Committee in formulating its recommendation, the Governing Body proposes a more severe adverse action, the member shall be entitled to a hearing.

Section 6. Additional Information Obtained Following Waiver

When, in considering an adverse Medical Executive Committee recommendation transmitted to it under Section 5.b of this Article VIII~~IX~~, the Governing Body acquires or is informed of additional relevant information not available to or considered by the Medical Executive Committee, the Governing Body shall refer the matter back to the Medical Executive Committee for reconsideration within a set time limit. If the source of the additional information referred to in this Section is the member or an individual or group functioning, directly or indirectly, on his or her behalf, the provisions of this Section shall not apply unless the member demonstrates to the satisfaction of the Medical Executive Committee that the information was not reasonably discoverable in time for presentation to and consideration by the party taking the initial adverse action.

a. If the Medical Executive Committee's recommendation following reconsideration is unchanged, the Governing Body shall act on the matter as provided in Section 5.b. of this Article.

b. If the Medical Executive Committee's recommendation following reconsideration is still adverse but is more severe than the action originally recommended, it is deemed a new adverse recommendation under Section 1.a of this Article and the matter proceeds as such.

c. A favorable Medical Executive Committee recommendation following reconsideration shall be forwarded as soon as reasonably practicable to the Governing Body by the Chief Medical Officer. The effect of the Governing Body action is as follows:

(1) Favorable: Favorable Governing Body action on a favorable Medical Executive Committee recommendation becomes effective immediately.

(2) Adverse: If the Governing Body's action is adverse, the member shall be entitled to a hearing.

Section 7. Notice of Time and Place for Hearing

The Chief Medical Officer shall deliver a timely and proper request for a hearing to the Chair of

the Medical Executive Committee or Chairperson of the Governing Body, depending on whose recommendation or action prompted the hearing request. The Chairperson of the Medical Executive Committee or the Chairperson of the Governing Body, as appropriate, shall then schedule a hearing. Hearings held by the Governing Body or any committee of the Governing Body under this Article of these Bylaws will be closed meetings pursuant to Chapter 151 of the Texas Occupations Code and Section 161.032 of the Texas Health & Safety Code. The hearing date shall be set for as soon as practicable after the Chief Medical Officer received the request but, in any event, no more than forty-five (45) days thereafter. The Chief Medical Officer shall send the member Special Notice of the time, place, and date of the hearing, and the identity of the hearing committee members or hearing officer not less than thirty (30) days from the date of the hearing. The notice provided to the member shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee or Governing Body, whichever is appropriate. The member must provide a list of the witnesses expected to testify on his behalf within ten (10) days of this notice. If the member is under suspension, he or she may request that the hearing be held not later than twenty (20) days after the Chief Medical Officer has received the hearing request. The Chief Medical Officer may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Chairperson of the Governing Body. If the member does not in good faith cooperate in scheduling a hearing date, and as a result, a hearing has not been scheduled within ninety (90) days from the date of the first proposal for a hearing date by the Medical Executive Committee or Chairperson of the Governing Body, the member shall be deemed to have waived the member's right to a hearing in accordance with this Article, Section 5, unless both parties agree to a delayed hearing date.

The notice of hearing shall contain a concise statement of the member's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

Section 8. Appointment of Hearing Committee or Hearing Officer

a. By Medical Staff

A hearing occasioned by an adverse Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chairperson of the Medical Executive Committee and composed of at least three (3) members of the Medical Staff. The Chairperson of the Medical Executive Committee shall designate one of the appointees as Chairperson of the committee.

b. By the Governing Body

A hearing occasioned by an adverse action of the Governing Body shall be conducted by a hearing committee appointed by the Chairperson of the Governing Body and composed of at least three (3) persons, including at least two (2) medical staff members when feasible. The Chairperson of the Governing Body shall designate one appointee as Chairperson of the committee.

c. Service on Hearing Committee

An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard the case or has knowledge of the facts involved or what he or she supposes the facts to be. Any member of the Hearing Committee shall not be in direct economic competition with the member involved. Direct economic competition may not be shown based solely on the member's medical school affiliation. Within ten (10) days

of receipt of the Notice of Hearing, the member under review may submit a written challenge to a member of the hearing panel, specifying the manner in which the hearing committee member is deemed to be disqualified along with supporting facts and circumstances. The Medical Executive Committee or Governing Body, as appropriate, shall consider and rule on the challenge.

d. Hearing Officer in Lieu of Hearing Committee

Subject to the approval of the Governing Body, the Medical Executive Committee may determine that the hearing will be conducted in front of a hearing officer to be appointed by the Medical Executive Committee. This officer shall not be in direct economic competition with the member involved. The term "hearing officer" as used in this Section ~~8~~VIII.d shall be used to refer to a hearing officer who is appointed in lieu of a Hearing Committee and shall not refer to an appointed presiding officer of a Hearing Committee, provided, however, that a presiding officer still may be appointed. The decision of a Hearing Officer appointed in lieu of a Hearing Committee shall have the same force and effect as a decision by the Hearing Committee.

Section 9. Final List of Witnesses

The witness lists required in Section 7 of this Article shall be amended as soon as possible by the appropriate party when additional witnesses are identified. The final list of witnesses must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the testimony of witnesses not disclosed within the required timeframe.

Section 10 Documents

All documents the parties plan to introduce into evidence at the hearing must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the introduction into evidence of documents not produced within the required timeframe.

Section 11 Personal Presence

The personal presence of the member is required throughout the hearing, unless the member's presence is excused for any specified time by the hearing committee. The presence of the member's representative does not substitute for the personal presence of the member. A member who fails, without good cause, to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with this Article of these Bylaws shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Sections 4 and 5 of this Article, if applicable.

Section 12 Presiding Officer~~/Chairperson~~

The hearing officer, if appointed pursuant to this Article of these Bylaws, or if not appointed, the hearing committee Chairperson, shall be the Ppresiding ~~officer~~Officer. The Ppresiding ~~o~~Officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not

act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed, he or she shall not be entitled to vote. If the Chairperson of the hearing committee serves as the presiding officer, he or she shall be entitled to vote.

Section 13 Representation

The member may be represented at the hearing by a member of the Medical Staff in good standing, a member of his or her local professional society, or an attorney of his or her choice. The Medical Executive Committee or Governing Body, depending on whose recommendation or action prompted the hearing, shall designate a medical staff member to support its recommendation or action and, in addition, may appoint an attorney to represent it.

Section 14 Rights of Parties

During the hearing, each party shall have the following rights, which shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

(1) provide an opening statement no longer than 5 minutes each;
(2) call and examine witnesses;
(3) introduce exhibits;
(4) cross-examine any witness on any matter relevant to the issues;
(5) impeach any witness; and
(6) rebut any evidence.

If the member does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

Section 15 Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding officer, and a copy must be provided to the other party. The hearing committee may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it is appropriate.

Section 16 Official Notice

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Texas. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute the officially noticed matters by written or oral presentation of authority, in a manner to be determined by the hearing committee. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 17 Burden of Proof

The body whose adverse action or recommended action occasioned the hearing shall have the burden of coming forward with evidence in support thereof. Thereafter, the member shall have

the burden of coming forward with evidence and proving by clear and convincing evidence that the adverse action or recommended action lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Section 18 Hearing Record

A court reporter shall be used to record the hearing, although those giving testimony need not be sworn by said reporter. The court reporter shall transcribe the hearing and submit a written copy to the presiding officer within 10 business days after adjournment of the hearing for his/her review. The presiding officer shall return any noted corrections to the court reporter within 7 days. The member may within ten days after the hearing's adjournment also request a copy of the hearing report upon payment of any reasonable costs associated with the preparation of said report and in such event may review the hearing report and return any noted corrections to the court reporter within 7 days. If the member fails to request a copy of the hearing report or if the hearing report is not returned in 7 days, the right to make any changes is waived.

Section 19 Postponement

Requests for postponement or continuance of a hearing may be granted by the presiding officer or hearing committee only upon a timely showing of good cause.

Section 20 Presence of Hearing Committee Members and Vote

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the hearing committee.

Section 21 Recesses and Adjournment

The hearing committee may recess and reconvene the hearing without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 22 Hearing Committee Report

Within twenty (20) days after adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations with such reference to the hearing record and other considered documentation as it deems appropriate. The hearing committee shall forward the report to the body whose adverse action or recommended action occasioned the hearing. The member shall also be given a copy of the report by Special Notice. The hearing record and other documentation shall be transmitted to the Medical Staff Office for safekeeping as official records and minutes of the Medical Staff and shall be made available for review by any party between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday, excluding holidays.

Section 23 Action on Hearing Committee Report

Within thirty (30) days after receiving the hearing committee report, the body whose adverse action or recommended action occasioned the hearing shall consider said report and affirm, modify, or reverse its action or recommended action. It shall transmit the result to the Chief Medical Officer.

Section 24 Notice and Effect of Result

a. Notice

As soon as is reasonably practicable, the Chief Medical Officer shall send a copy of the result to the member by Special Notice and to the Chairperson of the Medical Executive Committee.

b. Effect of Favorable Result

(1) Adopted by the Governing Body: If the Governing Body's determination is favorable to the member, it shall become effective immediately.

(2) Adopted by the Medical Executive Committee: If the Medical Executive Committee result is favorable to the member, the Chief Medical Officer shall, as soon as is reasonably practicable, forward it to the Governing Body which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Governing Body shall take action. Favorable action to the member by the Governing Body shall become effective immediately.

c. Effect of Adverse Result

If the hearing results in an adverse recommendation, the member shall receive Special Notice of his or her right to request appellate review.

Section 25 Request for Appellate Review

A member shall have thirty (30) days after receiving Special Notice of an adverse result to file a written request for an appellate review. The request must be delivered to the Chief Medical Officer by Special Notice.

Section 26 Waiver by Failure to Request Appellate Review

A member who fails to request an appellate review within the time and in the manner specified in Section 24 25 of this Article shall have waived any right to a review. The waiver has the same force and effect as provided in Sections 5 and 6 of this Article, if applicable.

Section 27 Notice of Time and Place for Appellate Review

The Chief Medical Officer shall deliver a timely and proper request for appellate review to the Chairperson of the Governing Body. As soon as practicable, said Chairperson shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the Chief Medical Officer received the request. If the member is under suspension, he or she may request that the appellate review be held not later than twenty (20) days after the Chief Medical Officer has received the appellate review request. The Chief Medical Officer may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Governing Body. At least thirty (30) days prior to the appellate review, the Chief Medical Officer shall send the member Special Notice of the time, place, and date of the review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause.

Section 28 Appellate Review Body

The appellate review may be conducted by the Governing Body. The Chairperson of the Governing Body will appoint a committee consisting of three (3) to nine (9) members of the

Governing Body to hear the appeal, including at least one (1) physician. The Chairperson shall designate one of the members as Chairperson.

Section 29 Nature of Proceedings

The proceedings by the review body are a review based upon the hearing record, the hearing committee's report, all subsequent results and actions, the written statements, if any, provided below, and any other material that may be presented and accepted. The presiding officer shall direct the Medical Staff Office to make the hearing record and hearing committee report available at the appellate review for use by any party. The review body shall determine whether the foregoing evidence demonstrates that the member has met the applicable burden of proof as required under Section ~~16~~ 17 of this Article.

Section 30 Written Statements

The member may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body and to the group whose adverse action or recommended action occasioned the review through the Chief Medical Officer at least five (5) days prior to the scheduled date of the review, except if the time limit is waived by the review body or its presiding officer. A similar statement may be submitted by the body whose adverse action or recommended action occasioned the review, and if submitted, the Chief Medical Officer shall provide a copy to the member and to the appellate review body at least ten (10) days prior to the scheduled date of the appellate review.

Section 31 Presiding Officer

The Chairperson of the appellate review body is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

Section 32 Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the review body.

Section 33 Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the review body and only if the party requesting consideration of the matter or evidence demonstrates to the satisfaction of the review body that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the Chief Medical Officer, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced at the review. Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment, and rebuttal provided at the hearing pursuant to Section ~~13~~ 14 of this Article.

Section 34 Powers

The appellate review body has all the powers granted to the hearing committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

Section 35 Presence of Members and Vote

A majority of the members of the review body must be present throughout the appellate review and deliberations. If a member is absent from any part of the proceedings, the presiding officer of the appellate review may, in his discretion, rule that said member shall not be permitted to participate further in the review or deliberations or in the decision of the review body.

Section 36 Recesses and Adjournments

The review body may recess and reconvene the proceedings without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 37 Action Taken

Within thirty (30) days after adjournment pursuant to Section 21 of this Article, the review body shall prepare its report and conclusion with the result as provided below. The Chief Medical Officer shall send notice of each action taken under Section 22 of this Article below to the Chairperson of the Medical Executive Committee for transmittal to the appropriate Staff authorities and to the member by Special Notice.

a. Governing Body Decision

(1) Within fifteen (15) days after adjournment, appellate review body shall make its decision, including a statement of the basis of the decision. The appellate review body may decide:

(a) that the adverse recommendation be affirmed;

(b) that the adverse recommendation be denied;

(c) that the matter be the subject of further hearing or other appropriate procedures within a specified time period; or

(d) that modification of the adverse recommendation be made so that it is no longer unreasonable, arbitrary, capricious, or discriminatory.

If the appellate review body finds that the procedures were substantially complied with and that the adverse recommendation which is the subject of the appeal was not unreasonable, arbitrary, capricious, discriminatory, or lacking in basis, it shall affirm the adverse recommendation in its decision.

(2) A majority vote of the members of the appellate review body authorized to vote is required for an adverse decision.

(3) The decision of the appellate review body on behalf of the Governing Body shall be effective upon the date of such decision, unless reversed or modified by the Governing Body within thirty (30) days.

(4) A copy of the appellate review body's decision shall be sent to the member by Special Notice within five (5) days following its decision.

Section 38 Hearing Officer Appointment and Duties

The use of a hearing officer to preside at the evidentiary hearing is optional and is to be determined by, and the actual officer if any to be used is to be selected by the Chairperson of the Medical Executive Committee in conjunction with the Chief Medical Officer. A hearing officer may or

may not be an attorney at law, but must be experienced in and recognized for conducting Medical Staff hearings in an orderly, efficient, and non-partisan manner.

Section 39 Number of Hearings and Reviews

Notwithstanding any other provision of these Bylaws, no member shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse action or recommended action giving use to the right.

Section 40 Release

By requesting a hearing or appellate review under this Article, a member agrees to be bound by the provisions of Article VII of these Bylaws.

ARTICLE IX – CHIEF MEDICAL OFFICER

Section 1. Appointment

The Chief Medical Officer shall be an employee of Harris Health and be a direct report of Harris Health's Chief Medical Executive.

Section 2. Responsibilities

The Chief Medical Officer is invested with the following duties and prerogatives, which he may perform personally or delegate to appropriate members of his or her leadership team:

1. Call and preside over Quality Improvement (QI) meetings.
2. Facilitate adherence of the Medical Staff of these Bylaws.
3. Be chief spokesperson and enunciator of policy for the Medical Staff.
4. Monitor adherence to policies with respect to patient rights.
5. Assist in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
6. Assist in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
7. Take the initiative in developing, on behalf of the Medical Staff, appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures.
8. Take the initiative in developing, on behalf of the Medical Staff, and overseeing Quality Improvement, Risk Management, and Peer Review programs in accordance with applicable standards.
9. Assist in arranging for ancillary services including laboratory, radiology, and pathology services.
10. Carry out all other duties specifically entrusted to him/her by the Medical Executive Committee, Governing Body, or any other provision of these Bylaws.

ARTICLE X — COMMITTEES

The Governing Body or Chief Medical Officer, may establish such committees as are necessary to fulfill the functions of Correctional Health.

Unless otherwise specified in these Bylaws or at the time of selection or appointment of a Committee, non-~~Medical~~medical staff members of a committee shall serve in an ex-officio capacity without a vote.

Committees of the Medical Staff described in these Bylaws all function as "medical committees"

and/or "medical peer review committees" pursuant to state law. Each committee's records and proceedings are, therefore, confidential, legally privileged, and protected from discovery under certain circumstances.

The function that the committee 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 committee, the committee's 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, committee meetings must be limited to only the committee members and invited guests who need to attend the meetings. The committee 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 committee 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 committee meetings, without prior approval from the Chair of the committee. Documents prepared by or considered by committee in the committee meetings must clearly indicate that they are not to be copied, are solely for use by the committee, and are privileged and confidential.

The records and proceedings of the Correctional Health and/or Harris Health departments ***that support*** the quality and peer review functions of a committee, such as the Patient Safety/Risk Management and Quality Program departments are also confidential, legally privileged, and protected from discovery, if the records are prepared by or at the direction of the committee, and are not kept in the ordinary course of business. Routine administrative records prepared by Correctional Health in the ordinary course of business are not legally privileged or protected from discovery. Documents that are gratuitously submitted to the committee, or which have been created without committee impetus and purpose, are also not protected.

Section 1. The Medical Executive Committee

a. Membership

All Medical Staff members are eligible for membership on the Medical Executive Committee. The Chief Medical Officer shall serve as the Chair of the Medical Executive Committee.

b. Voting Members

The Medical Executive Committee shall consist of five (5) members of the Medical Staff, including the Chief Medical Officer.

c. Election of Voting Members

Voting members of the Medical Executive Committee will be elected every two (2) years. Nominations and voting will occur at the beginning of the first Medical Executive Committee meeting of the new term. In the event a voting member is unable to complete his or her term, a special election will occur at the next Medical Executive Committee to fill the position.

d. Ex-officio Non-Voting Members:

(1) Harris Health System President & Chief Executive Officer;

(2) Harris Health System Chief Strategy Officer; and

(3) Harris Health System Chief Medical Executive.

e. Invited Guests

At the request of a committee member, non-voting guests may attend meetings of the Medical Executive Committee.

f. Duties

(1) Report to the Governing Body on all evaluation, monitoring and recommendations regarding the appropriateness and quality of health care services rendered to the patients;

(2) Review, investigate, and make recommendations on matters relating to the professional competence and conduct of Practitioners and APPs, including the merits of complaints and appropriate corrective action;

(3) Represent and act on behalf of the Medical Staff and APPs between meetings, subject to such limitations imposed by these Bylaws;

(4) Coordinate the activities of and initiate and implement general policies applicable to the Medical Staff;

(5) Receive and act upon committee reports;

(6) Act as the liaison between the Medical Staff and the Governing Body;

(7) Periodically review all information available concerning the performance and clinical competence of Practitioners and APPs with clinical privileges and make recommendations for reappointment or changes in clinical privileges;

(8) Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of the Practitioners and APPs with clinical privileges;

(9) Review credentials of all applicants to the Medical Staff, as well as APPs, make recommendations on initial appointment and reappointment to the medical staff, and delineate clinical privileges;

(10) Perform appropriate functions related to quality assessment and improvement, medical records, infection control, medical staff utilization, pharmacy and therapeutics, and other such functions; and

(11) Perform other duties as requested by the Governing Body.

(12) Monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

(13) Work with Service Chiefs to disseminate educational lessons learned from the review of cases pursuant to the Professional Practice Evaluation (PPE) Policy, either through peer learning sessions in the Service or through some other mechanism

(14) Educating the Correctional Health Medical Staff and other Correctional Health staff

regarding illness and impairment recognition issues specific to Practitioners and APPs;

(15) Encourage self-reporting by Practitioners and APPs and referral by other members of the Correctional Health Medical Staff

(16) Determining the best avenue of referral to care for a Practitioner or APP;

(17) Monitoring the progress of an affected Practitioner of APP until the rehabilitation process is complete

~~(11)~~(18) Reporting to the Correctional Health Medical Director or their designee, instances when there is evidence that a Practitioner or APP represents a clear and imminent danger to self, others, or patients.

ARTICLE XI— IMMUNITY FROM LIABILITY

The following shall be express conditions to any Medical Staff member's application for clinical privileges within Correctional Health:

Condition 1.

Any act, communication, report, recommendation, or disclosure, with respect to any such Medical Staff member performed, or made in good faith and without malice, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and immune from liability to the fullest extent permitted by law.

Condition 2.

All such privileges and immunities shall extend to members of Correctional Health Medical Staff and of its Governing Body, its other Practitioners, its Chief Medical Officer and his or her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations who provide information to an authorized representative of the Governing Body or of the Medical Staff.

Condition 3.

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Condition 4.

All such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities, including, but not limited to:

a. Applications for appointment or clinical privileges;
b. Periodic reappraisals for reappointment or clinical privileges;
c. Corrective action, including summary suspension;
d. Hearings and appellate reviews;
e. Medical care evaluations;
f. Utilization reviews; and
g. Other activities related to quality patient care and inter-professional conduct.

~~g.~~ Condition 5.

The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to a Medical Staff member's professional qualifications, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Condition 6.

Each Medical Staff member shall, upon request, execute a release in favor of the entities identified in the Second paragraph of this Section and consistent with the provisions of this Article.

ARTICLE XII — CONFLICTS OF INTEREST

Section 1. Definitions

Conflicts of Interest – A conflict of interest potentially exists when a Medical Staff member, or a relative, has direct or indirect interests, including financial and personal interests, or business transactions or professional activities, that may compromise or appear to compromise: (1) the Medical Staff member's clinical judgment; (2) the delivery of patient care; or (3) the Medical Staff member's ability to fulfill his or her Medical Staff obligations.

Section 2. Compliance

Medical Staff members must comply with the Conflict of Interest policies of their affiliated organization (e.g., The University of Houston College of Medicine or Harris Health).

Section 3. Disclosure of Potential Conflict of Interest

a. Medical Staff member shall have a duty to disclose any conflict of interest when such interest is relevant to a matter of action (including a recommendation to Harris Health Administration or the Governing Body) being considered by a committee, department or other body of the Medical Staff. In a Medical Staff member's dealings with and on behalf of Correctional Health, the Medical Staff member shall be held to a strict rule of honest and fair dealing with Correctional Health. The Medical Staff member shall not use his or her position, or knowledge gained there from, so that a conflict might arise between the interests of Correctional Health and those of the Medical Staff ~~membe~~member.

b. As a matter of procedure, the Chairperson of the Medical Staff committee or other body designated to consider a matter that may lead to the provision of items, services or facilities to Correctional Health by a third party or the establishment of a business relationship between a third party and Correctional Health shall inquire, prior to any discussion of the matter, whether any Medical Staff member has a conflict of interest. The existence of a potential conflict of interest on the part of any committee member may be called to the attention of the committee Chairperson by any Medical Staff member with knowledge of the matte

c. Any Medical Staff member with a conflict of interest on any matter should not vote or use his or her personal influence regarding the matter, and he or she should not be counted in determining the quorum for the body taking action or making a recommendation to the Governing Body. The minutes of that meeting should reflect that a disclosure was made, the abstention from voting, and the quorum ~~situatio~~situation.

d. The foregoing requirements should not be construed as preventing the Medical Staff member from briefly stating his or her position in the matter, nor from answering pertinent questions by the Governing Body or other Medical Staff members since his or her knowledge may be of great assistance.

ARTICLE XIII — CREDENTIALING POLICIES AND PROCEDURES

The Medical Staff shall adopt a Medical Staff Credentialing Procedures Manual as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner and APP in Correctional Health. Such Medical Staff Credentialing Procedures Manual shall be a part of these Bylaws, except that the Manual may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A majority vote of those present shall be required for amendment or repeal.

ARTICLE XIV — AMENDMENTS

Section 1. Amendment Process

a. Amendment(s) to the Bylaws may be proposed at any meeting of the Medical Executive Committee.

b. All proposed amendments to the Bylaws approved by the Medical Executive Committee shall be submitted to the members of the Active Medical Staff for approval. The proposed amendment(s) to be adopted shall require a majority vote of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws may be voted on at any regular or special meeting of the Medical Staff or submitted to the members of the Active Medical Staff for vote by written or electronic ballot, as approved by the Medical Executive Committee. Notice of such regular or special meeting shall be made at least fifteen (15) days in advance and shall include the Bylaws amendment(s) to be voted upon.

c. Bylaws Amendment(s) approved by the Medical Executive Committee and the Medical Staff shall be forwarded to the Governing Body, which shall approve, disapprove or approve with modifications. If the Governing Body modifies any Bylaw amendments approved by the Medical Executive Committee and the Medical Staff, such amendments, as modified, shall be returned to the Medical Executive Committee, which may accept or reject the modifications. If the Medical Executive Committee accepts the modifications, the amendment shall be submitted to the members of the Active Medical Staff for approval or disapproval as described in Section (b) above. If the Medical Executive Committee rejects the modification, the amendment shall be submitted again to the Governing Body, which may either approve or disapprove the amendment. Any disputes regarding proposed bylaws amendments shall be referred to the Joint Conference Committee for discussion and further recommendation to the Medical Executive Committee and the Governing Body.

d. Bylaws Amendments may also be proposed to the Governing Body by the Medical Staff by majority vote of the members of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws shall be brought before the Active Medical Staff by petition signed by 20% of the members of the Active Staff. Any such proposed Bylaw amendment shall be submitted to the Medical Executive Committee for review and comment before it is submitted to the voting members of the Active Medical Staff. Any Bylaw amendment approved by a majority of the Active Medical Staff shall be presented to the Governing Body for final action along with any comments from the Medical Executive Committee.

e. These Bylaws, and all amendments thereto, shall be effective when approved by the Governing Body, unless otherwise stated in the Bylaw provision or amendment approved by the Governing Body, and shall apply to all pending matters to the extent practical, unless

the Governing Body directs otherwise.

~~e.~~f. These Bylaws shall not be unilaterally amended by the Governing Body or the Medical Staff.

Section 2. Editorial Amendments

Notwithstanding Section 1 of this Article, Medical Staff Services shall have the authority to make non-substantive editorial changes to the Bylaws and to correct any typographical, formatting, and inadvertent errors.

Section 3. Review Process

These Bylaws shall be reviewed at least annually and amendments made according to the described amendment procedure.

ARTICLE XV — PARLIAMENTARY PROCEDURES

Where these Bylaws do not conflict, *Robert's Rules of Order* shall be used in the conduct of Medical Staff meetings.

ARTICLE XVI — CONFLICT MANAGEMENT

A conflict management process shall be developed and implemented when a conflict arises between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt provisions of, or amendments to, the Rules and Regulations or these Bylaws. The conflict management process shall include a meeting between the involved parties as early as possible to identify the conflict, gathering information about the conflict, working with all parties to manage and, to the extent possible, resolve the conflict, and ultimately protect patient safety and quality of care. As necessary, the Chief Medical Officer shall appoint an individual to act as mediator between the groups in an effort to resolve the conflict. The Governing Body shall have the ultimate discretion to determine an effective resolution to any conflict between the Medical Staff and the Medical Executive Committee, should the parties not be able to come to a resolution. The Governing Body shall regularly review whether the process is effective at managing conflict and shall revise the process as necessary.

ARTICLE XVII - ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Medical Executive Committee, shall replace any previous Bylaws, and shall become ~~immediately~~ effective when approved by the Governing Body ~~of Correctional Health~~, unless a specific effective date is listed below.

~~Accepted and adopted by the Chief Medical Officer/Chair of Medical Executive Committee of Correctional Health and the Governing Body of Correctional Health on February 24, 2022 with an effective date of March 1, 2022.~~

APPROVED BY THE ~~CHIEF MEDICAL OFFICER / CHAIR OF~~ MEDICAL EXECUTIVE COMMITTEE OF CORRECTIONAL HEALTH:

DATE: _____

Otis Egins, MD
Chief Medical Officer
Chair, Medical Executive Committee

~~Otis Egins, MD~~
~~Chief Medical Officer/Chair of Medical Executive Committee~~

APPROVED BY THE GOVERNING BODY ~~OF CORRECTIONAL HEALTH~~OF HARRIS COUNTY HOSPITAL DISTRICT D/B/A HARRIS HEALTH:

DATE: _____

Andrea Caracostis, MD
Chairperson, Governing Body

~~Art Bracey, MD~~

~~Chair, Governing Body~~

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, December 12, 2024

Consideration of Approval of the Appointment of 2025 Committees and Membership

---

Sara Thomas
Chief Legal Officer/Division Director
Harris County Attorney's Office
Harris Health System

Board of Trustees
2025 Board Committee Appointments

COMMITTEES	MEMBERS
Budget and Finance Committee	Jim Robinson (Chair) Board Chair (Ex-officio) Carol Paret Ingrid Robinson
Compliance and Audit Committee	Carol Paret (Chair) Board Chair (Ex-officio) Jim Robinson Afsheen Davis
Diversity Equity and Inclusion (DEI) Committee	Ingrid Robinson (Chair) Board Chair (Ex-officio) Dr. Cody M. Pyke Libby Viera-Bland
Governance Committee	Dr. Cody M. Pyke (Chair) Board Chair (Ex-officio) Afsheen Davis Libby Viera-Bland
Joint Conference Committee *Comprised of:* *Board Members* *Administration* *Medical Staff*	Dr. Andrea Caracostis (Chair) Board Chair (Ex-officio) Sima Ladjevardian **Joint Conference Committee:** **Non-Board Member Appointees** Chief of Staff – Ben Taub Chief of Staff – LBJ Assistant Chief of Staff – BCM Assistant Chief of Staff – UT Chair – Medical Executive Board Vice Chair – Medical Executive Board Harris Health Chief Executive Officer Harris Health Chief Operating Officer Harris Health Chief Medical Officer Harris Health Chief Medical Officer – ACS
Quality Committee	Dr. Andrea Caracostis (Chair) Board Chair (Ex-officio) Afsheen Davis Dr. Cody M. Pyke Sima Ladjevardian

Thursday, December 12, 2024

Consideration of Approval of the Tentative Harris Health 2025 Board of Trustees Calendar

HARRISHEALTH

2025 Board Calendar

BOARD (9:00 AM-1:00 PM)

JANUARY 23, 2025
FEBRUARY 27, 2025
MARCH 27, 2025
APRIL 24, 2025
MAY 22, 2025
JUNE 26, 2025
JULY 24, 2025
AUGUST 28, 2025
SEPTEMBER 25, 2025
OCTOBER 23, 2025
DECEMBER 11, 2025

SPECIAL CALL BOARD

NOVEMBER 13, 2025 (HRSA)

SPECIAL EVENTS

2025 THT Conference (June 12-14, 2025)

BUDGET WORKSHOP (1:00 PM-3:00 PM)

AUGUST 01, 2025

ASC AT LBJ GOVERNING BODY (9:00-10:00 AM)

FEBRUARY 20, 2025
MAY 15, 2025
AUGUST 21, 2025
NOVEMBER 20, 2025

DC AT QM GOVERNING BODY (10:15-11:15 AM)

FEBRUARY 20, 2025
MAY 15, 2025
AUGUST 21, 2025
NOVEMBER 20, 2025

GOVERNANCE COMMITTEE (11:00 AM-12:00 PM)

FEBRUARY 11, 2025
APRIL 08, 2025
JUNE 10, 2025
AUGUST 12, 2025
OCTOBER 07, 2025

QUALITY COMMITTEE (12:15-1:45 PM)

JANUARY 07, 2025
FEBRUARY 11, 2025
MARCH 11, 2025
APRIL 08, 2025
MAY 06, 2025
JUNE 10, 2025
AUGUST 12, 2025
SEPTEMBER 09, 2025
OCTOBER 07, 2025
NOVEMBER 11, 2025

BUDGET & FINANCE COMMITTEE (9:00-10:00 AM)

FEBRUARY 13, 2025
MAY 08, 2025
AUGUST 14, 2025
NOVEMBER 13, 2025

COMPLIANCE & AUDIT COMMITTEE (10:15-11:45 AM)

FEBRUARY 13, 2025
MAY 08, 2025
SEPTEMBER 11, 2025
NOVEMBER 13, 2025

DEI COMMITTEE (10:30 AM-12:00 PM)

JANUARY 07, 2025
MARCH 11, 2025
MAY 06, 2025
JUNE 12, 2025 (Thursday)
SEPTEMBER 11, 2025
NOVEMBER 11, 2025

JOINT CONFERENCE COMMITTEE (12:00 PM-1:00 PM)

JANUARY 09, 2025(virtual)
MARCH 13, 2025 (virtual)
MAY 08, 2025 (virtual)
SEPTEMBER 11, 2025 (virtual)
NOVEMBER 13, 2025 (virtual)

HARRIS HEALTH HOLIDAY CLOSURES:

01/01/25 (New Year's Day)
01/20/25 (MLK)
05/26/25 (Memorial Day)
06/19/25 (Juneteenth)
07/04/25 (Independence Day)
09/01/25 (Labor Day)
11/27/25 (Thanksgiving)
11/28/25 (Fri. After Thanksgiving)
12/25/25 (Christmas)
01/01/26 (New Year's Day)

Propose to Board: 12.12.24 I Board Approved: *Pending*

2024 Strategic Discussion Reporting Schedule

Strategic Pillar	Executive Owner	JAN 2024	FEB 2024	MAR 2024	APR 2024	MAY 2024	JUN 2024	JUL 2024	AUG 2024	SEP 2024	OCT 2024	NOV 2024	DEC 2024
Pillar 1: Quality & Patient Safety	Dr. Steven Brass												
Rollout of HRO Progress (Presented in Quality Committee)	Dr. Steven Brass			x									
Physician Engagement Survey (Presented in Joint Conference Committee)	Dr. Steven Brass			x									
Just and Accountable Culture	Omar Reid / Dr. Jackie Brock										x		
Pillar 2: People	Omar Reid / Dr. Jackie Brock												
Employee Engagement Survey	Omar Reid / Gary Marsh				x								
Workplace Safety (Presented in the Quality Committee)	Omar Reid / Dr. Jackie Brock										x		
Pillar 3: One Harris Health	Louis Smith												
Hospital at Home - Program Operations	Dr. Amy Smith / Dr. Shazia Sheikh					x							
Pillar 4: Population Health Management	Dr. Jennifer Small / Dr. Chethan Bachireddy												
Systematizing Screening & Referrals for Health-Related Social Needs (HRSN) (Presented in Quality Committee)	Dr. Hope Galvan / Denise LaRue	x											
Community Health Worker Home Visit Program (Presented in Diversity Committee)	Dr. Hope Galvan				x								
Social Determinants of Health: Medical Legal Partnership (Presented in Quality Committee)	Dr. Chethan Bachireddy / Dr. Hope Galvan								x				
Access to Care as a Social Determinant of Health (Presented in DEI Committee)	Dr. Chethan Bachireddy / Dr. Hope Galvan										x		
Pillar 5: Infrastructure Optimization	Louis Smith												
New LBJ Hospital and LBJ Campus Planning	Louis Smith / Trish Darnauer					x							
IT Technology Governance	Louis Smith / Ron Fuschillo						x						
New Hospital Construction and Costs	Louis Smith / Patrick Casey									x			
Pillar 6: Diversity & Inclusion	Omar Reid												
Minority / Women-owned Business Enterprise (MWBE) (Presented in DEI Committee)	Dr. Jobi Martinez / Derek Holmes				x								
M/WBE Annual Report (Presented in DEI Committee)	Dr. Jobi Martinez / Derek Holmes								x				
Overall Strategic Plan													
Harris Health 2021-2025 Strategic Plan Update	Maria Cowles												x

*Subject to Change
Revised: 12.3.24

Thursday, December 12, 2024

Presentation Regarding the Harris Health 2021-2025 Strategic Plan Update

---

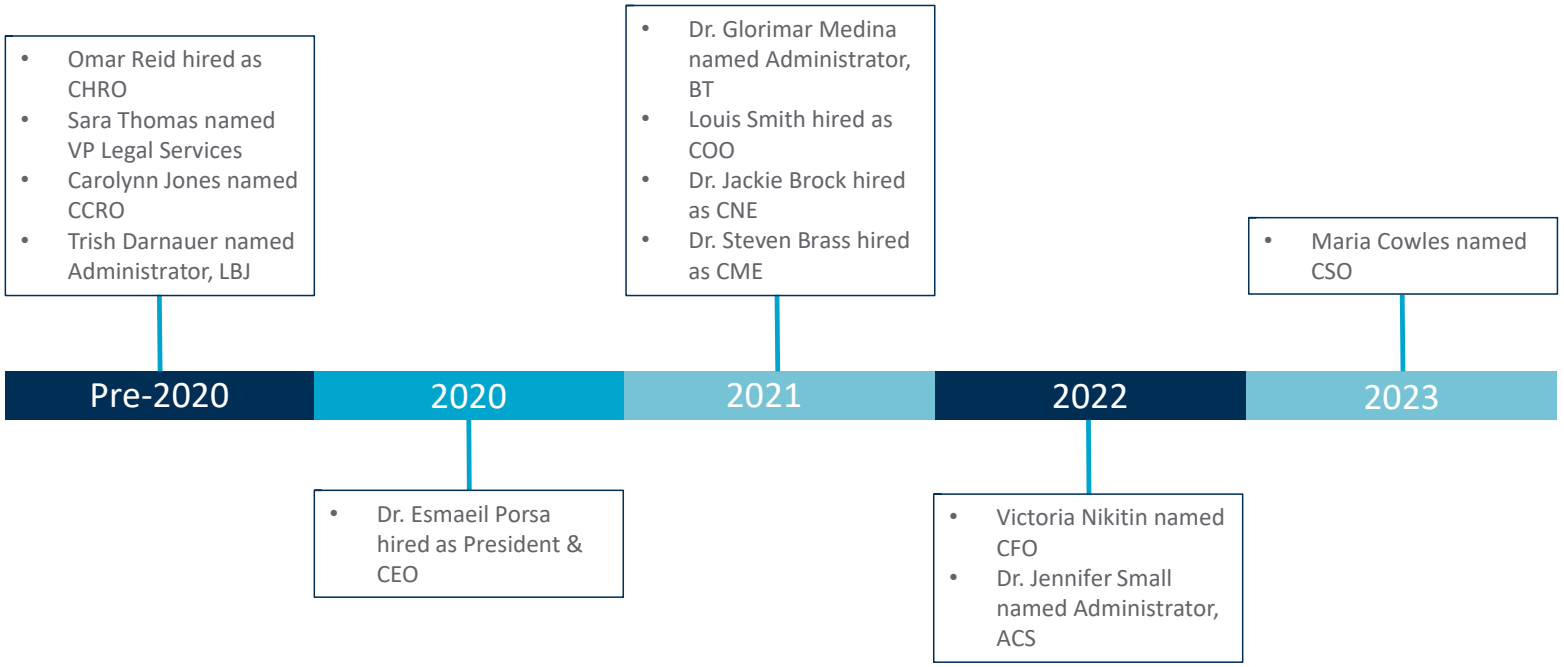
Maria M. Cowles
EVP, Chief Strategy Officer and Chief of Staff

2021 – 2025 Strategic Plan Update

Maria Cowles
Chief Strategy Officer

HARRISHEALTH

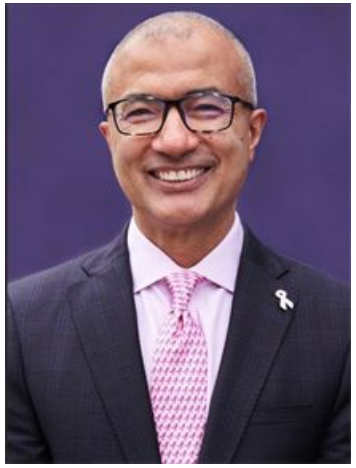
Harris Health Leadership Team Timeline



HARRISHEALTH

Setting the Stage: Harris Health From 2019 – 2020

- In 2019, an adverse safety event leads to an HHSC survey and letter of termination from CMS.
- Harris Health hires two consultants to assist with driving organizational change: Alvarez & Marsal and RELIA.
- Two additional adverse safety events drive more organizational change.
- Harris Health undergoes an intense CMS validation survey with issues identified and plans of correction created.



March 2020: Dr. Esmaeil Porsa joins Harris Health as President & CEO

- Harris Health completes CMS validation survey and deemed status is restored.
- Harris Health undergoes a full CLIA survey with issues identified and plans of correction created.
- Harris Health resolves CLIA findings and restores status.
- COVID pandemic begins.
- Strategic planning for 2021 – 2025 begins.
- A steam line bursts at LBJ, resulting in patient and staff injury.
- Harris Health's Board of Trustees approves Harris Health's 2021 – 2025 strategic plan.

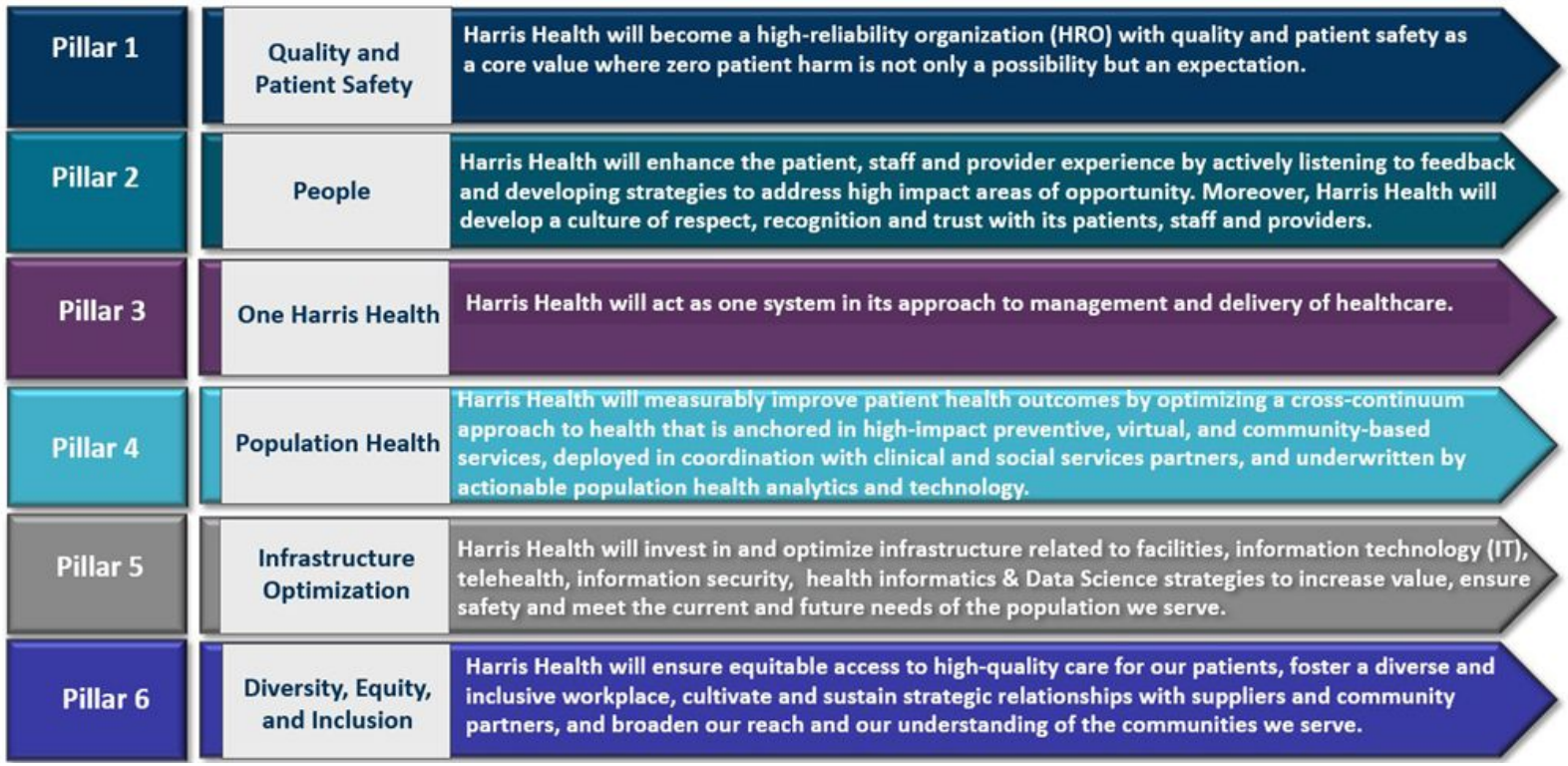
2021 – 2025 Strategic Plan

Many thanks to:

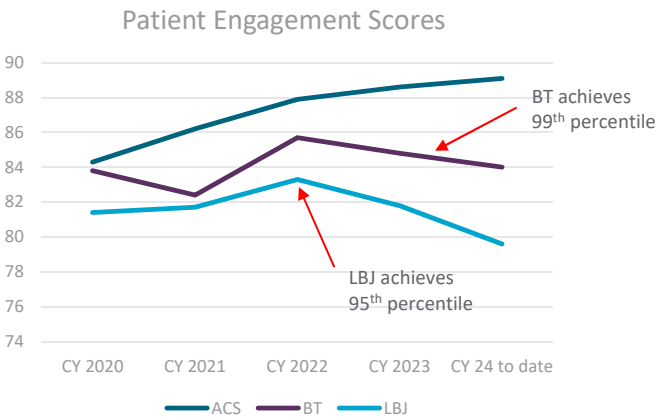
- Dr. Kim Monday, Chair
- Linda Morales, Vice Chair
- Elena Marks, Secretary
- Dr. Art Bracey
- Dr. Andrea Caracostis
- Anne Clutterbuck
- Larry Finder
- Dr. Ewan Johnson
- Alicia Reyes

- The 2021 – 2025 Strategic Plan took 8 months to complete, with another 2 months spent executing the communications plan.
- Feedback was obtained from via an all-employee/medical staff survey, 36 individuals, and 4 subgroups.
- Updates were provided at 5 Board meetings.
- 3 dedicated Board retreats provided a forum for more in-depth discussion.
- The plan was designed to address:
  - ❑ Quality and patient safety
  - ❑ Aging and deteriorating infrastructure
  - ❑ Primary and specialty care access
  - ❑ Non-medical determinants of health
  - ❑ Correctional health care
- The strategic facilities plan and strategic financial plan were developed in support of the strategic plan imperatives.

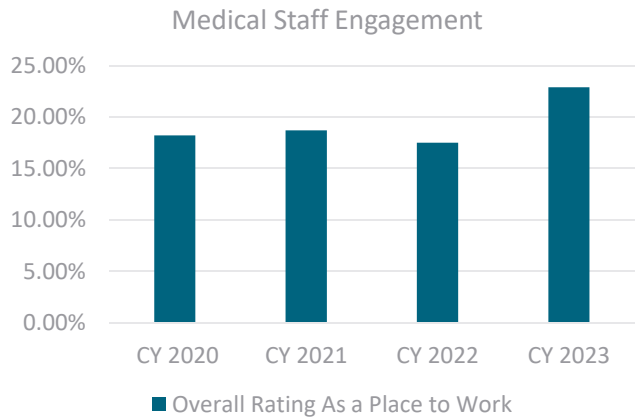
2021 – 2025 Strategic Plan

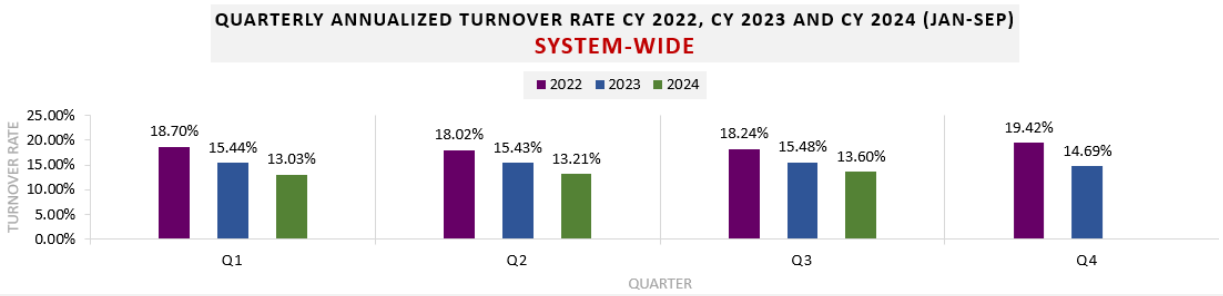


Pillar 2: People



ACS score: "Would Recommend Facility"
BT& LBJ score: HCAHPS Overall Rating





Employee Engagement

- BT and LBJ achieved ANCC Magnet Status in 2020
- ACS achieves Pathways to Excellence in 2023
- Implemented executive rounding program
- Launched eMBA program
- Expanded student debt repayment program
- Two minimum/living wage increases
- Developed Patient Care Assistant and Medical Assistant Programs in partnership with Houston Community College
- Developed Licensed Vocational Nurse Residency Program in ACS and Correctional Health
- Focus on additional residencies: nursing residency and fellowship, nurse externs, diagnostic medical imaging, physical therapy, clinical pastoral education

HARRISHEALTH

Pillar 3: One Harris Health System

72%

Voter Approval Rate

Bond Proposal

- 65 admissions to-date
- 195 bed days saved to-date

Hospital at Home

- 11 specialties performing e-consults with 45,664 performed
- 1,202,369 virtual visits
- Creation of services lines
- Deployment of huddle boards
- Creation of vertical care units and observation units

Additional Efficiency and Throughput Efforts

- Significant focus on labor productivity benchmarking
- Timely vendor payment percentage increased from 73% in FY23 to 86% FY24 YTD.
- Expansion of 340B program to HCJ and ASC

Financial Stability

Pillar 4: Population Health Management

Strawberry Health Center
May 2019

LBJ Hospital Campus
May 2021

FOOD Rx

Food Farmacy @ Settegast, El Franco, Gulfgate & MLK
Community Redemption @ Squatty Lyons & Cypress
Food Lockers @ Casa and Thomas Street at Quentin Mease
Coming Soon 2024 / 2025

August 2020
Acres Home Health Center

April 2023
Baytown Health Center - Hearts and Hands of Baytown Partnership

Food Farmacy Metrics
May 28, 2019 – June 30, 2024

Pillar 4: Population Health Management

Multi-Visit Patient (MVP) Program

- During the first two years of the program, annual MVP Emergency Department (ED) visits decreased more than 10% each year while total ED visits were increasing 4-5% per year.
- Three years into the program, the annual MVP visit count is down 23.2% (more than 1,500 visits per year) from baseline.
- These decreases in MVP visits have been mirrored by similarly substantial decreases in total length-of-stay hours among MVP patients, which have decreased 16,000 hours per year, down 36% from baseline.

Community Health Worker Program

Lives Impacted	Baseline A1c	Endline A1c	Change in A1c	% Reengaged with PCP	% Reengaged with Ancillary Services
520 Unique Patients	11.1%	8.7%	-2.4%	78% of patient	71% of patients

9

October 2023 – September 2024

HealthyConnect Remote Patient Monitoring

- Since April 2022, HealthyConnect has enrolled 3,384 patients who have received over 294,000 automated text messages and 34,000 phone calls.
- HealthyConnect enrolled historically marginalized patients – 49% Black and 45% Hispanic patients - taking a step towards addressing the inequities in blood pressure control rates between Hispanic and Black patients compared to our White patients.
- Since program launch, 1,587 patients have graduated with an average engagement of seven months. At baseline, the average blood pressure was 150/84 mmHg. After graduation, the average blood pressure was 128/75 mmHg.
- HealthyConnect initially launched in the three lowest-performing clinics, all of which had blood pressure control rates ranging from 44.2-55.9%. Now those three clinics have greatly improved their blood pressure control, with rates ranging from 61.3 – 68.7%.

HARRISHEALTH

Pillar 5: Infrastructure Optimization

LBJ Campus

Estimated Scope	Start Design/Assessment	Start Procurement	Start Construction	Estimated Duration
LBJ Hospital Expansion Project	2022 Q4	2023 Q4	2024 Q2	48 months
LBJ Legacy Project	2025 Q1	2026 Q4	2027 Q2	60 months
LBJ New Outpatient MOB	2028 Q3	2029 Q3	20230 Q1	24 months

Ben Taub Campus

Estimated Scope	Start Design/Assessment	Start Procurement	Start Construction	Estimated Duration
BT ICUs - 4 Phases	2023 Q4	2024 Q3	2025 Q1	48 months
BT Ancillary/Operation Support Areas	2023 Q4	2024 Q3	2025 Q1	30 months
BT Infrastructure (Mechnical, Electrial, Plumbing)	2023 Q4	2024 Q2	2024 Q4	36 months
BT Sanitary Sewer Pipe	2024 Q1	2024 Q3	2025 Q1	30 months
BT Expand Telemetry Capability for all Beds	2024 Q1	2024 Q2	2024 Q4	12 months
BT Women and Infant Services	2024 Q4	2025 Q3	2026 Q1	36 months
BT Bed Tower (120 Beds)	2025 Q4	2026 Q4	2027 Q2	36 months

Ambulatory Care Services

Estimated Scope	Start Design/Assessment	Start Procurement (Bidding)	Start Construction	Estimated Duration
Roofing/HVAC Refresh through all the ACS Facilities (Over 10 years)	2023 Q3	2023 Q4	2024 Q1	120 months
Sunset Heights Same Day Clinic (Expansion Build on Casa Property)	2024 Q1	2024 Q4	2025 Q2	24 months
Radiology/Radiation Therapy Modality refresh (Smith Clinic)	2024 Q4	2025 Q1	2025 Q2	96 months
Health Center Pasadena (Centrico) (Already in motion in partnership with Harris County)	2024 Q1	2024 Q4	2025 Q2	24 months
Vallbona Main Renovation, Campus, Annex/Robindell Same Day Clinic	2025 Q1	2025 Q4	2026 Q2	24 months
Harris Health Garage (Serving BT, QM, Smith)	2025 Q4	2026 Q4	2027 Q2	22 months
Net New Health Center (Number 1)*	2026 Q1	2026 Q4	2027 Q2	24 months
Health Center (Cypress) (Renovation/Expansion)	2026 Q3	2027 Q2	2027 Q4	14 months
Age Facility Replacement/Expansion - Acres Home	2027 Q1	2027 Q4	2028 Q2	24 months
Net New Health Center (Number 2)*	2028 Q2	2029 Q1	2029 Q3	24 months
Net New Health Center (Number 3)*	2029 Q1	2029 Q4	2030 Q2	24 months
Mobile Mammo Van (Refresh in 7-8 years)	2029 Q4	2030 Q1	2030 Q3	12 months
Age Facility Replacement - Gulfgate	2030 Q3	2031 Q3	2032 Q1	24 months

*Net New Health Centers will be located one each in precincts 2, 3 and 4 in the Harris Health Identified Area of Need

HARRISHEALTH

Pillar 5: Infrastructure Optimization

LBJ Campus Expansion

Quentin Mease Renovation

Ben Taub Expansion

HARRISHEALTH

Pillar 5: Infrastructure Optimization

New Central Fill Pharmacy: 10/24 Kickoff

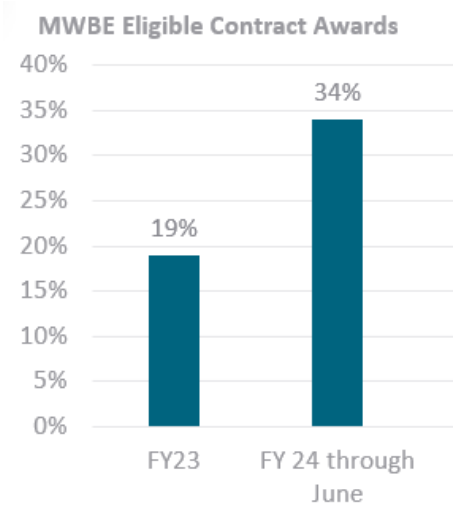
Sunset Heights (Casa Campus): In Validation

New Pasadena Clinic (Centrico): In Design

Vallbona/Robindell: In Validation

HARRISHEALTH

Pillar 6: Diversity, Equity and Inclusion



66 outreach events

MWBE Awards

FY 23: $45,810,075	FY 24 through June: $70,744,899

MWBE Payments

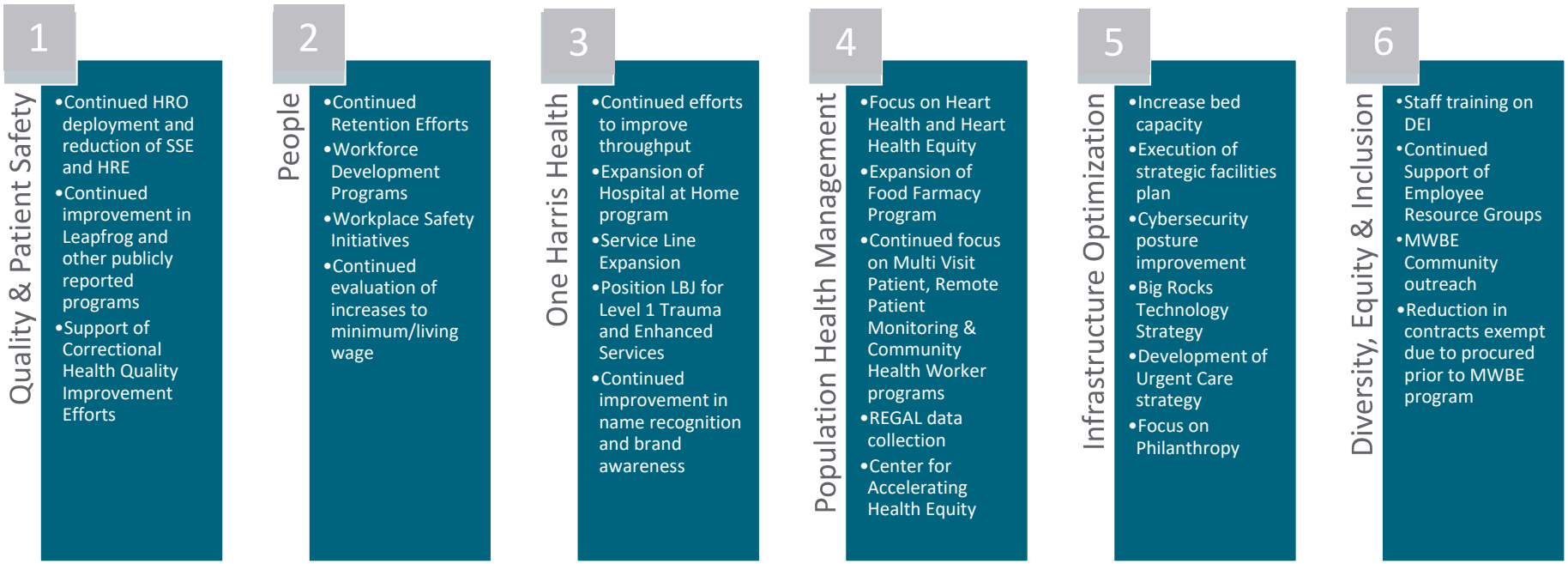
FY 23: $17,672, 998	FY 24 through June: $14,930,597

DEI Program Highlights

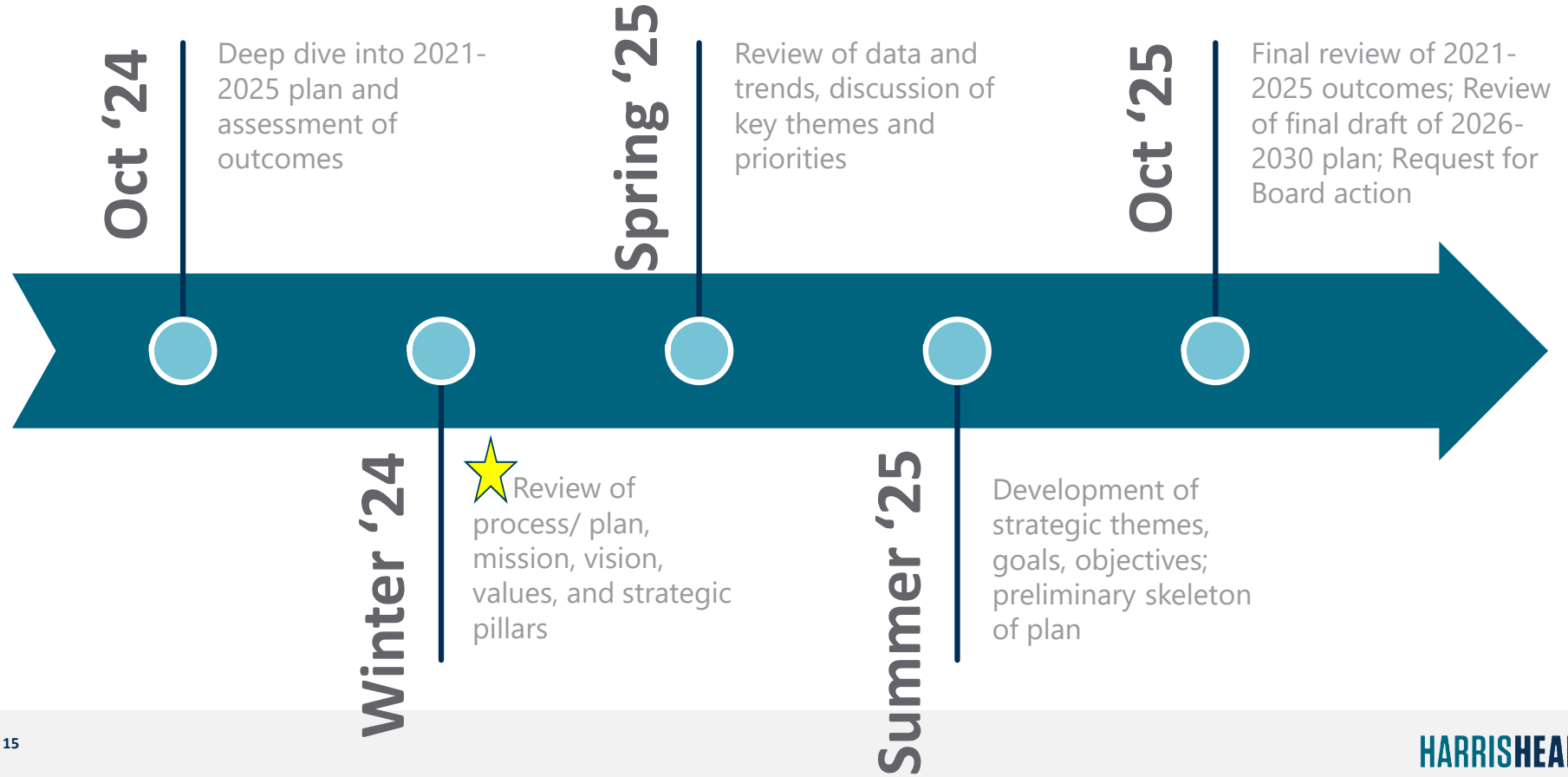
- Hired first Chief Diversity Officer
- Launched DEI Grand Rounds in partnership with Baylor College of Medicine
- Implemented Health Equity Speaker Series
- Developed 7 Employee Resource Groups
- Formed DEI Board Committee

2023 Employee Engagement Survey

Ongoing Strategic Efforts



2026 – 2030 Strategic Planning Process



HARRISHEALTH

Thursday, December 12, 2024

Presentation Regarding Governance Structure of the Patient and Family Advisory Council (PFAC)

Jennifer Small, AuD, MBA, CCC-A
EVP / Administrator, Ambulatory Care Services

Council at Large to PFAC Transition

HARRISHEALTH

PFAC model – Patient and Family Advisory Council

- The mission of the PFAC is to empower our patients and families to become our partners in care to ensure a patient experience that exceeds expectations, provides the ultimate value to our patients and delivers the best possible outcomes

- A consistent and established platform for patients and families to offer input and perspectives impacting all aspects of healthcare which is endorsed by Center for Medicare & Medicaid Services (CMS) and in alignment with Harris Health Strategic Pillars 2 (People) and 3 (One Harris Health)

- An industry best practice for “hearing the voice of the patient” to promote productive, bilateral communication in support of healthcare initiatives like Leapfrog, Magnet, Medical Home, etc.

PFAC Strategy - Current

- The PFAC approach currently exits in the acute Hospital services for consistency in those areas – One Harris Health
- PFAC – Acute care operations is comprised of councils at LBJ and BT Hospitals
- PFAC Scope
  - Includes a forum for “hearing the voice of the patient” promoting productive bilateral communication
- PFAC Membership
  - Includes patients and family members that have been served by our hospitals

Hospital PFAC Contribution Highlights

- Patient Committee for Safe and Quality Care
  - Colo-rectal cancer screening
  - Inpatient falls related to toileting
  - Addressing elopement
- Patient Experience Collaborative
  - Discharge Folder
  - Commit to Sit
- Remote Patient Monitoring
  - Provided input on patient materials and equipment used to learn if tracking chemotherapy symptoms at home may improve outcomes
- LBJ Expansion
  - Ongoing meetings, feedback and dialogue with architects and leaders
- Ben Taub EC Construction
  - ADA compliance opportunities for restrooms
  - Bilingual wayfinding signage and placement

HARRISHEALTH

PFAC System-wide Strategy

- Create Ambulatory Care Services (ACS) PFAC model that resembles the Hospital PFACs thus creating consistency throughout our system – One Harris Health
  - Expanding engagement throughout the entire system to include the ambulatory setting
  - Creating partnerships between patients, families, staff and administration to channel information, needs and concerns in support of strategic plan
  - Building structured opportunities for staff to learn from patients, families and community members

PFAC Governance

- ACS Administration drives agenda with focus on areas where ACS patient and family member engagement is necessary and valuable
- Membership
  - Current ACS patients and family members
  - Consists of executive leadership from ACS
  - Patient Experience leaders
  - Patient and Nursing co-chairs
- Meeting cadence
  - Hold 10 out of 12 months
  - Duration up to 90 minutes
  - Hybrid: Virtual and in person
  - Ad Hoc participation on additional committees as requested by leadership

ACS PFAC Governance

- ACS patients and family members are selected after:
  - Thorough review process after nomination by clinic staff or patient/family member self nomination
  - Application, background check, interview with existing leaders and members
- ACS PFAC members will serve for a term of two years with option to renew for up to three additional terms
- Member Expectations:
  - Regular attendance (>50%)
  - Actively engaged: Ask questions, provide open and honest feedback and contribute ideas during discussions
- Recruitment and appointment of members is ongoing
- Orientation and training of ACS PFAC members includes review of
  - Roles and responsibilities, HIPAA and confidentiality agreement
  - Annual mandatory refresher conducted

Next Steps

- Administration recommends the creation of a Patient and Family Advisory Council for Ambulatory Care Services, January 2025

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, December 12, 2024

November Committee Reports

November Committee Meetings:

- Governance Committee – November 12, 2024
  - Presentation Regarding Parliamentarian Training: Rules of Debate
  - Discussion Regarding Nomination of Board Officers Process
  - Discussion Regarding Videoconferencing Rules for Board Member Remote Participation in Board Meetings
  - Discussion Regarding Governance Structure of the Patient and Family Advisory Council (PFAC)
- Quality Committee – November 12, 2024
  A summary was attached for your review.
  - High-Reliability Organization (HRO) Recognition
  - Harris Health Safety Message: Minute for Medicine Video
    - Catheter Associated Urinary Tract Infection (CAUTI)
  - Presentation Regarding Harris Health's Annual Research and Quality Improvement Projects Report
- Budget & Finance Committee – November 14, 2024
  - Review of the Harris Health Fourth Quarter Fiscal Year 2024 Investment Report
  - Review of the Harris Health Third Quarter Calendar Year 2024 Pension Plan Report
  - Review of the Harris Health September 2024 Financial Report Subject to Audit
- Compliance & Audit Committee – November 14, 2024
  - Presentation Regarding the Harris Health Independent Auditor's Pre-audit Communication for the Year Ended September 30, 2024
  - Presentation Regarding the Harris Health Internal Audit Annual Update for the Period October 1, 2023 through September 30, 2024
  - Review of the Harris Health Fiscal Year 2025 Internal Audit Charter to the Harris Health Board of Trustees
- Joint Conference Committee – November 14, 2024
  - Physician Leadership Reports
  - Presentation Regarding Medical Staff Engagement Advisory Council & Related Physician Engagement Activities

Board of Trustees – Executive Summary
Patient Safety & Quality Programs – Open Session Presentations
December 12, 2024

Please refer to the reports presented at the Quality Committee Open Session on November 12, 2024 for additional details.

Awards Presentation

Pavilion Leaders received HRO Leadership awards.

HRO Safety Message – Video: Catheter Associated Urinary Infections (CAUTI)

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. Five principles of a High Reliability Organization (HRO) are: (1) Preoccupation with failure; (2) Reluctance to simplify interpretations; (3) Sensitivity to operations; (4) Commitment to resilience; and (5) Deference to expertise.

Annual Research & Quality Improvement Projects Report

The annual Harris Health Report on the Status of Human Subjects Research and Quality Improvement Projects conducted at Harris Health was presented for informational purposes. The rationale and development of the new Quality Improvement Project Review policy was discussed. The purpose, methods, major findings, conclusions and recommendations were shared from two research studies and one quality improvement project that were conducted at Harris Health facilities. These chosen projects reflect the inclusion and participation of the diverse community that Harris Health serves and ensures the equity of access for Harris Heath patients to research studies.

Paige McInnis
Harris County Purchasing Agent

November 20, 2024

Board of Trustees Office
Harris Health

RE: Board of Trustees Meeting – December 12, 2024
Budget and Finance Agenda Items

The Office of the Harris County Purchasing Agent recommends review of the attached procurement actions:

A. Expenditure Summary: Items for board approval
B. Expenditure Summary: Items for transmittal (information only, no action requested)
C. Transmittal of Supplier Annual Spend Report FY 2024 (information only, no action requested)

All recommendations are within the guidelines established by Harris County and Harris Health.

Sincerely,

Paige McInnis

Paige McInnis
Purchasing Agent

JA/ea
Attachments

1111 Fannin Street, 12th Floor, Houston, TX 77002 Tel 713-274-4400 Fax 713-755-6695

Budget and Finance Agenda Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

Expenditure Summary: December 12, 2024 (Approvals)

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A1	**McCarthy Building Companies, Inc.** MWBE Goal: 35%	**Construction Manager at Risk for the Construction of the Lyndon B. Johnson Hospital Replacement Project for Harris Health** - provides construction services for the LBJ replacement project. The owner contingency provides for coverage on unanticipated costs throughout the construction project. ***Job No. 23/0368, Board Motion 24.05-105***	Additional Funds	Patrick Casey	$ 358,801,674	**$ 639,702,700**
A2	**Tellepsen Builders, L.P.** MWBE Goal: 35%	**Construction Manager at Risk for the Construction of the Lyndon B. Johnson Hospital Replacement Project for Harris Health** - provides construction services for the expansion of the new central utility plant at Lyndon B. Johnson replacement project. The owner contingency provides for coverage on unanticipated costs throughout the construction project. ***Job No. 230419, Board Motion 24.07-105***	Additional Funds	Patrick Casey	$ 69,636,534	**$ 82,618,923**
A3	**Vaco, LLC DBA Pivot Point Consulting (HCHD- 1395)** MWBE Goal: 16%	**Information Technology Consulting and Staff Augmentation Services** - Additional funds are needed to cover anticipated additional staff augmentation for new IT projects for Harris Health. ***Job No. 24-0174, Board Motion 24.09-135***	Additional Funds August 21, 2024 through August 20, 2025	Ronald Fuschillo	$ 2,150,000	**$ 3,455,120**
A4	**Metropolitan Life Insurance Company (HCHD-927)** MWBE Goal: N/A Contract was procured prior to MWBE program	**Basic and Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance for Harris Health System** - The additional funds are needed to cover increase of life insurance coverage for Harris Health. ***Job No. 220341, Board Motion 23.03-41***	Ratify Additional Funds March 01, 2023 through September 30, 2024	Omar Reid	$ 5,300,636	**$ 1,500,000**
A5	**New York Life Insurance Company dba Life Insurance Company of North America (HCHD- 1170)** MWBE Goal: 6%	**Employee Benefits Coverage and Benefits Administration Services for Harris Health System** - The additional funds are needed to cover an increase of employee benefit coverages for Harris Health. ***Job No. 230212, Board Motion 24.01-10***	Additional Funds January01, 2024 through December 31, 2024	Omar Reid	$ 2,200,000	**$ 800,000**
A6	**Healthstream, Inc. (HCHD-516)** MWBE Goal: Exempt Sole Source	**Competency Development System for Harris Health** - To continue to provide an on-line competencyassessment using videos and clinical scenarios to determine the level of registered nurses' abilityto think criticallyand applyclinical judgment when caring for their patient population. ***Sole Source Exemption, Board Motion 24.01-10***	Renewal Sole Source Exemption January01, 2025 through December 31, 2025	Lourdes Moore Alicia Hernandez	$ 313,890	**$ 316,961**
A7	**Epic Systems Corporation (GA-04577)** MWBE Goal: Exempt Sole Source	**Epic VoIP (Voice over Internet Protocol) Subscription for Harris Health** - To provide services which will allow users of Epic Rover, Epic Haiku, and Epic Canto mobileapplications to call one another without a cellular connection using cloud services from directlywithin the application. This service is part of the “Big Rocks” approved Rover and Unified Communications Project. ***Sole Source Exemption***	Purchase Sole Source Exemption	David Burnett		**$ 314,100**
A8	**Bruker Scientific, LLC** MWBE Goal: Exempt Sole Source	**Maintenance Service Agreement for Harris Health** - To provide maintenance and service for Harris Health owned equipment used to perform mycobacterial testing and identification at LBJ Hospital. ***Sole Source Exemption***	Purchase Sole Source Exemption Seven-year initial term	James Young		**$ 254,520**
					Total Expenditures	$ 728,962,324
					Total Revenue	(0)

Budget and Finance Agenda Items for the Harris County Hospital District dba Harris Health System - Board of Trustees Report

Expenditure Summary: December 12, 2024 (Transmittals)

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B1	**McCoy Rockford, Inc. (TXMAS-24-42504)** MWBE Goal: 0% Drop Shipped	**Office Furniture** - To provide new furniture under the HHS FURNITURE REFRESH PROJECT-24-8F00124. McCoy Rockford, Inc. will be providing Steelcase manufactured furniture for patient rooms and guest areas. ***Texas Multiple Award Schedule (TXMAS) Cooperative Program***	Purchase Low quote	Teong Chai		**$ 6,587,927**
B2	**Olympus America (PP-OR-2312)** MWBE Goal: Exempt GPO	**Surgical Endoscopy - Flexible** - To add sixty-six (66) gastrointestinal (GI) video endoscopy units to meet the required operational needs of the new GI outpatient endoscopy suite at Quentin Mease. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 3,131,000**
B3	**Stryker Medical (PP-NS-1569)** MWBE Goal: Exempt GPO	**Stretchers** - This procurement is to replace two hundred and six (206) stretchers that are past their life expectancy at Ben Taub and LBJ Hospitals. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 2,792,000**
B4	**Hologic Sales and Service, LLC (PP-IM-295)** MWBE Goal: Exempt GPO	**Mammography Products and Services** - To replace six (6) 3Dimension mammography systems past their expected useful life at Smith Clinic. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 2,532,424**
B5	**Olathe Ford Sales Inc** MWBE Goal: 0% Drop Shipped	**Fleet Chasis** - The CFY24 Fleet Refresh project will replace old fleet vehicles throughout Harris Health. This purchase will replace 28 vehicles. ***Sourcewell***	Award Best quote meeting specifications	Peka Owens		**$ 1,880,000**
B6	**Olympus America (PP-OR-2312)** MWBE Goal: Exempt GPO	**Surgical Endoscopy - Flexible** - To replace thirty-seven (37) gastrointestinal (GI) video endoscopy units that are past their life expectancy and add four (04) new units at Ben Taub and LBJ Hospitals. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 1,750,600**
B7	**Mark III Systems, Inc** MWBE Goal: 0% Non-Divisible	**IBM Power FlashSystem hardware, software, and support** - To provide IBM Power FlashSystem hardware, software, and support to streamline cloud deployments and power mission-critical Harris Health applications ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Purchase Only quote One (1) year initial term	Antony Kilty		**$ 1,675,000**
B8	**Letourneau Interests, Inc. (PP-FA-2033)** MWBE Goal: Exempt GPO	**Furniture and Systems, Seating and Accessories** - To provide new furniture under the HHS FURNITURE REFRESH PROJECT - 24-8FN00124. Letourneau Interests, Inc. will be providing Stance manufactured tables and physician stools. ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer	Teong Chai		**$ 1,588,358**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B9	**Carefusion Solutions, LLC (HCHD-294) (PPPH28CFS01)** MWBE Goal: Exempt GPO	**Pharmacy Automated Medication Dispensing System for Harris Health** - Additional funds are required to cover all past due invoices and continue software maintenance and support services for Harris Health owned and leased automated supply cabinets. ***Premier Healthcare Alliance, L.P. Contract, Board Motion 23.09-146***	Additional Funds October 01, 2023 through September 30, 2024	Jian Zhou	$ 1,849,279	**$ 1,587,160**
B10	**Philips Healthcare (PP-IM-282)** MWBE Goal: Exempt GPO	**General Radiography** - To replace five (05) radiographic systems that are past their life expectancy throughout Harris Health. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 1,370,000**
B11	**CDW LLC** MWBE Goal: Exempt GPO	**Ergotron Carts for Harris Health** - To provide medical carts that will serve as workstations on wheels for Harris Health. ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer	Tai Nguyen		**$ 1,243,051**
B12	**Mark III Systems, Inc** MWBE Goal: 0% Non-Divisible	**IBM Storage Area Network (SAN) hardware, software, and support** - To provide IBM SAN hardware, software, and support of Harris Health's storage area network ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Purchase Only quote Three-year initial term	Antony Kilty		**$ 1,108,000**
B13	**Sequel Data Systems, Inc (DIR-TSO-4160)** MWBE Goal: 100%	**Hewlett Packard Enterprise Company storage hardware, software, and support services for Epic and Clinical Systems infrastructure** - To provide Hewlett Packard Enterprise Company storage hardware, software, and support services for Harris Health's Epic and clinical systems infrastructure ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Low quote One (1) year initial term	Antony Kilty		**$ 1,103,000**
B14	**Model 1 Commercial Vehicles, Inc. dba Creative Bus Sales, Inc.** MWBE Goal: 0% Drop Shipped	**Buses - Shuttles, Transits, Trams, & Other Specialty Buses** - To add five (5) shuttle buses to the Harris Health Park and Ride program. ***Houston-Galveston Area Council (H-GAC) Cooperative Purchasing Program***	Purchase Low quote	Timothy Brown		**$ 1,099,925**
B15	**Steris Corporation (PP-OR-1951)** MWBE Goal: Exempt GPO	**OR Lights and Booms** - To replace the ceiling mounted surgical lights, anesthesia booms, and equipment booms that are past their life expectancy at LBJ. Estimated amount includes delivery, installation, and removal services. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 960,000**
B16	**Stryker Sales, LLC (PP-CA-526)** MWBE Goal: Exempt GPO	**External Defibrillators and Related Products** - To replace forty (40) defibrillators that are past their life expectancy at Ben Taub & LBJ Hospitals, and Smith Clinic. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 860,000**
B17	**Hill-Rom Company, Inc. (PP-NS-1577)** MWBE Goal: Exempt GPO	**Patient Beds, Mattresses and Therapeutic Surfaces – Purchase** - To replace eighty (80) medical surgical beds that are past their expected useful life at Ben Taub and LBJ Hospitals. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 833,423**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B18	**Belmont Instrument, LLC dba Belmont Medical Technologies (PP-OR-2418)** MWBE Goal: Exempt GPO	**Patient Warming – Blood and Fluid Warming** - Belmont will supply twenty three (23) rapid infusers for Ben Taub and LBJ Hospitals as well as the Ben Taub Cath Lab. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 807,261**
B19	**Pivot Technology Services Corporation** MWBE Goal: 0% Non-Divisible	**NetApp upgrade of hardware, software and support** - To provide NetApp upgrade to software, hardware, and support for Harris Health data storage management and data protection ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Low quote One (1) year initial term with one (1) one-year renewal options	Antony Kilty		**$ 636,400**
B20	**Philips Healthcare (PP-NS-1948)** MWBE Goal: Exempt GPO	**Physiological Monitoring Systems** - To add eleven (11) physiological monitoring equipments to meet the patient care needs as part of relocation and expansion of CATH Lab at Ben Taub Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 508,300**
B21	**Mark III Systems, Inc.** MWBE Goal: 0% Drop Shipped	**IBM Power 10 Compute Nodes** - Replacing 7-year-old infrastructure at the Harris Health Houston and Bryan data centers with two IBM Power 10 compute nodes. ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Only quote	A. Kilty		**$ 446,408**
B22	**Philips Healthcare (PP-IM-287)** MWBE Goal: Exempt GPO	**Ultrasound** - This project is to replace two (02) echo ultrasound machines (EPIQ CVx) that are past their life expectancy with new units at Ben Taub hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 439,800**
B23	**Mark III Systems - Government Solutions, LLC (DIR-TSO-3763)** MWBE Goal: 100%	**VSan hardware, software, and support** - To provide vSan software, hardware, and support of Dell PowerEdge servers needed to maintain the Harris Health network ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Purchase Only quote Three-year initial term	Antony Kilty		**$ 347,000**
B24	**Stryker Sales, LLC dba Stryker Instruments (AD-OR-2032)** MWBE Goal: Exempt GPO	**Orthopedic Power Tools and Accessories** - To replace bone surgical drills that are past their life expectancy and are no longer supported by the manufacturer at LBJ Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Single Source ASCEND Contract	Arun Mathew		**$ 344,000**
B25	**Trace3 LLC (DIR-TSO-4361)** MWBE Goal: 0% Non-Divisible	**CyberArc security software license** - To provide CyberArc identity and access management security software to protect Harris Health against unauthorized network access ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Only quote One (1) year initial term with one (1) one-year renewal options	Tom Oduor		**$ 334,500**
B26	**GE OEC Medical Systems, Inc. (PP-IM-268)** MWBE Goal: Exempt GPO	**Mobile C-arms** - To add one (1) new mobile c-arm with vascular software package to the interventional radiology department at LBJ Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 286,156**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B27	**Crown Castle USA Inc (GSA-35F-465DA)** MWBE Goal: 0% Non-Divisible	**Crown Castle to replace existing ATT and Lumen Circuits** - Crown Castle will provide three new circuits for Ben Taub, Fournace, and LBJ to enhance network redundancy for Harris Health's data centers. The new circuits will replace two expiring AT&T circuits and one Lumen circuit. ***Government Services Administration (GSA) Cooperative Purchasing Program***	Award Only quote Three-year initial term	Mohammad Manekia		**$ 270,000**
B28	**Facility Interiors, Inc. (PP-FA-2016)** MWBE Goal: Exempt GPO	**Furniture and Systems, Seating and Accessories** - To provide new furniture under the HHS FURNITURE REFRESH PROJECT - 24-8FN00124. Facility Interiors, Inc. will be providing Kwalu manufactured gliders for Labor & Delivery units as well as Neonatal Intensive Care units. ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer	Teong Chai		**$ 256,732**
B29	**Pineapple Contracts, Inc. (TIPS Contract 230301)** MWBE Goal: 0% Drop Shipped	**Furniture, Furnishings, and Services** - To provide new furniture for the FY24 HHS Furniture Lifecycle. Pineapple Contracts, Inc. will be providing Behavorial Health furniture for the In-Patient Unit at Ben Taub NPC. ***The Interlocal Purchasing System (TIPS)***	Award Only quote	Teong Chai		**$ 251,424**
B30	**Draeger Inc.** MWBE Goal: Exempt GPO	**Anesthesia Equipment, Accessories and Supplies** - To add three (3) anesthesia gas vaporizer units at Ben Taub Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 246,516**
B31	**SonoSite (PP-IM-317)** MWBE Goal: Exempt GPO	**Ultrasound Equipment** - To replace three (3) point of care ultrasound machines that are past their expected useful life with new equipment at Ben Taub Hospital Emergency Department. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 239,000**
B32	**Medtronic USA, Inc.** MWBE Goal: Exempt Sole Source	**Maintenance and Software Service Support for Harris Health** - To provide maintenance and software service support for the O-Arm Imaging System unit at Ben Taub Hospital. ***Sole Source Exemption***	Purchase Sole Source Exemption Three-year initial term	James Young		**$ 234,000**
B33	**Mark III Systems - Government Solutions, LLC (DIR-TSO-4288)** MWBE Goal: 100%	**VMWare Cloud Foundation 5 License** - To provide VMWare Cloud Foundation 5 to support Epic ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Only quote One (1) year initial term with one (1) one-year renewal options	Antony Kilty		**$ 218,500**
B34	**Alacrinet Consulting Services, Inc** MWBE Goal: 0% Non-Divisible	**IBM QRadar software, hardware, and support for security incident and event monitoring** - To provide upgrade to software, hardware and support to manage Harris Health's network security ***OMNIA Partners, Public Sector Cooperative Purchasing Program***	Award Low quote One (1) year initial term	Tom Oduor		**$ 216,610**
B35	**Nelson Mullins Riley & Scarborough LLP (HCHD-1474)** MWBE Goal: 0% Specialized, Technical, or Unique in Nature	**Special Counsel for Harris Health** - To provide special counsel to Harris Health related to AI governance matters. ***Professional Services Exemption***	Award Professional Services Exemption One (1) year initial term with two (2) one-year renewal options	L. Sara Thomas		**$ 200,000**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B36	**Midmark Corp. through Henry Schein (PP-FA-1072)** MWBE Goal: Exempt GPO	**Exam Room Furniture Equipment** - To replace twenty eight (28) exam tables that are past their expected useful life throughout various ACS clinics within Harris Health. ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer	Arun Mathew		**$ 197,891**
B37	**Edwards Lifesciences, LLC** MWBE Goal: Exempt Sole Source	**Cardiac Output Monitors for Harris Health** - To add three (3) new cardiac output monitors for Ben Taub Cath Lab expansion project. ***Sole Source Exemption***	Purchase Sole Source Exemption	Arun Mathew		**$ 197,085**
B38	**Carefusion Solutions, LLC (PPPH28CFS01)** MWBE Goal: Exempt GPO	**Equipment Purchase and Support - Operating Room (OR) Satellite Pharmacy Project for Ben Taub Hospital** - OR Satellite Pharmacy at Ben Taub Hospital will be relocating to a smaller footprint and pyxis equipment added to the OR will provide medication inventory readily available and closer to the point of care for patients. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Contract(s)	Jabeen Pattassery John David Wilson		**$ 193,425**
B39	**Medtronic USA, Inc.** MWBE Goal: Exempt Sole Source	**NIM Vital System for Harris Health** - To replace the NIM Vital Systems that are past their life expectancy at Ben Taub & LBJ Hospitals. ***Sole Source Exemption***	Purchase Sole Source Exemption	Arun Mathew		**$ 192,000**
B40	**Global Healthcare Exchange, LLC (HCHD-1491)** MWBE Goal: Exempt Sole Source	**eCommerce Procurement Cycle Solutions and Subscription Services for Harris Health** - To provide eCommerce solutions including but not limited to transaction automation, order analytics, electronic invoice processing, item formulary management, consignment bill only workflow, increased visibility and standardization, etc. Subscriptions include TradingNet, Contract Center Xpert, Provider Exchange, MetaTrade, Provider Intelligence, Market Place, OnDemand AP, and Clinical ConneXion. ***Sole Source Exemption***	Purchase Sole Source Exemption One (1) year initial term with two (2) one-year renewal options	Joemon James Jacob Titus Kris Jackson Anil George		**$ 186,189**
B41	**Abbott Laboratories, Inc. (HCHD-001063)** MWBE Goal: Exempt Public Health or Safety	**Cardiac Rhythm Management Products for Harris Health** - Additional funds are required to provide additional cardiac rhythm management products for Harris Health. ***Public Health or Safety Exemption, Board Motion 24.01-10***	Additional Funds Public Health or Safety Exemption March 16, 2024 through March 15, 2025	Charles Motley	$ 697,549	**$ 185,600**
B42	**Vyaire Medical Inc (PP-NS-1815)** MWBE Goal: Exempt GPO	**Ventilators** - To replace seven (07) bi-level positive airway pressure (BiPAP) machines at Ben Taub that are no longer supported by the manufacturer. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 183,000**
B43	**Carefusion Solutions, LLC (PPPH28CFS01)** MWBE Goal: Exempt GPO	**Equipment Purchase and Support - Ben Taub Hosipital Cath Lab Expansion Project** - Pyxis Anesthesia Stations and Pyxis Machinery needed to meet anesthesia and nursing medication needs for patients in the new Cath lab PACU area. Ben Taub will expand from 2 Cath lab rooms on the 6th floor to 3 Cath lab rooms on the 2nd floor, and a PACU will be added. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	David Wilson Jabeen Pattassery John		**$ 178,720**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B44	**Boehringer Laboratories, LLC (PP-FA-1041)** MWBE Goal: Exempt GPO	**Medical Gas Pipeline Equipment, Service and Accessories** - Boehringer will supply Harris Health with suction regulators, components, and fittings to be used at Ben Taub Cath Lab and LBJ Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Tim Tatum		**$ 174,734**
B45	**Johnson and Johnson Health Care (HCHD- 1390)** MWBE Goal: 0% Specialized, Technical, or Unique in Nature	**Ophthalmology Products** - To provide Harris Health with ophthalmology products. ***Public Health or Safety Exemption***	Award Public Health or Safety Exemption One-year initial term with two (2) one-year renewal options	Charles Motley		**$ 172,612**
B46	**Aggreko LLC (OMNIA#02-94)** MWBE Goal: 0% Drop Shipped	**Rental of Generators for Harris Health** - Additional funds are needed to continue the rental of generators at Smith Clinic through the end of hurricane season. ***OMNIA Partners, Public Sector Cooperative Purchasing Program***	Additional Funds	Patrick Casey	$ 168,000	**$ 169,097**
B47	**Insight Direct USA, Inc.** MWBE Goal: Exempt GPO	**Imprivata Resident Engineering Management (REM) Support Services for Harris Health** - To provide Imprivata Resident Engineering Management (REM) services to assist with supporting the Imprivata infrastructure used to support Harris Health's Epic environment, as well as other clinical and business applications. This service also provides Imprivata administration and system configuration, issue escalation and management, service desk support, onsite configuration, assessments, etc. ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer November 10, 2024 through November 09, 2025	Ronald Fuschillo		**$ 164,400**
B48	**Luminex/Diasorin (PP-LA-660)** MWBE Goal: Exempt GPO	**Molecular Rapid Qualitative Screening** - To purchase consumables needed to continue providing COVID, FLU and RSV testing. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Contract(s) One (1) year initial term with four (4) one-year renewal options	Michael Nnadi		**$ 155,000**
B49	**Dentons US LLP** MWBE Goal: 0% Specialized, Technical, or Unique in Nature	**Special Counsel for Harris Health** - To provide special counsel to Harris Health related to Medicaid supplemental programs and health law matters. ***Professional Services Exemption***	Award Professional Services Exemption One (1) year initial term with two (2) one-year renewal options	L. Sara Thomas		**$ 150,000**
B50	**Reliance Wholesale Inc.** MWBE Goal: Exempt Public Health or Safety	**Victoza 18mg/3mL Inj Sol 2x3mL Pens** - To provide Victoza 18mg/3mL Injection Pens that were not currently available via primary distributor. ***Public Health or Safety Exemption***	Purchase Public Health or Safety Exemption	Michael Nnadi		**$ 139,800**
B51	**Boston Scientific Corporation (PP-OR-2323)** MWBE Goal: Exempt GPO	**Specialty Urological Products** - To replace one (1) CO2 surgical laser at Ben Taub which is no longer supported by the manufacturer with a new CO2 Surgical Laser. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 133,275**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B52	**PeriGen Inc [GA-07106]** MWBE Goal: Exempt Sole Source	**Maintenance and Support for Fetal Monitoring Software System for Harris Health** - To provide maintenance and support for the PeriGen fetal monitoring system software application. Maintenance and support includes technical support, patch fixes and version upgrades. ***Sole Source Exemption, Board Motion 23.06-95***	Renewal Sole Source Exemption August 01, 2024 through July 31, 2025	Justin Williams Antony Kilty	$ 154,088	**$ 132,994**
B53	**Hologic Sales and Service, LLC (PP-IM-295)** MWBE Goal: Exempt GPO	**Mammography Products and Services** - To replace one (1) breast biopsy specimen radiography system past its expected useful life at LBJ Hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 131,875**
B54	**SonoSite (PP-IM-317)** MWBE Goal: Exempt GPO	**Ultrasound Equipment** - To add two (2) point of care ultrasound machines to the Ben Taub Cath Lab in order to expand their scope of services to CV patients. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 128,880**
B55	**Crown Castle USA Inc (GSA-35F-465DA)** MWBE Goal: 0% Non-Divisible	**Crown Castle fiber connectivity for M365 Services** - Crown Castle will provide a direct fiber connection to Microsoft Azure, where M365 services are hosted. ***Government Services Administration (GSA) Cooperative Purchasing Program***	Award Only quote Three-year initial term	Mohammad Manekia		**$ 126,000**
B56	**Edward Don & Company, LLC** MWBE Goal: 0% Non-Divisible	**Dishwasher for Harris Health** - To replace one (1) dishwasher at Lyndon B. Johnson Hospital. ***Offer No. NMB092524***	Purchase Best offer meeting requirements	Shweta Misra		**$ 120,792**
B57	**Mark III Systems - Government Solutions, LLC** MWBE Goal: 100%	**Hardware maintenance for Dell servers.** - Hardware maintenance for Dell servers is essential to ensure the reliability, longevity, and cost-effectiveness of the server infrastructure. It helps minimize downtime, reduces repair costs, and provides access to expert technical support in the event of issues. ***State of Texas Department of Information Resources (DIR) Cooperative Contract***	Award Low quote July 14, 2024 through July 13, 2025	A. Kilty, J. Lee		**$ 119,179**
B58	**Draeger, Inc. (PP-OR-2049)** MWBE Goal: Exempt GPO	**Anesthesia Equipment, Accessories and Supplies** - To add two (2) Draeger anesthesia machines to the new GI outpatient endoscopy suite at Quentin Mease. ***Premier Healthcare Alliance, L.P. Contract***	Award Best Offer(s) Meeting Requirements	Arun Mathew		**$ 117,459**
B59	**Insight Direct USA Inc** MWBE Goal: Exempt GPO	**Indeed employee recruiting software platform** - To provide Indeed employee recruiting software platform including Sponsorship, Smart Sourcing and Employer Branding in support of Harris Health operations ***Premier Healthcare Alliance, L.P. Contract***	Award Lowest Offer One (1) year initial term with one (1) one-year renewal options	Elle Pallugna		**$ 113,727**
B60	**Olympus America Incorporated (GA-07591)** MWBE Goal: 0% Non-Divisible	**Repair and Maintenance Program for Endoscopy and Video Equipment** - Additional funds are needed to pay outstanding invoices for the extended term. ***Sole Source Exemption***	Additional Funds Extension Sole Source Exemption September 07, 2024 through October 31, 2024	James Young	$ 1,439,956	**$ 110,121**

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
B61	**Philips Healthcare (PP-NS-1948)** MWBE Goal: Exempt GPO	**Physiological Monitoring Systems** - To add eighteen (18) IntelliVue MX40 patient wearable monitors and three (03) charging stations to meet the increased patient volume needs at LBJ hospital. ***Premier Healthcare Alliance, L.P. Contract***	Award Only Offer Received	Arun Mathew		**$ 109,200**
B62	**Edwards Lifesciences, LLC** MWBE Goal: Exempt Sole Source	**Cardiac Output Monitors for Harris Health** - To add two (2) hemosphere advanced monitoring systems to the Ben Taub Cath Lab as part of the Cath Lab expansion project. ***Sole Source Exemption***	Purchase Sole Source Exemption	Arun Mathew		**$ 108,390**
B63	**Sebia, Inc. (HCHD-915)** MWBE Goal: 0% Drop Shipped	**Hemoglobin A1c Testing Analyzers, including Reagents, Consumables and Service for Harris Health** - Additional funds are needed to purchase analyzers and consumables to perform Electrophoresis testing. ***Job No. 220076***	Additional Funds May 18, 2024 through May 17, 2025	Michael Nnadi	$ 380,986	**$ 103,412**
B64	**Eurofins J3 Resources, Inc. (HCHD-1312)** MWBE Goal: 7%	**Laboratory Analysis Testing Services** - To provide Laboratory Analysis for Environmental Testing Services to ensure laboratory environment is free from contamination. ***Offer No. AB240712***	Award Lowest priced offer meeting requirements One (1) year initial term with four (4) one-year renewal options	Sunny Ogbonnaya		**$ 101,735**
					Total Expenditures	$ 42,681,067
					Total Revenue	$ (0)

Thursday, December 12, 2024

Consideration of Approval of Grant Recommendations
(Item C1 of the Grant Matrix)

Grant Recommendation:

C1. Grant Amendment extends the term for another year to provide routine HIV screening services at Harris Health

- Grantor: The City of Houston - Department of Health, funded by the Centers for Disease Control and Prevention
- January 01, 2025 – December 31, 2025
- Award Amount: $150,000.00
- Project Owner: Dr. Jennifer Small

Grant Agenda Items for the Harris County Hospital District dba Harris Health, Board of Trustees Report
Grant Matrix: December 12, 2024

No.	Grantor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Award Amount
C1	The City of Houston - Department of Health, *Funded by the Centers for Disease Control and Prevention*	Consideration of Approval of an Amendment between the Harris County Hospital District d/b/a Harris Health and The City of Houston Department of Health Services funded by the Centers for Disease Control and Prevention to provide **Routine HIV Screening Services** at Harris Health. This amendment extends the term for another year.	**Grant Amendment**	01/01/2025 though 12/31/2025	Dr. Jennifer Small	$ 150,000.00
					TOTAL AMOUNT:	**$ 150,000.00**

Thursday, December 12, 2024

Consideration of Approval of Contract Recommendations
(Item D1 of the Contract Matrix)

Contract Recommendation:

D1. Interlocal Agreement (ILA) for a Community Garden at the Barbara Jordan Career Center between Harris Health and the Houston Independent School District

- Promisor: Houston Independent School District (HISD)
- Term: 7 Years from execution
- Project Owner: Aown Syed
- Notes: Under the terms of the ILA, Harris Health will convert open space on the Campus into a garden for the production of fruits and vegetables.

Contract Agenda Item(s) for the Harris County Hospital District dba Harris Health, Board of Trustees Report
Contract Matrix: December 12, 2024

No.	Promisor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Promisor Cost	Promisee Cost
D1	Houston Independent School District (HISD)	Consideration of Approval to Enter into an Interlocal Agreement for a Community Garden at the Barbara Jordan Career Center between Harris Health and the Houston Independent School District. Harris Health will be responsible for all soil work, irrigation maintenance, weeding, planting, harvesting, and otherwise managing all aspects of fruit and vegetable production in the Garden. Harvests from the Garden will be split in half, with 50% allocated to HISD (for use by the Culinary Arts students) and 50% to Harris Health (for the Food Farmacy program).	**Interlocal Agreement**	7 Years from Execution Date *(automatic renewals annually until either party terminates in writing)*	Aown Syed	HISD will be responsible for installation and cost of a new valve with an in-line water submeter to calculate water usage.	Harris Health will reimburse HISD for fifty percent (50%) of the water usage costs for the Garden on a quarterly basis.

Thursday, December 12, 2024

Consideration of Approval of the Harris Health Investment Policy

The Harris Health Investment Policy is adopted annually by the Harris Health Board of Trustees as the governing body pursuant to Chapter 2256 of the Texas Government Code, "Public Funds Investment Act." Harris County recently modified their policy to include the updates summarized below. The attached policy includes changes applicable to Harris Health and related to the sections addressed below. Administration has reviewed the policy and recommends the updates.

Section 7.01. Socially Responsible Investing.
The following changes were made to this section to be in alignment with the Harris County Investment Policy effective October 1, 2024: The County will seek to invest, to the extent that a reasonable spread can be earned over comparable maturity Treasuries, in Fannie Mae and Freddie Mac debt obligations "providing a stable source of liquidity to support low- and moderate-income mortgage borrowers and renters by enabling greater access to affordable home and rental housing finance in all markets and at all times," as well as Federal Home Loan Bank obligations, which provide liquidity to member banks to finance housing and economic development activities. The County will also seek investment in debt obligations from the Federal Farm Credit Bank System which provides affordable credit to agricultural businesses in the U.S. In addition, the County shall consider investment in municipal bonds geared toward low-income or affordable housing, and/or serving a county listed on the Federal Financial Institutions Examination Council's (FFIEC) underserved or distressed areas, https://www.ffiec.gov/cra/pdf/2021distressedorunderservedtracts.pdf, or bonds of a school district issuer with 50% or more of students eligible for free or reduced lunch. It is understood that the County may not have continual or regular access to these municipal bonds, and at times such bonds may not meet credit ratings as outlined in state statutes.

Exhibit "B" Harris Health & CHC Authorized Designees
Revised titles of designees.

Exhibit "C" Approved Broker/Dealers, Money Market Funds, and Investment Pools for the Investment of Harris Health and CHC Funds
J.P. Morgan Chase Bank, N.A. and US Bancorp was added to the list of approved banks while Robert W. Baird & Co., Inc. (Baird) was removed. First American and J.P. Morgan Empower Shares were added to the listing of approved Money Market Mutual Funds.

Administration recommends that the Board approve the updated Harris Health Investment Policy to be effective January 1, 2025.

Victoria Nikitin
EVP – Chief Financial Officer

INVESTMENT POLICY

This Investment Policy (the "Policy") is adopted by the Harris Health System Board of Trustees, as the governing body of the Harris County Hospital District d/b/a/Harris Health System ("Harris Health") and Community Health Choice, Inc. and Community Health Choice Texas, Inc. (collectively, "CHC"), discretely presented component units of Harris Health, pursuant to the Texas Government Code, Title 10, Chapter 2256 (Public Funds Investment Act) and Texas Local Government Code, Chapter 116.112. The Policy will be reviewed and adopted at least annually in accordance with the Texas Government Code 2256.005(e).

ARTICLE I
PURPOSE

Section 1.01. Purpose

The purpose of this Policy is to provide guidance in the investment of Harris Health and CHC investments to help ensure safety of principal, liquidity for Harris Health and CHC operations, and return on investment.

ARTICLE II
SCOPE

Section 2.01. Scope

The Policy applies to all financial assets of Harris Health and CHC.

Harris County, through the Financial Management Division acts as an Investment Agent for Harris Health and CHC.

ARTICLE III
DEFINITIONS

Section 3.01. Definitions

Unless the context requires otherwise, the following terms and phrases used in this Policy shall mean the following:

(a) **"Barbell Approach"** means an investment strategy whereby investments are concentrated at both the short end and the long end of the Policy permitted maturity range, instead of buying securities with maturity dates to correspond with specific expenditures.

(b) "**Board of Trustees"** means the Harris Health Board of Trustees.

(c) "**CHC Designees**" means the employees of Community Health Choice, Inc. and Community Health Choice Texas, Inc. (collectively, "CHC") authorized by the Investment Officer to process investments for CHC.

It is specifically noted that at this time, CHC has contracted with the Harris County Director of the Financial Management Division to have personnel of such office handle the purchase and sale of investments for CHC. Exhibit B attached hereto sets forth a list of CHC Designees, which includes CHC personnel specifically authorized to purchase/sell securities for CHC and personnel of the Harris County Financial Management Division who are authorized to purchase/sell securities for CHC.

(d) **"CHC funds"** means the general operating funds, the bond funds, and any specific purpose funds.

(e) **"Collateral"** means any security or other obligation which Harris Health or CHC authorizes to serve as security for the deposit of Harris Health or CHC funds in Article V hereof.

(f) **"Collateral Act"** means Chapter 2257, Texas Government Code, as amended from time to time.

(g) **"Commissioners Court"** means the elected governing body of Harris County consisting of the County Judge and four (4) Precinct Commissioners.

(g) **"County Designees"** means the officials and/or employees of the Harris County Financial Management Division authorized to process investments for Harris Health or CHC.

(h) "**Delivery vs. Payment (DVP)"** means a method of settling trades in which cash is exchanged for securities simultaneously.

(i) **"Depository Bank"** means the banking institution that is contracted to process Harris Health or CHC's receipts, disbursements, and investments and to provide safekeeping services.

(j) **"Depository Trust Co. (DTC)"** means the book entry depository for municipal and corporate bonds, equities, commercial paper and various other obligations. The corporation is owned by banks and brokerage firms and holds securities, arranges for securities receipt and delivery, and arranges for the payments in settlement of trades.

(k) **"Employee"** means any person employed by Harris Health or CHC, but does not include independent contractors or professionals hired by Harris Health or CHC as outside consultants.

(l) "**Financial Management Division"** means the Harris County office responsible for cash and banking management, debt management, investment management, and management of collateral of all Harris County funds as required.

(m) **"Harris Health Designees"** means the Board of Trustees, officers, and employees of Harris Health authorized to process investments for Harris Health, as well as the persons, other political subdivision or business entities engaged and authorized to process investments for Harris Health.

It is specifically noted that at this time, Harris Health has contracted with the Harris County Director of the Financial Management Division to have personnel of such office handle the purchase and sale of investments for Harris Health. Exhibit B attached hereto sets forth a list of Harris Health Designees, which includes Harris Health personnel specifically authorized to purchase/sell securities for Harris Health and personnel of the Harris County Financial Management Division who are authorized to purchase/sell securities for Harris Health.

(n) **"Harris Health funds"** means the general operating funds, the bond funds, and any specific purpose funds.

(o) **"Investment Act"** means Chapter 2256, Texas Government Code, as amended from time to time, also referred to as the Texas Public Funds Investment Act.

(p) **"Investment Officer"** means the Employee appointed by the Commissioners Court to administer all investment activity of Harris Health and CHC funds under the Investment Act standard of care "prudent person" and to monitor compliance and management-level controls.

(q) **"Laddered Approach"** means an investment strategy that positions maturities that occur in regular intervals, providing a known stream of cash.

(r) **"Matching Approach"** means an investment strategy that matches maturities of investments to coincide with known predictable cash needs. This approach requires a reasonably accurate forecast of cash flow and disbursement requirements.

(s) **"Pooled Fund Group"** means an internally created fund of an investing entity in which one or more accounts of the investing entity are invested.

(t) **"Reserve Investment Officer"** means those certified investment officers within the Financial Management Division who have been designated and trained as backup or relief Harris Health Designees.

(u) **"Trustee"** means a person appointed to serve on the Harris Health Board of Trustees.

ARTICLE IV
INVESTMENT OFFICER

Section 4.01. Investment Officer

In accordance with the Local Government Code, Section 116.112(a) and the Government Code, Sections 2256.005(f) and (g), the Commissioners Court hereby appoints the Deputy Executive Director of the Office of Management and Budget to serve as Investment Officer to manage and oversee the investment of Harris Health and CHC funds. In the event the Investment Officer is unable to perform the functions of that office, the Investment Director of the Office of Management and Budget is hereby authorized to perform such functions until the Investment Officer is able to perform them or another Investment Officer is appointed by the Commissioners Court. The Investment Officer shall be responsible for investing Harris Health and CHC funds in accordance with this Policy. The Investment Officer shall invest Harris Health and CHC funds using judgment and care under then prevailing circumstances that a person of prudence, discretion, and intelligence would exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of capital. The standard of care to be used by the Investment Officer and Harris Health and CHC Designees shall be the "prudent person" standard and shall be applied in the context of managing an overall portfolio. The Investment Officer, and Harris Health and CHC Designees (1) acting in accordance with this Policy and any written procedures approved by the Board of Trustees and (2) exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided that deviations from expectation are reported in a timely fashion and appropriate action is taken to control adverse developments. The Investment Officer and Harris Health and CHC Designees will also be required to adhere to financial procedures prescribed by the County Auditor for financial transaction processing. Reference Exhibit B for authorized personnel to invest Harris Health and CHC funds.

Section 4.02. Training

Harris Health Designees and CHC Designees shall be active members of the Texas Association of Counties Investment Academy or in the active process of attaining membership and attend investment training as required by the Investment Act. Under this Policy, all individuals are required to submit written confirmation of completion of such training to the Investment Officer.

Section 4.03. Disclosure of Relationships with Persons Selling Investments to Harris Health or CHC

The Investment Officer of Harris Health who has a personal business relationship with a business organization offering to engage in an investment transaction with the entity shall file a statement disclosing that personal business interest. An Investment Officer who is related within the second degree by affinity or consanguinity, as determined under Chapter 573, to an individual seeking to sell an investment to the Investment Officer's entity shall file a statement disclosing that relationship. A statement required under this subsection must be filed with the Texas Ethics Commission and the Board of Trustees. The Investment Act, Section 2256.005(i) should be referred to for more qualifying events and it is the responsibility of the Investment Officers, Harris Health Designees, CHC Designees, and broker/dealers to be knowledgeable of and compliant with reportable events and relationships. Under this Policy, an Investment Officer is prohibited from accepting any

gifts, including meals, from a broker/dealer unless authorized by the Executive Director of the Office of Management and Budget.

Section 4.04. Reporting by the Investment Officer

Not less than quarterly and within a reasonable time after the end of the quarter being reported, the Investment Officer, assisted by Harris Health and CHC Designees, shall prepare and submit to the Board of Trustees a written report of the investment transactions for all funds of Harris Health and CHC for the preceding reporting period. The reports must (1) describe in detail the investment position of Harris Health and CHC on the date of the reports, (2) be prepared jointly by the Investment Officer and/or Harris Health or CHC Designees, (3) be signed by the Investment Officer and/or Harris Health or CHC Designees, (4) contain a summary statement of each pooled fund group that states the beginning market value and fully accrued interest for the reporting period, (5) state the book value and the market value of each separately invested asset at the beginning and end of the reporting period by the type of asset and fund type invested, (6) state the maturity date of each separately invested asset that has a maturity date, (7) state the Harris Health and CHC account or fund or pooled group fund for which each individual investment was acquired, (8) state the compliance of the investment portfolio as it relates to this Policy and the relevant provisions of the Investment Act, and (9) disclose any investments that no longer have the minimum rating required by law and the liquidation, or plan for liquidation, of such investments consistent with the provisions of Section 2256.021. All investments must comply with the Investment Act and all federal, state, and local statutes, rules and regulations.

Section 4.05. Selection of Banks and Securities Dealers

Harris Health and CHC will seek to include qualified and registered minority, women, veteran, and disabled-owned financial institutions when selecting broker/dealers for investments and depository banks in the depository procurement process.

Depository banks shall be selected through the Harris Health's depository procurement process, which shall begin with a formal request for proposals every four years, or as otherwise determined by Harris Health and allowed by law.

All financial institutions and broker/dealers desiring to become approved broker/dealers for Harris Health and CHC investment transactions must supply the Financial Management Division with the following: (1) the most recent audited financial statements for the financial institution or broker/dealer and (2) evidence of registration with the appropriate regulatory agency. Bank dealers must be registered with the appropriate regulatory authority as a government securities dealer, municipal securities dealer, or both. For a securities firm, this requires a statement that the firm is registered with the Financial Industry Regulatory Authority (FINRA), Municipal Securities Regulatory Board (MSRB), and/or the Securities and Exchange Commission (SEC). Securities dealers will be selected by the Financial Management Division and then submitted to Commissioners Court for final approval. All transactions will be conducted on a Delivery vs. Payment basis per the Investment Act, Section 2256.005(b). Reference Exhibit A for approved banks. Harris Health and CHC mirror the list of approved broker/dealers, money market funds, and investment pools as listed in the most current Harris County Investment policy as noted in Exhibit C.

Section 4.06. Certifications from Approved Broker/Dealers

A written copy of the investment policy shall be presented to a qualified representative of any business offering to engage in an investment transaction with Harris Health and CHC. A business organization includes banks, broker/dealers, and investment pools (Harris Health only). Nothing in this subsection relieves the Investment Officer of the responsibility for monitoring the investments made by Harris Health and CHC for compliance with the investment policy. The qualified representative of the business organization offering to engage in an investment transaction shall execute a written instrument in a form acceptable to Harris Health and CHC substantially to the effect that the business organization has: (1) received and reviewed the investment policy of the entity; and (2) acknowledged that the business organization has implemented reasonable procedures and controls in an effort to preclude investment transactions not authorized within the investment policy, except to the extent that this authorization is dependent on an analysis of the makeup of the entire portfolio or requires an interpretation of subjective investment standards. The Investment Officer may not acquire or otherwise obtain any authorized investment described in the investment policy from a person who has not delivered the required document.

ARTICLE V
INVESTMENT OBJECTIVES

Section 5.01. General Objectives

Harris Health funds and CHC funds will be invested in accordance with federal and state laws and this investment policy. Harris Health and CHC will invest according to investment or fund policies and strategies for each fund as they will or have been adopted by the Board of Trustees. This policy shall apply to all funds of the Harris Health System, Community Health Choice, Inc. and Community Health Choice Texas, Inc.

1. Harris Health and CHC emphasize these primary general objectives in investing its funds, listed in the order of importance:
   a. preservation and safety of original investment principal;
   b. maintenance of sufficient liquidity to meet the County's operating needs as they are planned or become due;
   c. marketability of the investment if the need arises to liquidate the investment before final maturity;
   d. diversification of the investment portfolio;
   e. maximization of return (yield).

2. Safety of principal is the foremost objective of Harris Health and CHC. In each investment transaction, Harris Health and CHC shall seek first to ensure that capital losses are avoided, whether they are from securities defaults or erosion of market value.

3. Investment decisions shall favor preservation of principal over income or yield.

4. The investment portfolio shall be structured to be sufficiently liquid to enable Harris Health and CHC to meet all operating requirements which might be reasonably anticipated. This need for investment liquidity may be tempered to the extent that Harris Health and CHC is allowed to borrow on a short-term basis to meet its operating requirements, if needed, taking into consideration the net cost to Harris Health and CHC.

5. The investment portfolio shall be designed with the objective of attaining a fair market yield throughout budgetary and economic cycles, taking into account investment risk constraints and liquidity needs. A fair market yield rate shall equal or exceed the available yield at the time of purchase on a U.S. Treasury security having a comparable maturity date.

6. Investments shall be made to avoid incurring unreasonable and avoidable risks.

7. No investments shall be made for the purpose of speculation, such as anticipating an appreciation of capital through changes in market interest rates.

8. All Harris Health Designees and CHC Designees shall seek in the investment process to act responsibly as custodians of the public trust. Harris Health Designees and CHC Designees shall avoid any transaction, including personal transactions that might impair public confidence in Harris Health's ability to operate effectively. Nevertheless, the Board of Trustees recognizes that in a diversified portfolio, occasionally losses may occur due to fluctuating market conditions and must be considered within the context of the overall portfolio's investment return, provided that adequate diversification has been implemented.

9. Harris Health and CHC, as a general objective, plans to hold investments to final maturity which protects principal and liquidity while obtaining the most prudent competitive yield possible at the date of the investment trade. Investments will be purchased for their interest yield expectations over their remaining life to final maturity rather than for speculative purposes. Although Harris Health and CHC's intent upon purchase is to hold securities until maturity, Harris Health and CHC may, whenever appropriate, exchange securities with similar maturity and risk characteristics in order to enhance total returns, provided that safety of principal is given first consideration.

10. Pooling of fund groups for the purposes of investment is approved and allowed and must be done in accordance with any applicable bond indentures.

Section 5.02 Monitoring and Pricing of the Portfolio

Harris Health and the Harris County Financial Management Division use a combination of resources, such as Bloomberg Investment Service, the Federal Reserve Board's economic research and data, broker/dealer matrices, and third party pricing services to monitor the market and to value the portfolio. The financial advisor, Investment Officer, and the Finance Committee may also assist in monitoring the portfolio periodically.

Section 5.03. Authorized Investment Instruments

Harris Health and CHC funds governed by this Policy may be invested in the instruments described below, all of which are authorized in the Public Funds Investment Act:

1. Direct obligations of the United States, its agencies, and instrumentalities.

2. Other obligations, the principal, and interest of which are unconditionally guaranteed, insured, or backed by the full faith and credit of the State of Texas, the United States, or any obligation fully guaranteed or fully insured by the Federal Deposit Insurance Corporation (FDIC).

3. Direct obligations of the State of Texas or its agencies provided the agency has the same debt rating as the State of Texas.

4. Obligations of states, agencies, counties, cities, and other political subdivisions located in the United States and rated not less than A, or its equivalent, by a nationally recognized investment rating firm.

5. Fully insured or collateralized certificates of deposit/share certificates issued by a state and national banks, or a savings bank, a state or federal credit union (having its main or branch office in Texas) guaranteed or insured by the Federal Deposit Insurance Corporation (FDIC) or its successor; and secured by obligations as stated on Item 1 of this section. In addition to Harris Health's authority to invest funds in certificates of deposit and share certificates as stated above, an investment in certificates of deposit made in accordance with the following conditions is an authorized investment under the Texas Gov't. Code, Section 2256.010 (b): (1) the funds are invested by the Financial Management Division through a clearing broker registered with the Securities and Exchange Commission (SEC) and operating pursuant to SEC, Rule 15c3-3 (17 C.F.R., Section 240.15c3-3) with its main office or branch office in Texas and selected from a list adopted by the Financial Management Division as required by Section 2256.025; or a depository institution that has its main office or a branch office in this state and that is selected by the Financial Management Division; (2) the broker or the depository institution selected by the County arranges for the deposit of the funds in certificates of deposit in one or more federally insured depository institutions, wherever located, for the account of Harris Health and CHC; (3) the full amount of the principal and accrued interest of each of the certificates of deposit is insured by the United States or an instrumentality of the United States; (4) the broker or depository institution selected by the County acts as custodian for the County with respect to the certificates of deposit issued for the account of Harris Health and CHC.

6. Fully collateralized repurchase agreements, provided the Financial Management Division has on file, a signed Master Repurchase Agreement detailing eligible collateral, collateralization ratios, standards for collateral custody and control, collateral valuation, and conditions for agreement termination. The repurchase agreement must have a defined termination date and be secured by obligations as stated on Item 1 of this section. It is required that the securities purchased as part of the repurchase agreement must be assigned to Harris Health/CHC, held in Harris Health/CHC's name, and deposited at the time the investment is made with our custodian or with a third-party approved by Harris Health and/or CHC. Securities purchased as part of a repurchase agreement shall be marked-to-market no less than weekly. All

repurchase agreements must be conducted through a primary government securities dealer as defined by the Federal Reserve or a financial institution doing business in Texas. Maturities shall be limited to 90 days. The 90-day limit may be exceeded in the case of flexible repurchase agreements ("flex repos") provided the investment type is specifically authorized within individual bond ordinances and final maturity does not exceed the anticipated spending schedule of bond proceeds.

7. Securities lending programs if the loan is fully collateralized, including accrued income, by securities described in Texas Gov't. Code, Section 2256.009, by irrevocable bank letters of credit issued by a bank under the laws of the United States, or any other state, continuously rated not less than A by at least one nationally recognized investment rating firm, or by cash invested in accordance with the Investment Act. Securities held as collateral must be pledged to the investing entity, held in the investing entity's name, and deposited at the time the investment is made. A loan must be placed through a primary government securities dealer or a financial institution doing business in Texas. A loan must allow for termination at any time and must have a term of one year or less.

8. Commercial paper with a stated maturity of 270 days or less from the date of issuance, rated not less than A-1 or P-1 or an equivalent rating by at least two nationally recognized rating agencies, and not under review for possible downgrade at time of purchase. Regardless of whether commercial paper is purchased directly from the issuer or from a broker/dealer in the secondary market, a competitive bid process is required, in which the investment yield is compared to other available commercial paper having a comparable maturity and credit rating. An exception may be made to the competitive offer process when seeking to purchase municipal commercial paper securities due to very limited quantity.

9. Local government investment pools with a dollar weighted average maturity of 60 days or less, approved through resolution of the Board of Trustees to provide services to Harris Health/CHC, continuously rated no lower than AAA or equivalent by at least one nationally recognized rating service. Harris Health/CHC may not invest an amount that exceeds 10 percent of the total assets of any one local government investment pool. On a monthly basis, the Investment Officer shall review a list of securities held in the portfolio of any pool in which Harris Health and CHC funds are being held. To be eligible to receive funds from and invest funds on behalf of Harris Health an investment pool must furnish to the Investment Officer or other authorized representative an offering circular or other similar disclosure instrument that contains information required by the Tex. Gov't. Code, Section 2256.016. Investments will be made in a local government investment pool only after a thorough investigation of the pool and review by the County Designees.

10. A Securities and Exchange Commission (SEC) registered, no-load money market mutual fund which has a dollar-weighted average stated maturity of 60 days or less. Furthermore, it must be rated not less than AAA or equivalent by at least one nationally recognized rating service and Harris Health/CHC must be provided with a prospectus and other information required by the SEC Act of 1934 or the Investment Company Act of 1940. Harris Health/CHC may not invest an amount that exceeds 10 percent of the total assets of any one fund. Investments will be made in a money market mutual fund only after a thorough investigation of the fund and review by the County Designees.

11. Interest-bearing banking deposits that are guaranteed or insured by: (A) the FDIC or its successor; or (B) the National Credit Union Share Insurance Fund or its successor; and interest-bearing banking deposits other than described above if: (A) the funds invested in the banking deposits are invested through: (i) a broker with a main office or branch office in Texas that the County Designee selects from a list of its governing body or designated investment committee adopts as required by Section 2256.025; or (ii) a depository institution with a main office or branch office in Texas that the County Designee selects (B) the broker or depository institution selected as described above arranges for the deposit of the funds in one or more federally insured depository institutions, regardless of where located, for Harris Health's account; (C) the full amount of the principal and accrued interest of the deposits is insured by the United States or an instrumentality of the United States; and (D) Harris Health/CHC appoints as the custodian of the bank deposits issued for Harris Health's and CHC's account: (i) the depository institution selected as described above; (ii) an entity described by Section 2257.041(d); or (iii) a clearing broker dealer registered with the Securities and Exchange Commission and operating under Securities and Exchange Commission Rule 15c3-3 (17 C.F.R. Section 240.15c3-3).

Section 5.04 Unauthorized Investment Instruments

Harris Health and CHC authorized investment options are more restrictive than those allowed by state law. Furthermore, this Policy specifically prohibits investment in the securities listed below:

1. Any obligation whose payment represents the coupon payments on the outstanding principal balance of an underlying mortgage-backed security, but pays no principal (IO).

2. Any obligation whose payment represents the principal stream of cash flow from an underlying mortgage-backed security, but pays no interest (PO).

3. Any obligation whose interest rate is determined by an index that adjusts opposite to the changes in a market index (Inverse Floater).

4. Any Collateralized Mortgage Obligation (CMO).

5. An investment that requires a minimum credit rating does not qualify as an authorized investment during the period the investment does not have the minimum credit rating, even if the investment had the appropriate rating at the time of purchase. The Investment Officer shall take all prudent measures that are consistent with this Policy to liquidate an investment that does not have the minimum rating.

Section 5.05. Internal Controls

The Investment Officer, assisted by County Designees, shall prepare a system of management-level and internal accounting controls which shall be documented in writing. The controls may be reviewed by Harris Health and CHC's independent auditor or the County Auditor during quarterly report audits or at any time. Controls deemed most important include controls to avoid or detect collusion, segregation of duties, segregation of transaction authority from accounting and record

keeping, custodial safekeeping, clear delegation of authority, specific limitations regarding securities losses and remedial action, approved written confirmation of telephone transactions, minimizing the number of authorized investment personnel, documentation of transactions and strategies, and adherence to ethics standards.

Section 5.06. Maturity

Fund investment may not exceed the following maturities, or as restricted by specific bond indentures:

Fund Name	Maximum Maturity (in years)
Debt Service Funds	5
General Concentration Pool	5
Construction Funds/Capital Project Funds	5
Specific Purpose Funds	5
Insurance Reserves	5
Bond Reserve Funds	*Final maturity of bonds*

In addition, the weighted average maturity of the overall portfolio shall not exceed three years.

Section 5.07. Diversification

It is the policy of Harris Health to diversify its investment portfolio. All funds shall be diversified to eliminate the risk of loss resulting from over concentration of assets in a specific maturity, a specific issuer or a specific class of securities. In establishing specific diversification strategies, the following general policies and constraints shall apply:

1. Portfolio investment maturities shall be staggered in a way that avoids undue concentration of assets in a specific maturity sector. Maturities shall be selected which provide for stability of income and reasonable liquidity.

2. Liquidity shall be maintained through practices that ensure that the liquidity needs of the next disbursement date and payroll date are covered through liquid deposits, maturing investments, or marketable securities.

3. Risks of market price volatility shall be limited through maturity diversification accomplished by various investment strategies including, but not limited to, the Matching, Barbell, Laddered, or combination of the investment approaches.

4. The following diversification limitations shall be imposed on the portfolio:

    a. **Maturity**. No more than 50% of the portfolio, excluding those investments held for construction/capital projects, debt service payments, bond fund reserve accounts, and capitalized interest funds may be invested beyond three years, and the average maturity of the overall portfolio, with the previous exceptions, shall not exceed three years.

    b. **Default Risk**. The restrictions on legally authorized investments and the legal requirements for full collateralization are intended to reduce the potential of default

risk. Nonetheless, no more than 25% of the overall portfolio may be invested in time deposits, including certificates of deposit, of a single issuer.

c. **Marketability**. At least 15% of the portfolio, excluding those investments held for future major capital expenditures, debt service payments, bond fund reserve accounts, and capitalized interest funds, shall be invested in overnight instruments or in marketable securities which can be sold to raise cash within one day's notice.

Section 5.08. Risk Tolerance

Harris Health recognizes that investment risks can result from issuer defaults, market price changes or various technical complications leading to temporary illiquidity. Portfolio diversification is employed as a way to control these risks. The Investment Officer and Designees are expected to display prudence in the selection of securities and no individual investment transaction shall be undertaken which jeopardizes the total capital position of the overall portfolio.

In addition to these general policy considerations, the following specific policies will be strictly observed:

1. All investment transactions will be conducted with approved banks as listed in Exhibit A, broker/dealers, money market funds, and investment pools as listed in Exhibit C.

2. All transactions will be settled on Delivery vs. Payment basis.

3. A competitive bid/offer process will be used to place all security sales and purchases. The competitive bid/offer process shall also be utilized for newly issued securities to verify whether a comparable secondary market security is available with a better price and yield. All competitive bid information shall be documented and saved with the confirming email, offering communication, or verbal communique details maintained with the transaction. Any transactions not competitively bid must be explained in writing and approved by the Executive Director of the Office of Management and Budget, the Deputy Executive Director, or the Investment Director before the trade is accepted. An exception may be made to the competitive offer process when seeking to purchase municipal securities. Due to the very limited quantity of any specific municipal bond, government agency bonds with comparable maturity dates may be considered.

4. The Board of Trustees will at least annually approve a recommended broker/dealer list, or sooner if circumstances require a change. The approved broker/dealer list will be posted in this Harris County Investment Policy and Harris County website. Based on an evaluation performed at least biennially, banks and securities dealers will be removed from or continued on the eligibility list. The following criteria will be used in the evaluation:

    a. Number and value of transactions competitively won;

    b. Prompt and accurate confirmation of transactions;

    c. Efficient securities delivery;

d. Account servicing;

e. Moral character and public ethics of both broker and firm;

f. Qualifications and experience of the broker.

Section 5.09. Safekeeping and Custody

Safekeeping and custody of Harris Health and CHC investment securities shall be in accordance with state law. All security transactions, except investment pool and money market fund transactions, shall be conducted on a Delivery vs. Payment basis. All investment securities will be held by a third party custodian designated by Harris Health/CHC, and this custodian shall be required to issue monthly statements listing all securities held on account.

Section 5.10. Policy of Securing Deposits of Harris Health and CHC Funds – Applicable to All Deposited Harris Health and CHC Funds

1. Harris Health recognizes that FDIC or its successor's insurance is available for Harris Health and CHC funds deposited at any one Texas based financial institution (including branch banks) only up to a maximum of $250,000 (including accrued interest) for each of the following: (i) demand deposits, (ii) time and savings deposits, and (iii) deposits made pursuant to an indenture or pursuant to law in order to pay a bond or note holder. It is the policy of Harris Health that all deposited funds in each of the Harris Health accounts shall be insured by the FDIC, or its successor, or secured by Collateral pledged to the extent of the fair market value of the amount not insured in compliance with the Collateral Act, Government Code, Section 2257.2. If it is necessary for the Harris Health depositories to pledge collateral to secure the Harris Health deposits, the Collateral pledge agreement must be (1) in writing, (2) approved by the depository's board of directors or loan committee and reflected in the minutes of the meeting and (3) kept in the official records of the depository. The depository must approve the collateral pledge agreement and provide to the Investment Officer a copy of the minutes of the meeting of the depository's board or loan committee at which the collateral pledge agreement is approved prior to the deposit of any Harris Health and CHC funds requiring the pledge of Collateral in such financial institution.

2. Collateral pledged by a depository shall be held in safekeeping at the Federal Home Loan Bank and the Investment Officer pursuant to this Policy, shall obtain safekeeping receipts from the Federal Reserve Bank. Collateral may also be pledged with the use of an Irrevocable Standby Letter of Credit issued by the Federal Home Loan Bank. Principal and accrued interest on deposits in accordance with this Policy, if authorized, shall not exceed the FDIC, or its successor's, insurance limits or the Collateral pledged as security for Harris Health investments. It shall be acceptable for Harris Health to periodically receive interest on deposits to be deposited to the credit of Harris Health if needed to keep the amount of the funds under the insurance or collateral limits. The Investment Officer, with the help of the Harris Health Designees, shall ensure that the Collateral pledged to the Harris Health is pledged only to Harris Health and shall review the fair market value of the Collateral pledged to secure the funds to ensure that the Harris Health Funds are fully secured.

3. Certificates of deposit, to the extent that they are not insured, may be secured by any securities allowed under the Investment Act and depository contract.

4. Demand deposits (for example, checking accounts) and savings accounts, to the extent that they are not insured, may be secured by any securities allowed under the Collateral Act.

Section 5.11. The Investment Policy Review

The Investment Policy shall be formally reviewed and approved by the Board of Trustees at least annually or when amended.

Section 5.12 Finance Committee

Although not required by the Investment Act, Harris Health has established a Finance Committee composed of members of the Board of Trustees, and attended by the Chief Financial Officer and a representative of the Harris Health's financial advisor. This committee will seek to meet at least once after the completion of each fiscal quarter and will include in its discussions a review of cash, investment and debt reports, projects, bond deals, policy compliance, recommendations, and other relevant finance related matters.

ARTICLE VI
INVESTMENT STRATEGIES FOR FUNDS

Section 6.01. Debt Service Funds

Debt service funds are used to account for the accumulation of resources to fund periodic principal and interest payments on outstanding obligations. The investment strategy for these funds is the Matching Approach. Debt service funds may be pooled for investment purposes.

Section 6.02. Debt Service Reserve Funds

Debt service reserve funds are used as required by debt covenants and may be invested for a period not to exceed the maturity of the bond. The Matching, Barbell, and/or Laddered Approaches are used for the debt service reserve funds investment strategy.

Section 6.03. General Fund

Unrestricted revenues and most of Harris Health operating expenditures and supplements to debt service are accounted for in the general fund. The investment strategy for the General Fund combines the Matching and/or Laddered Approaches. The average maturity of these investments is one year or less.

Section 6.04. Capital Project Funds/Construction Funds

Capital project funds and construction funds are used to account for construction and other nonrecurring capital expenditure activity. A Matching, Barbell, and/or Laddered Approach may be used for these funds, depending on the liquidity needs and prevailing interest rate environment.

Section 6.05. Specific Purpose Funds

This is funded from grants or restricted donations. The Matching Approach is used.

Section 6.06. Insurance Reserves

Insurance reserves are pledged to satisfy insolvency and other reserves as required by the Texas Department of Insurance. The Matching, Barbell, and/or Laddered Approaches are used for the debt service reserve funds investment strategy.

ARTICLE VII
MISCELLANEOUS

Section 7.01 Socially Responsible Investing

Harris Health will seek to invest, to the extent that a reasonable spread can be earned over comparable maturity Treasuries, in Fannie Mae and Freddie Mac debt obligations "providing a stable source of liquidity to support low- and moderate-income mortgage borrowers and renters by enabling greater access to affordable home and rental housing finance in all markets and at all times," as well as Federal Home Loan Bank obligations, which provide liquidity to member banks to finance housing and economic development activities. Harris Health will also seek investment in debt obligations from the Federal Farm Credit Bank System which provides affordable credit to agricultural businesses in the U.S. In addition, Harris Health shall consider investment in municipal bonds geared toward low-income or affordable housing, and/or serving a county listed on the Federal Financial Institutions Examination Council's (FFIEC) underserved or distressed areas, https://www.ffiec.gov/cra/pdf/2021distressedorunderservedtracts.pdf, or bonds of a school district issuer with 50% or more of students eligible for free or reduced lunch. It is understood that Harris Health may not have continual or regular access to these municipal bonds, and at times such bonds may not meet credit ratings as outlined in state statutes.

Section 7.02. Superseding Clause

This Policy supersedes any prior policies adopted by the Board of Trustees regarding investment or securitization of Harris Health and CHC funds.

Section 7.03. Open Meeting

The Board of Trustees officially finds, determines and declares that this Investment Policy was reviewed, carefully considered, and adopted at a regular meeting of the Board of Trustees, and that a sufficient written notice of the date, hour, place and subject of this meeting was posted as required by

the Texas Open Meetings Act, Chapter 551, Texas Government Code, and that this meeting had been open to the public as required by law at all times during which this Policy was discussed, considered and acted upon. The Board of Trustees further ratifies, approves and confirms such written notice and the contents and posting thereof.

EXHIBIT A

List of Approved Banks

Cadence Bank
Amegy Bank, a division of ZB, N.A.
JP Morgan Chase Bank, N.A.

EXHIBIT B

Harris Health System & CHC
Authorized Designees

Authorized Personnel of Harris Health

President and Chief Executive Officer
Executive Vice President and Chief Financial Officer
Vice President - Controller
Director - Treasury and Cash Management

Authorized Personnel of CHC

President and Chief Executive Officer
Chief Financial Officer
Vice President - Controller
Treasurer & Director of Investment Management

Authorized Personnel of Harris County

Deputy Executive Director, Office of Management and Budget
Investment Director, Financial Management Division
Investment Manager, Financial Management Division
Reserve Investment Officer(s), Financial Management Division

EXHIBIT C

Approved Broker/Dealers, Money Market Funds, and Investment Pools for the Investment of Harris Health and CHC Funds

Approved Banks and Broker/Dealers:

Firm/Bank	Minority/ Women/ Disabled/Veteran Business Enterprise
Academy Securities	Service-Disabled Veteran Business Enterprise
BNY Mellon Capital Markets, LLC	
Cabrera Capital Markets, Inc.	Minority Business Enterprise
Cadence Bank	
Cantor Fitzgerald & Co.	
CastleOak Securities	Minority Business Enterprise
Daiwa Capital Markets	
FHN Financial Capital Markets	
Great Pacific Securities	Minority Business Enterprise
Hilltop Securities, Inc.	
J.P. Morgan Chase Bank, N.A.	
Jefferies, LLC	
Loop Capital Markets	Minority Business Enterprise
Mischler Financial Group	Service-Disabled Veteran & Minority Business Enterprise
Multi Bank Securities	Service-Disabled Veteran Business Enterprise
Oppenheimer & Co., Inc.	
RBC Capital Markets	
Raymond James & Assoc.	
Siebert Williams Shank & Co., LLC	Minority & Women's Business Enterprise
Stifel Nicolaus & Co., Inc.	
StoneX Financial	
US Bancorp	
Unity National Bank	Minority Business Enterprise
Wells Fargo Securities, LLC	

Money Market Mutual Funds:
Dreyfus
Fidelity Investments
First American
Invesco Aim
J.P. Morgan
J.P. Morgan Empower Shares

Investment Pools:
TexPool/TexPool Prime
TexSTAR/LOGIC
First Public/Lone Star
Texas CLASS

EXHIBIT D

Harris County Hospital District dba Harris Health System
Financial Management Products Policy

1. General Considerations. The Harris Health System ("Harris Health") may consider the use of financial management products such as interest rate swaps, caps, floors and other similar transactions in connection with outstanding or authorized debt. Harris Health shall enter into financial management products in a prudent and professional manner and will take into account relevant risk factors ad market conditions when evaluating its asset and liability management objectives. The term of a financial management product shall not extend beyond the final maturity date of the underlying debt or the maturity date of the referenced investments. Harris Health may evaluate the use of financial management products by comparison to traditional financing structures and will only use a risk management product if it produces significant quantifiable value or reduces the risk exposure associated with management of the debt portfolio. The Harris Health Chief Financial Officer, the Deputy Executive Director of the Office of Management and Budget and the Harris Health Swap Advisor (the "Financial Management Products Committee") will periodically review current market conditions for risk management products and will evaluate how current conditions affect existing and/or any proposed future risk management products.

2. Policy Considerations Specific to Financial Management Products.

   A. Interest rate swaps may be used by Harris Health to lower interest expense, manage financial risk or to create a risk profile not otherwise achievable through traditional debt or investment instruments.

   B. Risk factors to evaluate when considering interest rate swaps:

      i. Interest rate risk
      ii. Termination risk
      iii. Counterparty risk
         a. Credit Quality
         b. Concentration
      iv. Basis Risk
      v. Collateral posting requirements
      vi Liquidity risk
      vii. Tax Risk
      viii. Accounting risk and ability to receive independent third party fair market valuation

   C. Criteria for selecting counterparty shall be determined by the Harris Health System Board of Trustees, consistent with other applicable regulations, and shall include:

      i. Counterparty shall be rated at AA-/Aa3/AA- by at least two of Standard & Poor's Rating Services ("S&P"), Moody's Investors Service ("Moody's), and Fitch Ratings ("Fitch"), respectively; or

ii. If rated below AA-/Aa3/AA- by at least two of S&P's Moody's, and Fitch, respectively, or if not rated, then the counterparty shall obtain credit enhancement with respect to its obligations under the financial management transaction from a provider that is rated at least AA-/Aa3/AA- by at least two of S&P, Moody's, and Fitch, respectively; or

iii. If rated below AA-/Aa3/AA- by least two of S&P, Moody's, and Fitch, respectively, or if not rated, then the counterparty shall provide credit support that requires the counterparty to deliver collateral for the benefit of the Harris Health System (a) that is of a kind and in such amounts as are specified therein and which related to various rating threshold levels of the counterparty or its guarantor, beginning at AA-/Aa3/AA- (S&P/Moody's/Fitch) and (b) that, in the judgment of the Harris Health System, is reasonable and customary for similar transactions, taking into account all aspects of the financial management product including, without limitation, the economic terms of the financial management product and the creditworthiness of the counterparty or its guarantor.

iv. Counterparty must disclose any payments made to a third party in connection with the procurement of the transaction as required by Texas Government Code §1371.056.

D. Limitations on fixed rate and basis swaps:

Fixed rate and basis swaps may not exceed 35% of total outstanding par value of the Harris Health bonds and outstanding debt net of any offsetting swap transactions.

E. Limitation on counterparty termination exposure;

Uncollateralized counterparty termination exposure shall not exceed $75 million per counterparty.

3. Reporting Requirements

A. Prior to the execution of any financial management product, Harris Health will submit a record of the proceedings of Harris Health authorizing the execution of the financial management product and any contract providing revenue or security to pay the financial management product to the Texas Attorney General for review and approval as required under Texas Government Code §1371.057.

B. As required under Texas Government Code §1371.056, the governing body or an authorized officer of Harris Health shall make a determination that each financial management product conforms to Harris Health's Financial Management Products Policy after reviewing a report of the chief financial officer that identifies with respect to each financial management product:

i. Its purpose;

ii. The anticipated economic benefit and the method used to determine the anticipated benefit;

iii. The use of the receipts of the transaction;

iv. The notional amount, amortization, and average life compared to the obligation;

v. Any floating indices;

vi. Its effective date and duration;

vii. The identity and credit rating of the counterparties; or credit support entities;

viii. The cost and anticipated benefit of transaction insurance;

ix. The financial advisors and the legal advisors and their fees;

x. Any security for scheduled and early termination payments;

xi. Any associated risks and risk mitigation features; and

xii. Early termination provisions.

C. As required by Texas Government Code §1371.061, on at least an annual basis an authorized designee of Harris Health, in consultation with the Financial Management Products Committee, shall report in writing the status of all outstanding financial management products to the Board of Trustees. Any such report shall include, but not be limited to, the following information:

(i) Disclosure of all changes to financial management products or new financial management products entered into by Harris Health since the last report to the Board of Trustees;

(ii) A summary of each financial management product including, but not limited to, the type of financial management product, specific terms, cash flows, the marked-to-market value, the final maturity date, and other information of interest to the Board of Trustees;

(iii) A statement as to whether the continuation of each financial management product would comply with this Financial Management Products Policy;

(iv) The total notional amount of financial management products detailed by counterparty;

(v) The credit ratings of each counterparty to Harris Health, and those of any credit enhancer insuring or guaranteeing financial management product payments (as applicable);

(vi) Any default or rating change by a counterparty to Harris Health, and the results of default or rating change including the financial impact to Harris Health, if any;

(vii) Collateral posted by each counterparty to Harris Health, if any, and by Harris Health, if any, detailed by each financial management product and in total by counterparty; and

(viii) The market movement or rating change required to trigger a collateral posting requirement, as applicable.

4. Regulatory Compliance Guidelines. Pursuant to the authority of Section 731 of Title VII of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 ("Dodd-Frank"), which includes amendments to the Commodity and Exchange Act (the "CEA") regarding over-the-counter derivative instruments including financial management products, regulations were published by the Commodity Futures Trading Commission (the "CFTC") that define business conduct between swap dealers and their counterparties, including swap dealers engaged in swap transactions with state and local governmental counterparties such as Harris Health (referred to in the regulations as "Special Entities"). Following is a list of regulatory requirements imposed under the authority of Dodd-Frank with which Harris Health shall make every reasonable effort to comply:

A. As required by CFTC Regulation 23.450, which includes language added to Section 4s(h) (5) of the CEA, it is Harris Health's policy to procure a qualified independent representative (the "QIR") as its swap advisor. In order to qualify as a QIR, the swap advisor must meet the following criteria:

(i) Has sufficient knowledge to evaluate the transaction and associated risks;

(ii) Is not subject to a statutory disqualification;

(iii) Is independent of the swap dealer (counterparty);

(iv) Undertakes a duty to act in the best interests of Harris Health;

(v) Makes appropriate and timely disclosure to Harris Health;

(vi) Evaluates, consistent with any guidelines provided by Harris Health, fair pricing and the appropriateness of the financial management products; and

(vii) Is subject to restrictions on certain political contributions imposed by the CFTC, the Securities and Exchange Commission (the "SEC"), or a self-regulatory organization subject to the jurisdiction of the CFTC or the SEC.

B. At least annually, Harris Health shall conduct a review of its QIR to ensure that it still meets the criteria listed in Part A above.

C. In order to ensure that Harris Health is in compliance with all regulatory reform imposed by Dodd-Frank, Harris Health may, but is not required to, execute an ISDA August 2012 DF Protocol Agreement (each a "Protocol Agreement") with its QIR and each counterparty prior to executing any financial management product. If Harris Health elects not to execute a Protocol Agreement with each counterparty, then Harris Health shall provide an alternate form of written representation to each counterparty that meets all applicable disclosure requirements as required by Dodd-Frank.

D. Section 2(h)(1) of the CEA requires that certain financial management products, including those commonly entered into by state and local governmental entities such as Harris Health, must be cleared through a derivatives clearing organization unless otherwise exempt from clearing under the "End User Exception" in Section 2(h)(7) of the CEA. In order to qualify for the End User Exception, Harris Health must report to the CFTC on either an annual or a transaction-by-transaction basis that is (i) is not a financial entity; (ii) is using financial management products to hedge or mitigate commercial risk; and (iii) will notify the CFTC, in a manner set forth by the CFTC, how it generally meets it financial obligations associated with entering into non-cleared financial management products. Harris Health, in consultation with the QIR, shall make its best efforts to comply with Sections 2(h) (1) and 2(h) (7) of the CEA, as applicable.

Thursday, December 12, 2024

Consideration of Acceptance of the Harris Health October 2024 Financial Report Subject to Audit

Attached for your review and consideration is the October 2024 Financial Report.

Administration recommends that the Board accept the financial report for the period ended October 31, 2024, subject to final audit.

Victoria Nikitin
EVP – Chief Financial Officer

HARRISHEALTH

Financial Statements

As of October 31, 2024
Subject to Audit

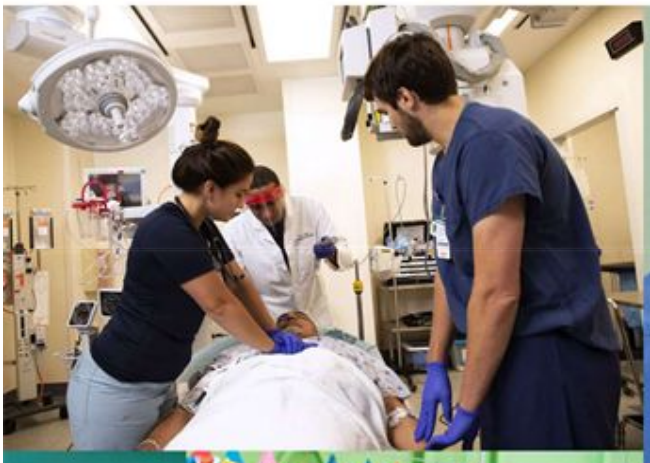


Table of Contents

HARRISHEALTH

Operating income for the month ended October 31, 2024 was $2.5 million compared to budgeted income of $8.6 million.

Total net revenue for the month ended October 31, 2024 of $213.0 million was $9.2 million or 4.12% less than budget. Net patient revenue and ad valorem taxes were $7.1 million and $2.0 million, respectively, less than budget. Medicaid Supplemental programs were $2.0 million more than expected primarily due to the receipt of a refund for program year 2024.

As of October 31, 2024, total expenses of $210.5 million were $3.0 million or 1.41% less than budget. Total services had a favorable variance of $4.6 million driven mostly by lower maintenance and physician expense.

Through the month ended October 31, 2024, total patient days and average daily census increased 2.4% compared to budget. Inpatient case mix index, a measure of patient acuity, and length of stay were 2.5% lower and 1.2% higher, respectively, than budget. Emergency room visits were 7.8% higher than planned for the month. Total clinic visits, including telehealth, were 7.0% higher compared to budget. Births were up 8.4%.

Total cash receipts for the month were $57.7 million. The System has $1,288.0 million in unrestricted cash, cash equivalents and investments, representing 196.2 days cash on hand. Harris Health System has $141.2 million in net accounts receivable, representing 77.8 days of outstanding patient accounts receivable at October 31, 2024. The October balance sheet reflects a combined net receivable position of $119.2 million under the various Medicaid Supplemental programs. The current portion of ad valorem taxes receivable is $1,020.8 million, which is offset by ad valorem tax collections as received. Accounts payable and accrued liabilities include $937.4 million in deferred ad valorem tax revenues that are released as ad valorem tax revenue is recognized. As of October 31, 2024, no current ad valorem tax collections were received and $85.2 million in current ad valorem tax revenue was recognized.

Income Statement

HARRISHEALTH

As of October 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH			YEAR-TO-DATE			
	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	CURRENT YEAR	CURRENT BUDGET	PERCENT VARIANCE	PRIOR YEAR	PERCENT VARIANCE
REVENUE								
Net Patient Revenue	$ 56.2	$ 63.3	-11.2%	$ 56.2	$ 63.3	-11.2%	$ 51.8	8.6%
Medicaid Supplemental Programs	55.9	53.9	3.7%	55.9	53.9	3.7%	68.0	-17.8%
Other Operating Revenue	11.1	12.5	-11.6%	11.1	12.5	-11.6%	11.1	-0.1%
Total Operating Revenue	**$ 123.2**	**$ 129.8**	**-5.1%**	**$ 123.2**	**$ 129.8**	**-5.1%**	**$ 130.9**	**-5.8%**
Net Ad Valorem Taxes	83.1	85.1	-2.3%	83.1	85.1	-2.3%	74.8	11.1%
Net Tobacco Settlement Revenue	-	-	0.0%	-	-	0.0%	-	0.0%
Capital Gifts & Grants	-	0.8	0.0%	-	0.8	-100.0%	-	0.0%
Interest Income & Other	6.7	6.5	3.4%	6.7	6.5	3.4%	7.1	-5.1%
Total Nonoperating Revenue	**$ 89.8**	**$ 92.4**	**-2.8%**	**$ 89.8**	**$ 92.4**	**-2.8%**	**$ 81.9**	**9.7%**
Total Net Revenue	**$ 213.0**	**$ 222.2**	**-4.1%**	**$ 213.0**	**$ 222.2**	**-4.1%**	**$ 212.7**	**0.1%**
EXPENSE								
Salaries and Wages	$ 81.0	$ 80.4	-0.7%	$ 81.0	$ 80.4	-0.7%	$ 79.2	-2.3%
Employee Benefits	27.6	27.7	0.2%	27.6	27.7	0.2%	29.0	4.9%
Total Labor Cost	**$ 108.6**	**$ 108.1**	**-0.5%**	**$ 108.6**	**$ 108.1**	**-0.5%**	**$ 108.2**	**-0.4%**
Supply Expenses	29.1	29.3	0.7%	29.1	29.3	0.7%	25.4	-14.6%
Physician Services	37.2	38.7	4.1%	37.2	38.7	4.1%	36.8	-1.1%
Purchased Services	26.9	29.9	10.0%	26.9	29.9	10.0%	20.4	-31.6%
Depreciation & Interest	8.7	7.5	-16.6%	8.7	7.5	-16.6%	7.7	-12.9%
Total Operating Expense	**$ 210.5**	**$ 213.5**	**1.4%**	**$ 210.5**	**$ 213.5**	**1.4%**	**$ 198.5**	**-6.0%**
Operating Income (Loss)	**$ 2.5**	**$ 8.6**		**$ 2.5**	**$ 8.6**		**$ 14.2**	
Total Margin %	**1.2%**	**3.9%**		**1.2%**	**3.9%**		**6.7%**	

Balance Sheet

HARRISHEALTH

October 31, 2024 and 2023 (in $ Millions)

	CURRENT YEAR	PRIOR YEAR
CURRENT ASSETS		
Cash, Cash Equivalents and Short Term Investments	$ 1,288.0	$ 1,274.7
Net Patient Accounts Receivable	141.2	173.0
Net Ad Valorem Taxes, Current Portion	1,020.8	907.6
Other Current Assets	177.8	172.7
Total Current Assets	**$ 2,627.8**	**$ 2,527.9**
CAPITAL ASSETS		
Plant, Property, & Equipment, Net of Accumulated Depreciation	$ 562.3	$ 522.0
Construction in Progress	232.7	147.6
Right of Use Assets	36.1	43.1
Total Capital Assets	**$ 831.1**	**$ 712.7**
ASSETS LIMITED AS TO USE & RESTRICTED ASSETS		
Debt Service & Capital Asset Funds	$ 34.0	$ 39.8
LPPF Restricted Cash	34.1	32.9
Capital Gift Proceeds	53.9	55.2
Other - Restricted	1.0	1.0
Total Assets Limited As to Use & Restricted Assets	**$ 123.1**	**$ 128.9**
Other Assets	33.1	35.4
Deferred Outflows of Resources	182.3	234.8
Total Assets & Deferred Outflows of Resources	**$ 3,797.4**	**$ 3,639.7**
CURRENT LIABILITIES		
Accounts Payable and Accrued Liabilities	$ 217.4	$ 192.6
Employee Compensation & Related Liabilities	146.3	132.3
Deferred Revenue - Ad Valorem	937.4	833.3
Estimated Third-Party Payor Settlements	30.3	18.0
Current Portion Long-Term Debt and Capital Leases	35.3	36.6
Total Current Liabilities	**$ 1,366.7**	**$ 1,212.7**
Long-Term Debt	280.3	299.7
Net Pension & Post Employment Benefits Liability	686.7	777.3
Other Long-Term Liabilities	8.2	7.1
Deferred Inflows of Resources	110.4	115.3
Total Liabilities	**$ 2,452.3**	**$ 2,412.2**
Total Net Assets	**$ 1,345.1**	**$ 1,227.6**
Total Liabilities & Net Assets	**$ 3,797.4**	**$ 3,639.7**

Cash Flow Summary

HARRISHEALTH

As of October 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE	
	CURRENT YEAR	PRIOR YEAR	CURRENT YEAR	PRIOR YEAR
CASH RECEIPTS				
Collections on Patient Accounts	$ 74.2	$ 64.8	$ 74.2	$ 64.8
Medicaid Supplemental Programs	(25.8)	403.4	(25.8)	403.4
Net Ad Valorem Taxes	0.0	0.0	0.0	0.0
Tobacco Settlement	-	-	-	-
Other Revenue	9.2	15.4	9.2	15.4
Total Cash Receipts	**$ 57.7**	**$ 483.7**	**$ 57.7**	**$ 483.7**
CASH DISBURSEMENTS				
Salaries, Wages and Benefits	$ 103.2	$ 118.4	$ 103.2	$ 118.4
Supplies	35.9	24.4	35.9	24.4
Physician Services	35.2	35.8	35.2	35.8
Purchased Services	29.1	22.2	29.1	22.2
Capital Expenditures	29.4	16.4	29.4	16.4
Debt and Interest Payments	0.3	0.3	0.3	0.3
Other Uses	0.0	5.4	0.0	5.4
Total Cash Disbursements	**$ 233.1**	**$ 222.7**	**$ 233.1**	**$ 222.7**
Net Change	**$ (175.4)**	**$ 261.0**	**$ (175.4)**	**$ 261.0**

Unrestricted cash, cash equivalents and investments - Beginning of year	$ 1,463.4
Net Change	$ (175.4)
Untrestricted cash, cash equivalents and investments - End of period	**$ 1,288.0**

Performance Ratios

HARRISHEALTH

As of October 31, 2024 and 2023 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE		
	CURRENT YEAR	CURRENT BUDGET	CURRENT YEAR	CURRENT BUDGET	PRIOR YEAR
OPERATING HEALTH INDICATORS					
Operating Margin %	1.2%	3.9%	1.2%	3.9%	6.7%
Run Rate per Day (In$ Millions)	$ 6.5	$ 6.7	$ 6.5	$ 6.7	$ 6.2
Salary, Wages & Benefit per APD	$ 2,348	$ 2,399	$ 2,348	$ 2,399	$ 2,369
Supply Cost per APD	$ 630	$ 651	$ 630	$ 651	$ 557
Physician Services per APD	$ 804	$ 860	$ 804	$ 860	$ 805
Total Expense per APD	**$ 4,553**	**$ 4,741**	**$ 4,553**	**$ 4,741**	**$ 4,349**
Overtime as a % of Total Salaries	3.4%	3.2%	3.4%	3.2%	3.8%
Contract as a % of Total Salaries	3.3%	2.9%	3.3%	2.9%	5.0%
Full-time Equivalent Employees	10,429	10,342	10,429	10,342	10,286
FINANCIAL HEALTH INDICATORS					
Quick Ratio			1.9		2.1
Unrestricted Cash (In $ Millions)			$ 1,288.0	$ 1,326.4	$ 1,274.7
Days Cash on Hand			196.2	198.9	205.1
Days Revenue in Accounts Receivable			77.8	75.8	103.6
Days in Accounts Payable			45.4		51.3
Capital Expenditures/Depreciation & Amortization			374.5%		241.1%
Average Age of Plant (years)			9.7		10.6

Harris Health System Key Indicators

Statistical Highlights

HARRISHEALTH

As of October 31, 2024 and 2023

	MONTH-TO-MONTH			YEAR-TO-DATE				
	CURRENT QUARTER	CURRENT BUDGET	PERCENT CHANGE	CURRENT YEAR	CURRENT BUDGET	PERCENT CHANGE	PRIOR YEAR	PERCENT CHANGE
Adjusted Patient Days	46,246	45,039	2.7%	46,246	45,039	2.7%	45,659	1.3%
Outpatient % of Adjusted Volume	64.3%	62.4%	3.0%	64.3%	62.4%	3.0%	62.3%	3.2%
Primary Care Clinic Visits	50,654	47,980	5.6%	50,654	47,980	5.6%	46,759	8.3%
Specialty Clinic Visits	23,589	21,306	10.7%	23,589	21,306	10.7%	20,797	13.4%
Telehealth Clinic Visits	10,862	10,244	6.0%	10,862	10,244	6.0%	10,064	7.9%
Total Clinic Visits	**85,105**	**79,530**	**7.0%**	**85,105**	**79,530**	**7.0%**	**77,620**	**9.6%**
Emergency Room Visits - Outpatient	12,793	11,743	8.9%	12,793	11,743	8.9%	11,786	8.5%
Emergency Room Visits - Admitted	1,850	1,842	0.4%	1,850	1,842	0.4%	1,918	-3.5%
Total Emergency Room Visits	**14,643**	**13,585**	**7.8%**	**14,643**	**13,585**	**7.8%**	**13,704**	**6.9%**
Surgery Cases - Outpatient	996	925	7.7%	996	925	7.7%	1,040	-4.2%
Surgery Cases - Inpatient	1,017	864	17.7%	1,017	864	17.7%	858	18.5%
Total Surgery Cases	**2,013**	**1,789**	**12.5%**	**2,013**	**1,789**	**12.5%**	**1,898**	**6.1%**
Total Outpatient Visits	**141,107**	**129,687**	**8.8%**	**141,107**	**129,687**	**8.8%**	**128,494**	**9.8%**
Inpatient Cases (Discharges)	2,621	2,720	-3.6%	2,621	2,720	-3.6%	2,942	-10.9%
Outpatient Observation Cases	1,061	882	20.3%	1,061	882	20.3%	983	7.9%
Total Cases Occupying Patient Beds	**3,682**	**3,602**	**2.2%**	**3,682**	**3,602**	**2.2%**	**3,925**	**-6.2%**
Births	503	464	8.4%	503	464	8.4%	428	17.5%
Inpatient Days	16,505	16,918	-2.4%	16,505	16,918	-2.4%	17,215	-4.1%
Outpatient Observation Days	3,642	2,757	32.1%	3,642	2,757	32.1%	2,962	23.0%
Total Patient Days	**20,147**	**19,675**	**2.4%**	**20,147**	**19,675**	**2.4%**	**20,177**	**-0.1%**
Average Daily Census	649.9	634.7	2.4%	649.9	634.7	2.4%	650.9	-0.1%
Average Operating Beds	702	700	0.3%	702	700	0.3%	696	0.9%
Bed Occupancy %	92.6%	90.7%	2.1%	92.6%	90.7%	2.1%	93.5%	-1.0%
Inpatient Average Length of Stay	6.30	6.22	1.2%	6.30	6.22	1.2%	5.85	7.6%
Inpatient Case Mix Index (CMI)	1.670	1.712	-2.5%	1.670	1.712	-2.5%	1.653	1.0%
Payor Mix (% of Charges)								
Charity & Self Pay	43.4%	43.4%	0.1%	43.4%	43.4%	0.1%	45.7%	-5.0%
Medicaid & Medicaid Managed	18.7%	19.4%	-3.8%	18.7%	19.4%	-3.8%	20.0%	-6.7%
Medicare & Medicare Managed	10.7%	11.4%	-6.5%	10.7%	11.4%	-6.5%	11.6%	-7.7%
Commercial & Other	27.2%	25.8%	5.6%	27.2%	25.8%	5.6%	22.7%	19.8%
Total Unduplicated Patients - Rolling 12				**247,828**			**248,536**	**-0.3%**
Total New Patient - Rolling 12				**90,180**			**88,091**	**2.4%**

Harris Health

Statistical Highlights

October FY 2025

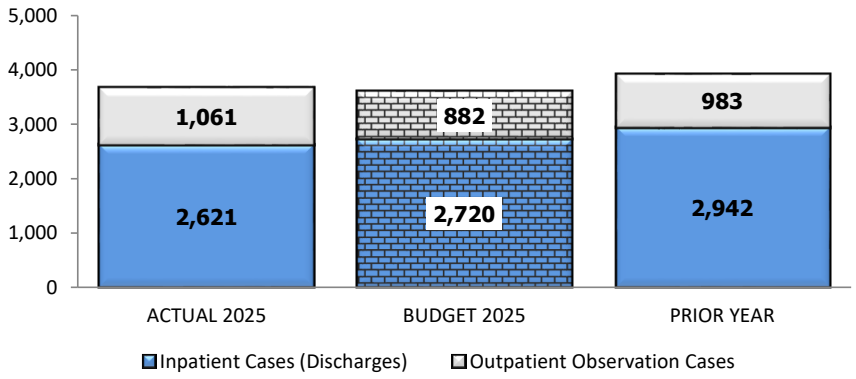
Cases Occupying Beds - CM		
Actual	Budget	Prior Year
3,682	3,602	3,925

Cases Occupying Beds - YTD		
Actual	Budget	Prior Year
3,682	3,602	3,925

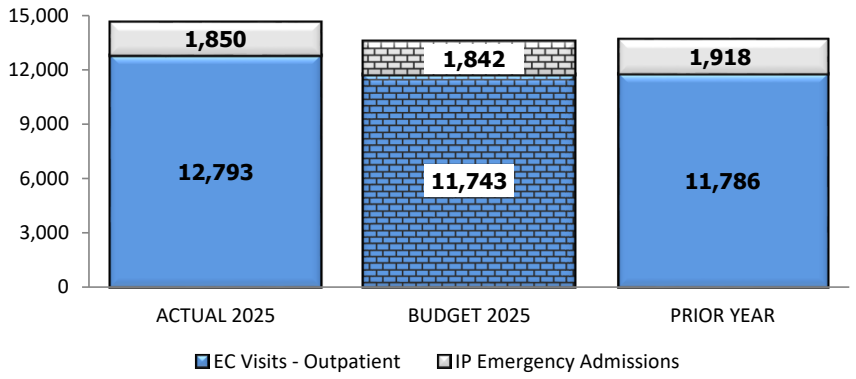
Emergency Visits - CM		
Actual	Budget	Prior Year
14,643	13,585	13,704

Emergency Visits - YTD		
Actual	Budget	Prior Year
14,643	13,585	13,704

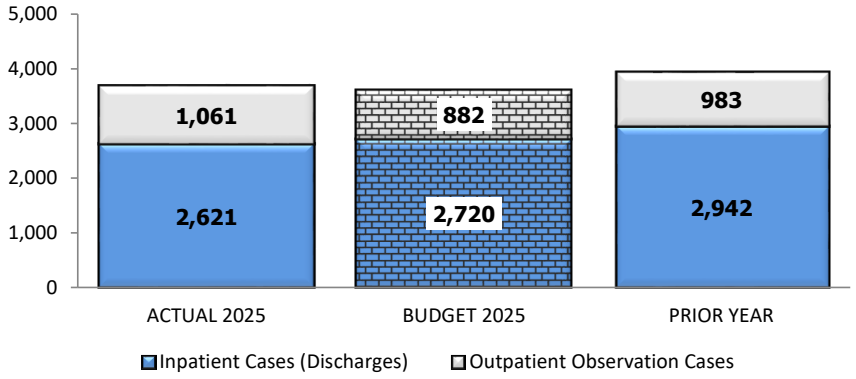
Cases Occupying Beds - Current Month



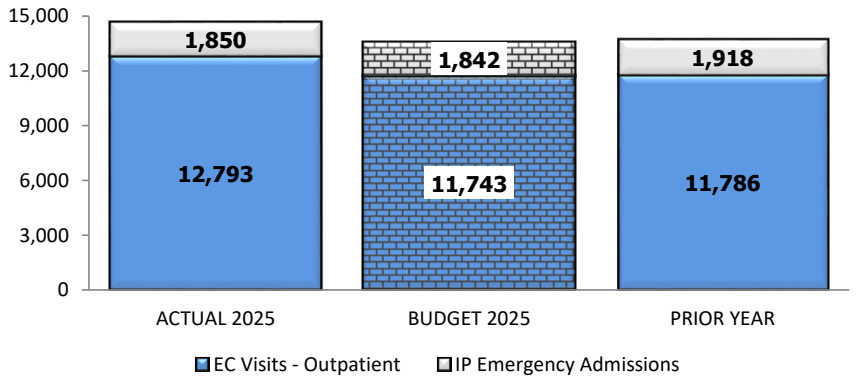
Emergency Visits - Current Month



Cases Occupying Beds - YTD



Emergency Visits - YTD



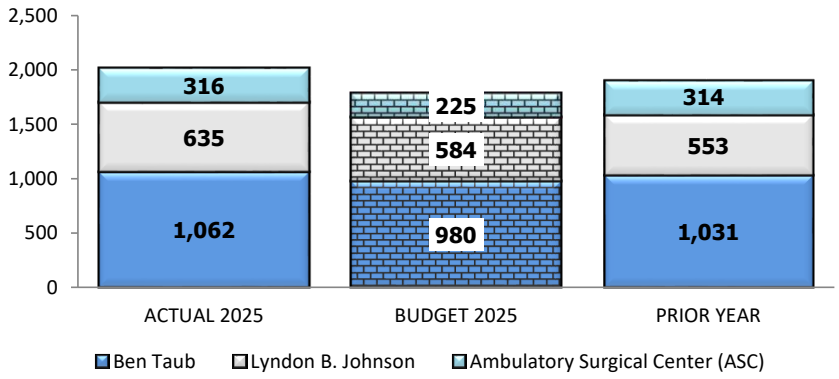
Harris Health

Statistical Highlights

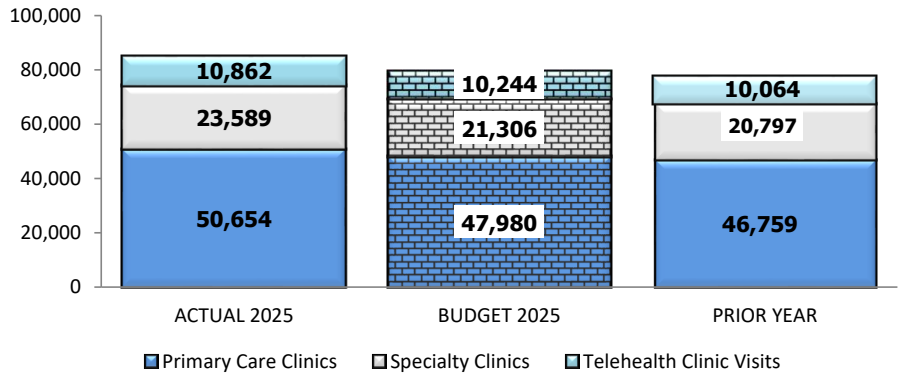
October FY 2025

Surgery Cases - CM			Surgery Cases - YTD			Clinic Visits - CM			Clinic Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
2,013	1,789	1,898	2,013	1,789	1,898	85,105	79,530	77,620	85,105	79,530	77,620

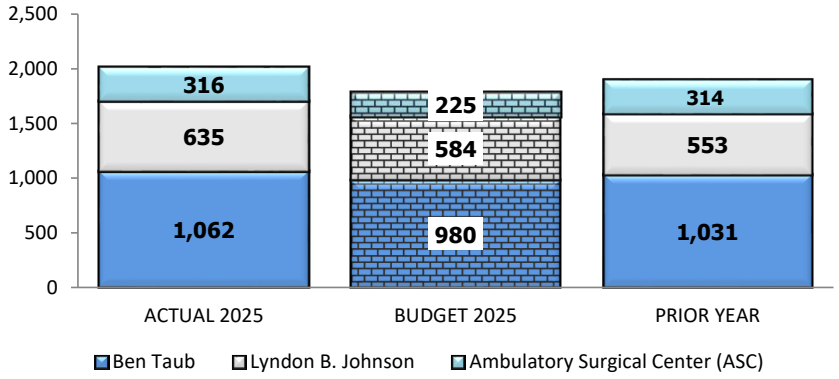
Surgery Cases - Current Month



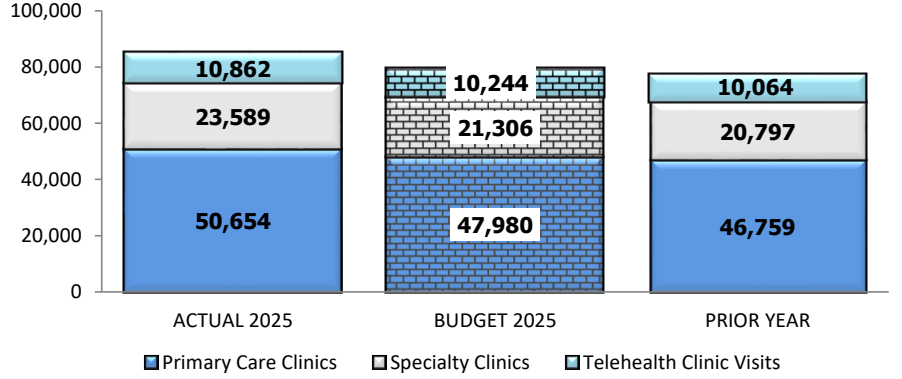
Clinic Visits - Current Month



Surgery Cases - YTD



Clinic Visits - YTD



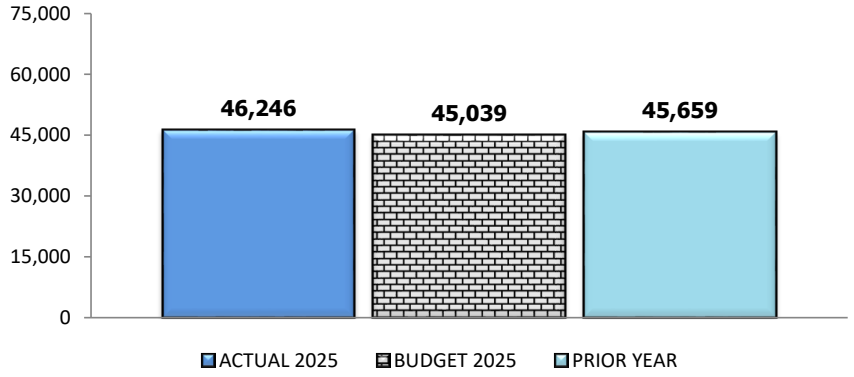
Harris Health

Statistical Highlights

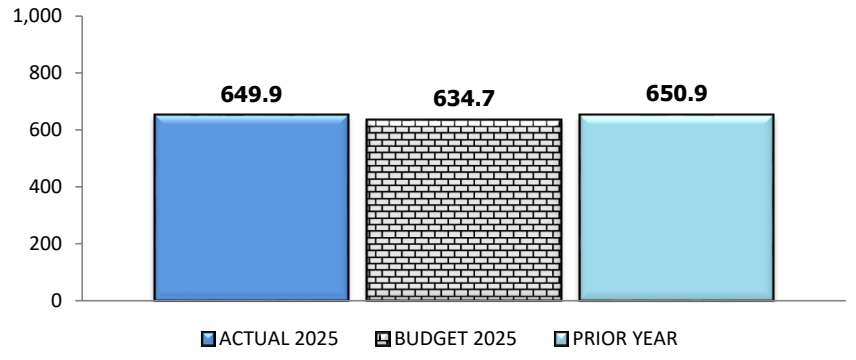
October FY 2025

Adjusted Patient Days - CM	Adjusted Patient Days - YTD	Average Daily Census - CM	Average Daily Census - YTD
46,246	46,246	649.9	649.9

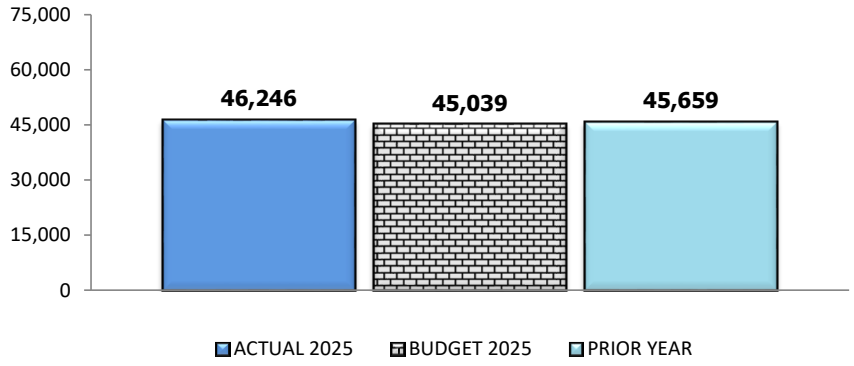
Adjusted Patient Days - Current Month



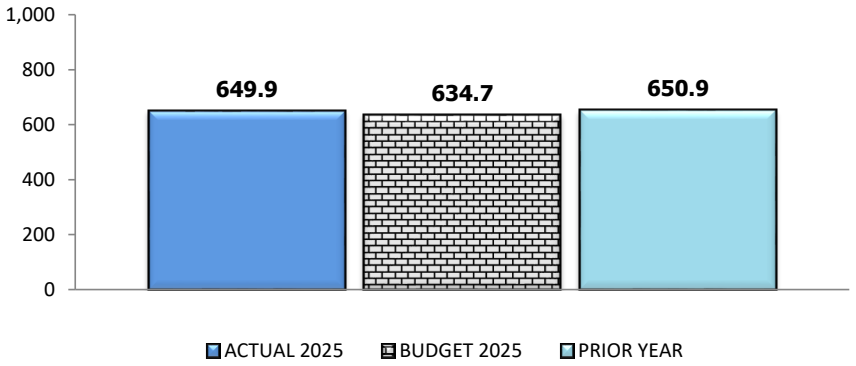
Average Daily Census - Current Month



Adjusted Patient Days - YTD



Average Daily Census - YTD



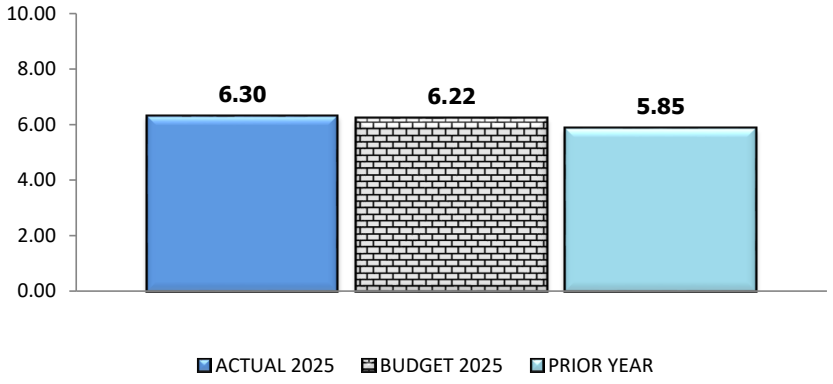
Harris Health

Statistical Highlights

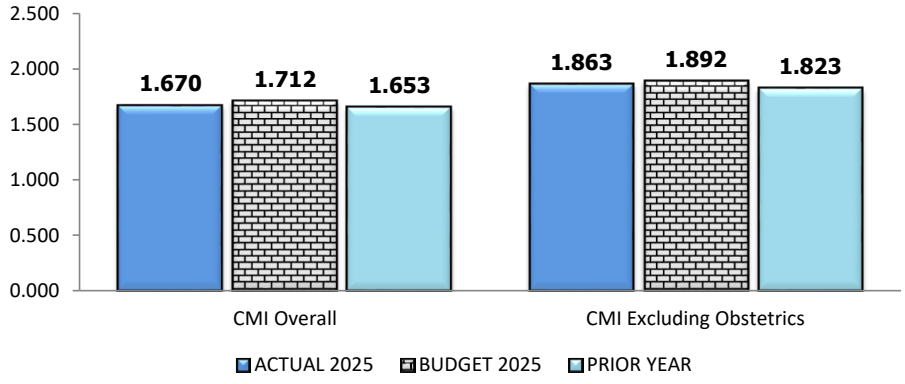
October FY 2025

Inpatient ALOS - CM	Inpatient ALOS - YTD	Case Mix Index (CMI) - CM		Case Mix Index (CMI) - YTD	
		Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
6.30	6.30	1.670	1.863	1.670	1.863

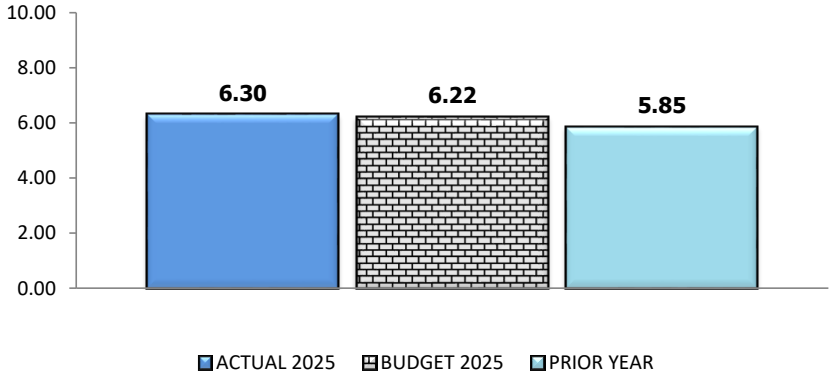
Inpatient ALOS - Current Month



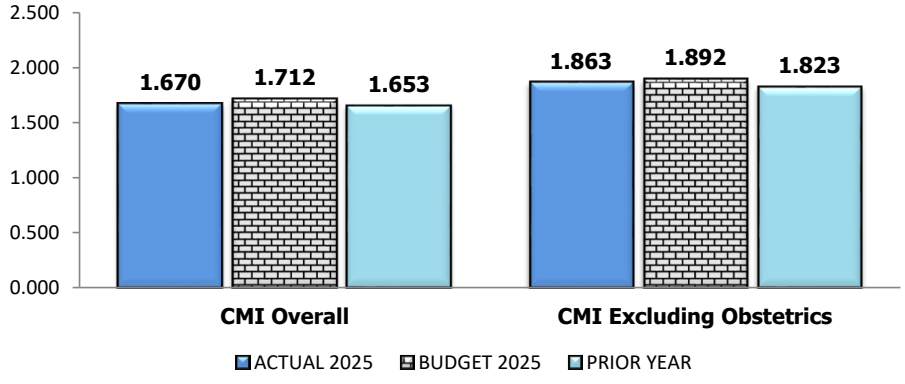
Case Mix Index - Current Month



Inpatient ALOS - YTD



Case Mix Index - YTD



Harris Health

Statistical Highlights - Cases Occupying Beds

October FY 2025

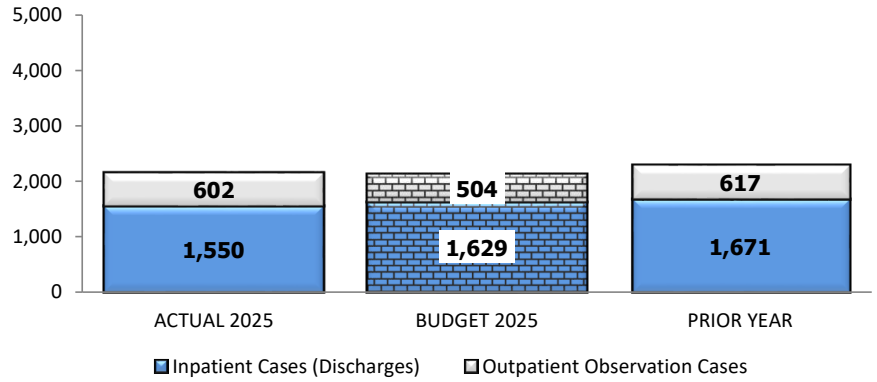
BT Cases Occupying Beds - CM		
Actual	Budget	Prior Year
2,152	2,133	2,288

BT Cases Occupying Beds - YTD		
Actual	Budget	Prior Year
2,152	2,133	2,288

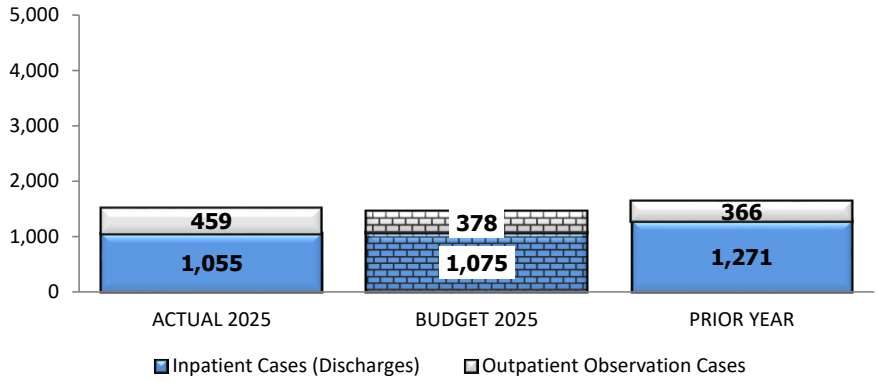
LBJ Cases Occupying Beds - CM		
Actual	Budget	Prior Year
1,514	1,453	1,637

LBJ Cases Occupying Beds - YTD		
Actual	Budget	Prior Year
1,514	1,453	1,637

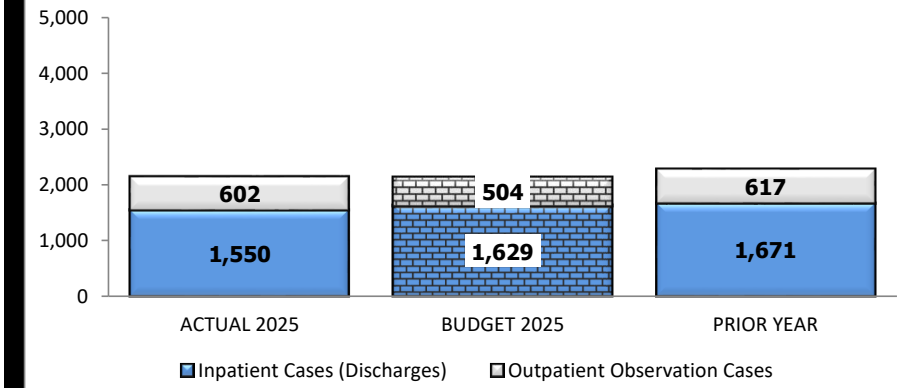
Ben Taub Cases - Current Month



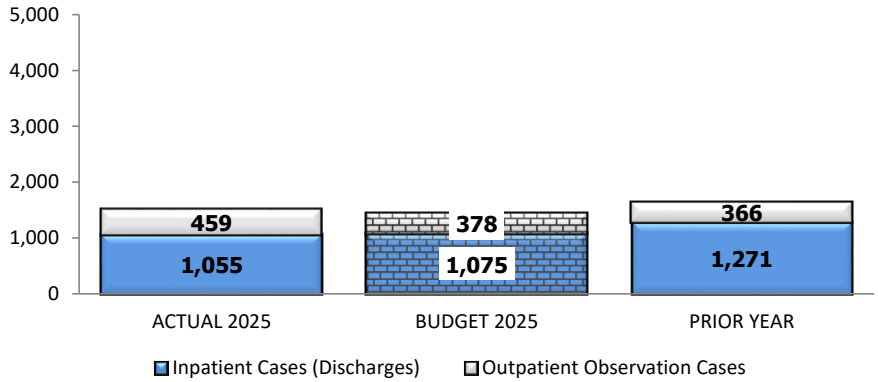
Lyndon B. Johnson Cases - Current Month



Ben Taub Cases - YTD



Lyndon B. Johnson Cases - YTD

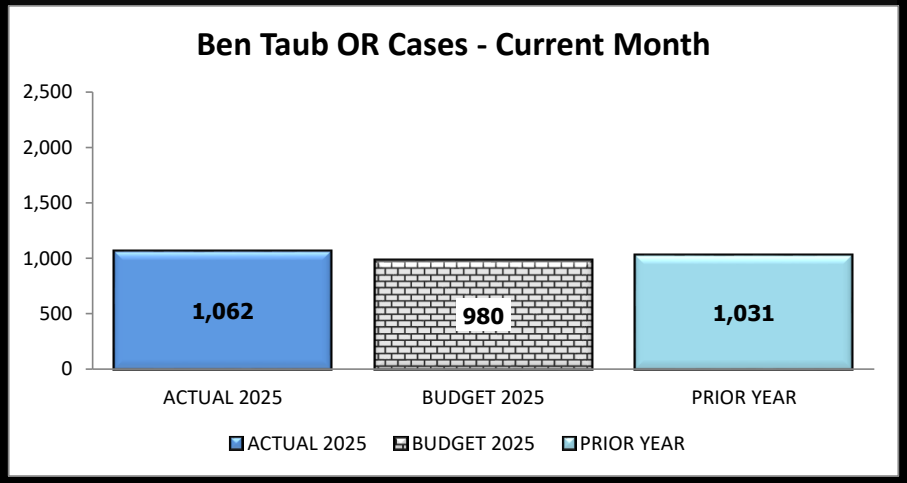


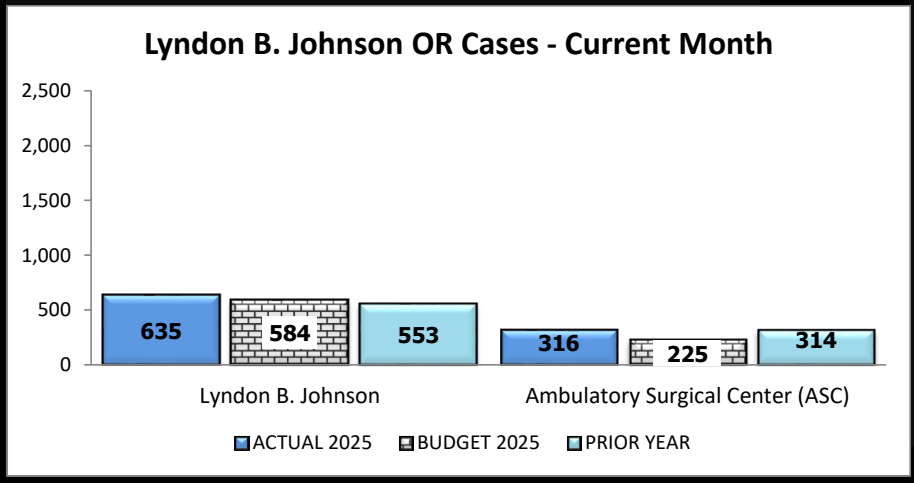
Harris Health

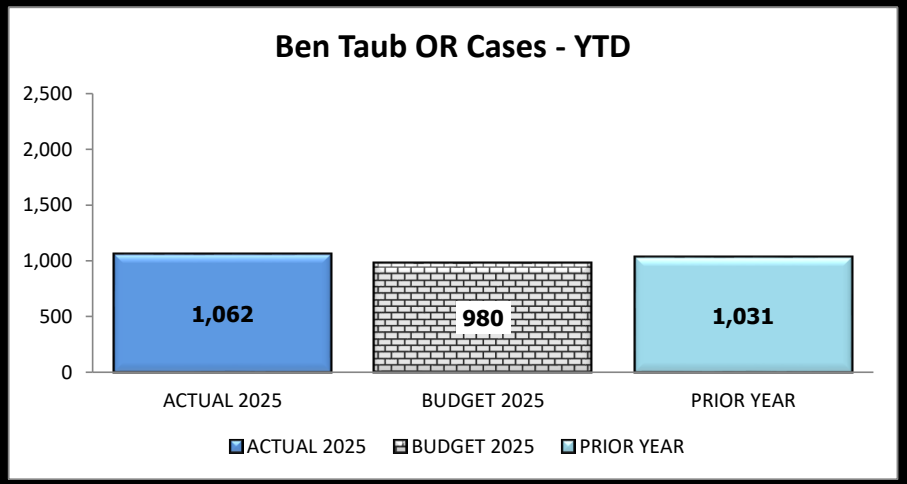
Statistical Highlights - Surgery Cases

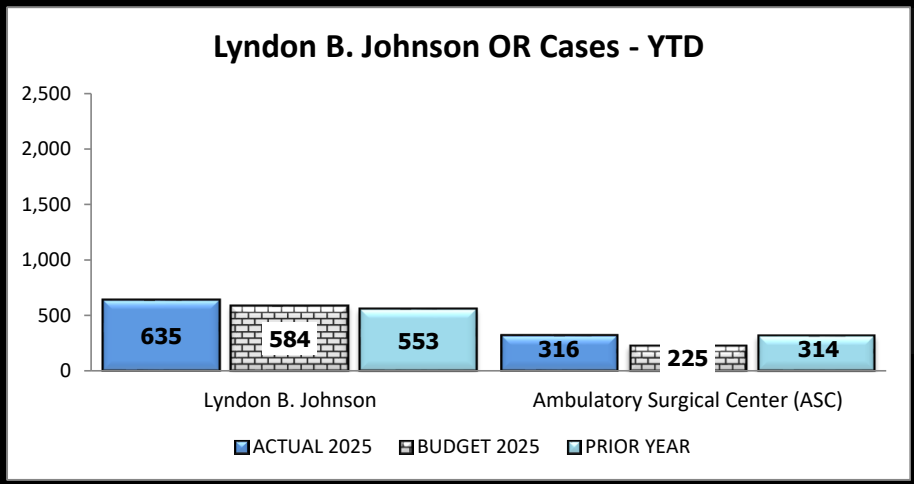
October FY 2025

BT Surgery Cases - CM			BT Surgery Cases - YTD			LBJ Surgery Cases - CM			LBJ Surgery Cases - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
1,062	980	1,031	1,062	980	1,031	951	809	867	951	809	867







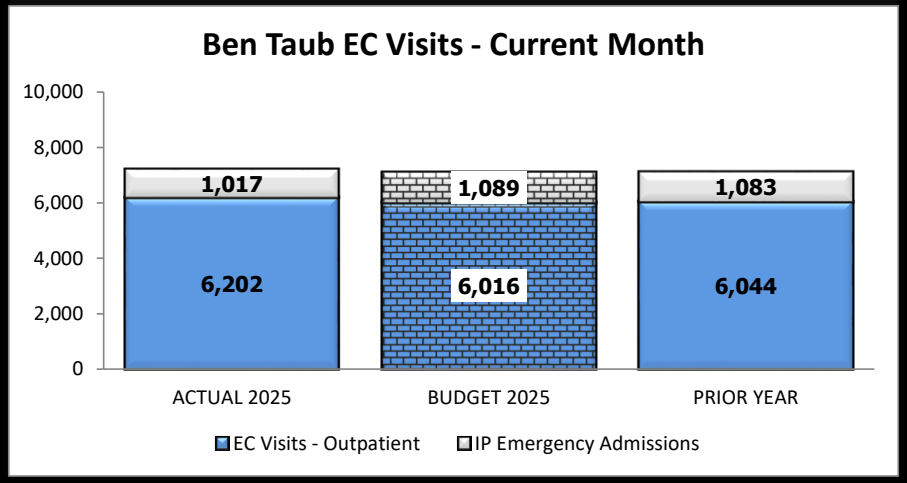


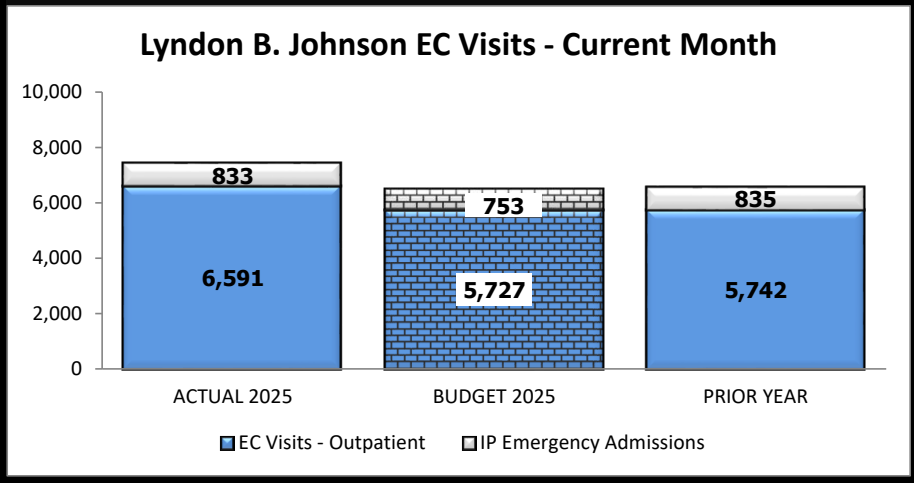
Harris Health

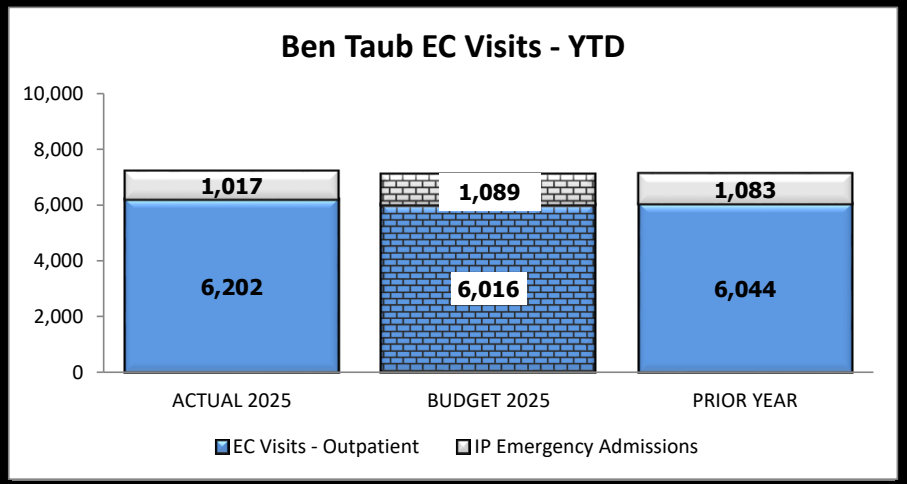
Statistical Highlights - Emergency Room Visits

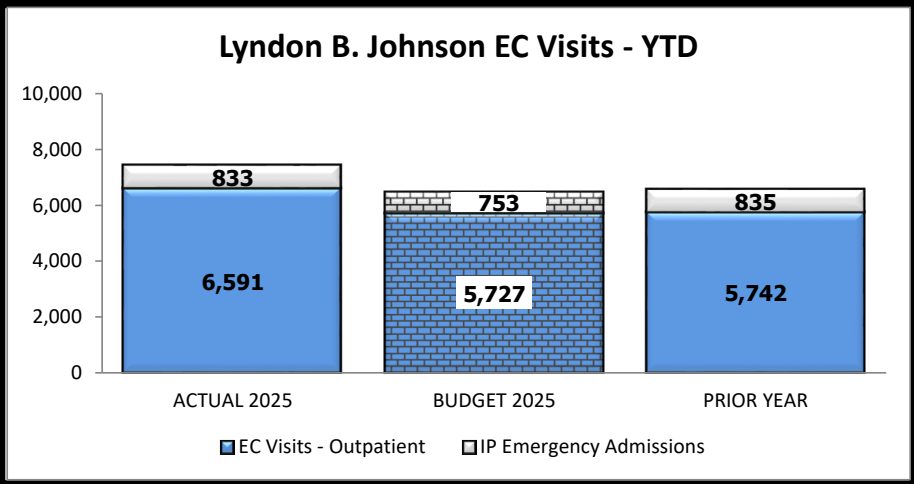
October FY 2025

BT Emergency Visits - CM			BT Emergency Visits - YTD			LBJ Emergency Visits - CM			LBJ Emergency Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
7,219	7,105	7,127	7,219	7,105	7,127	7,424	6,480	6,577	7,424	6,480	6,577







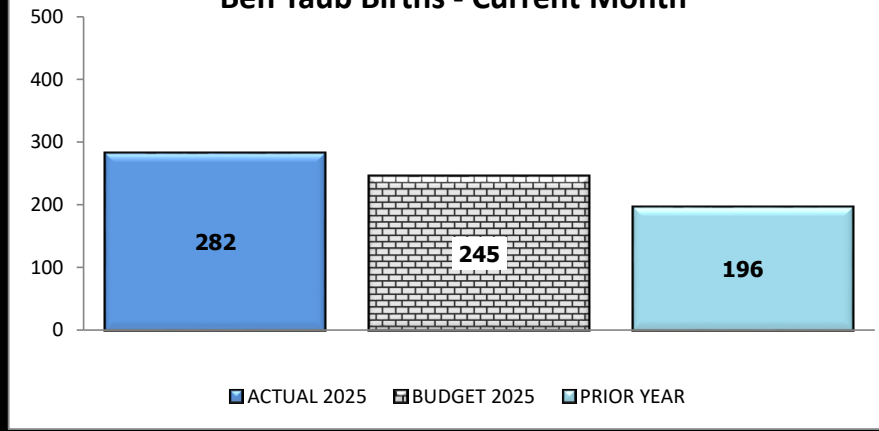


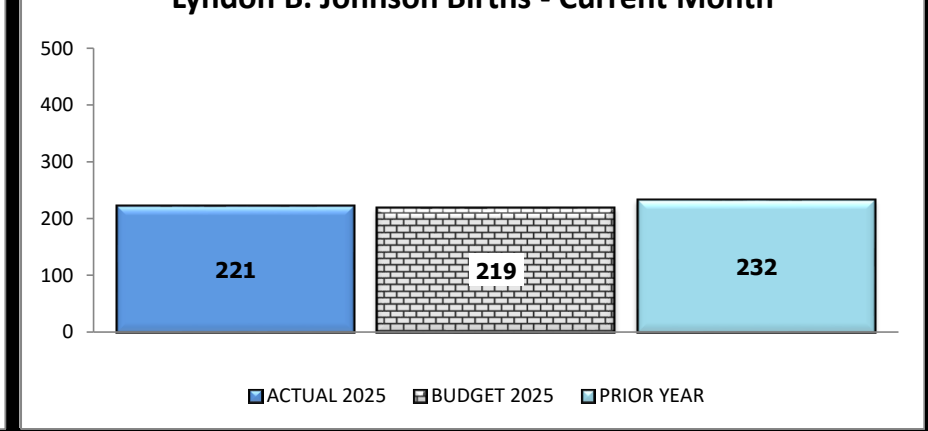
Harris Health

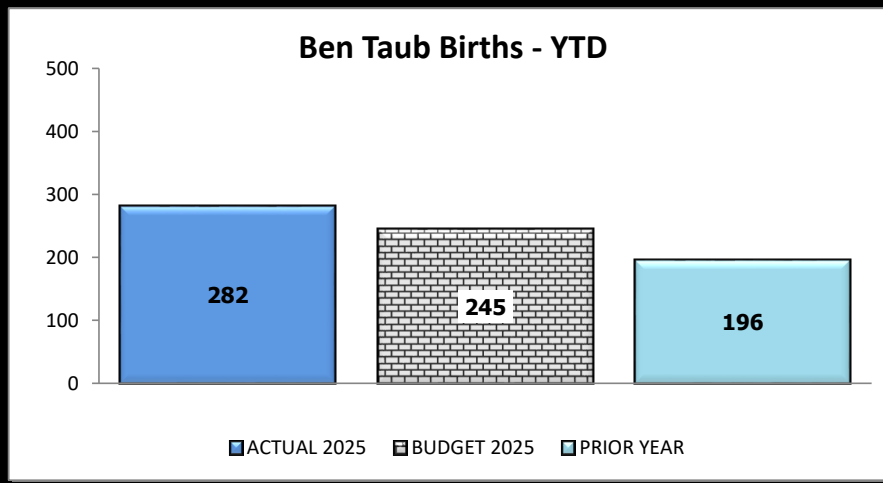
Statistical Highlights - Births

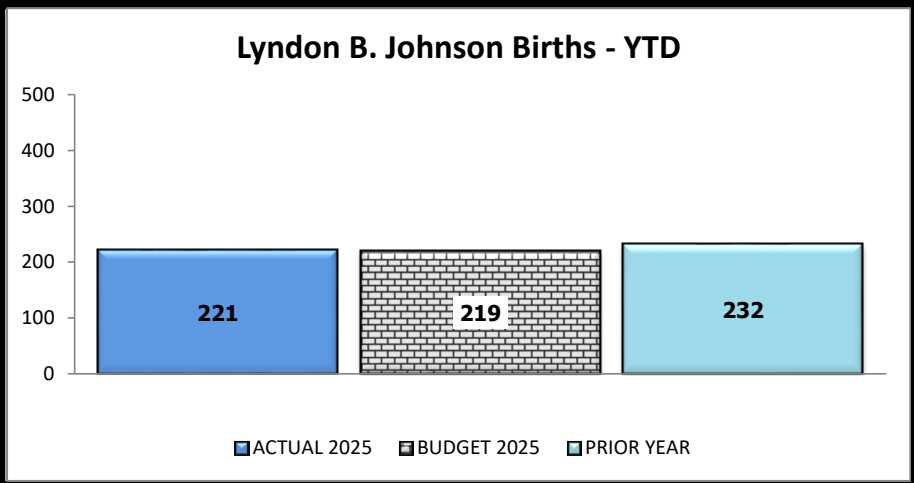
October FY 2025

BT Births - CM			BT Births - YTD			LBJ Births - CM			LBJ Births - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
282	245	196	282	245	196	221	219	232	221	219	232









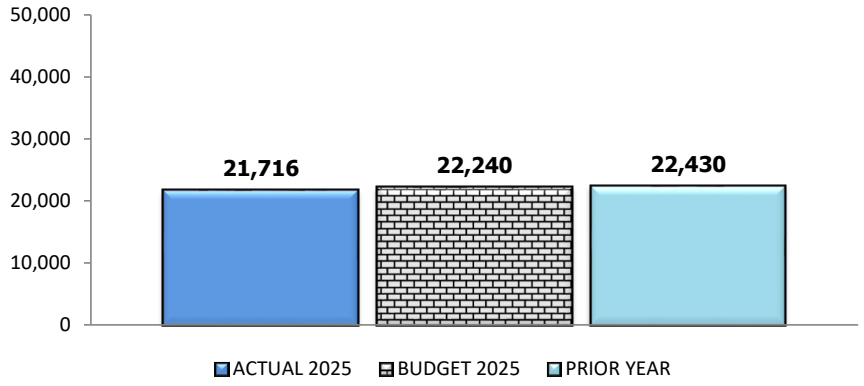
Harris Health

Statistical Highlights - Adjusted Patient Days

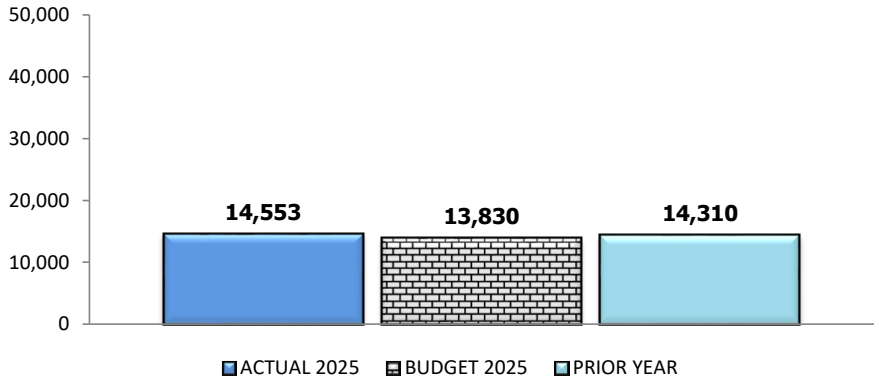
October FY 2025

BT Adjusted Patient Days - CM	BT Adjusted Patient Days - YTD	LBJ Adjusted Patient Days - CM	LBJ Adjusted Patient Days - YTD
21,716	21,716	14,553	14,553

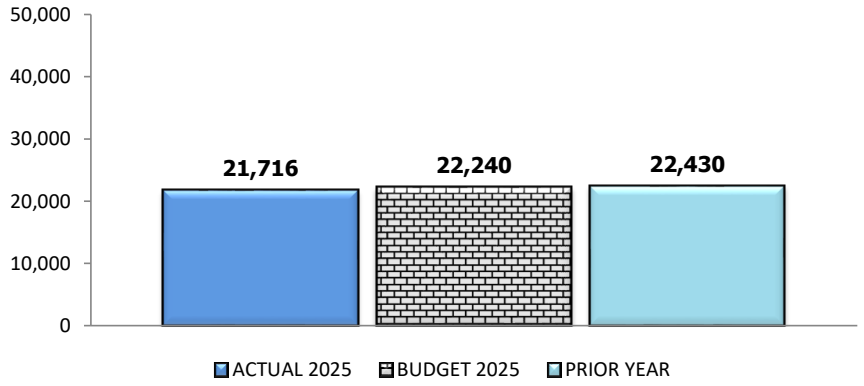
Ben Taub APD - Current Month



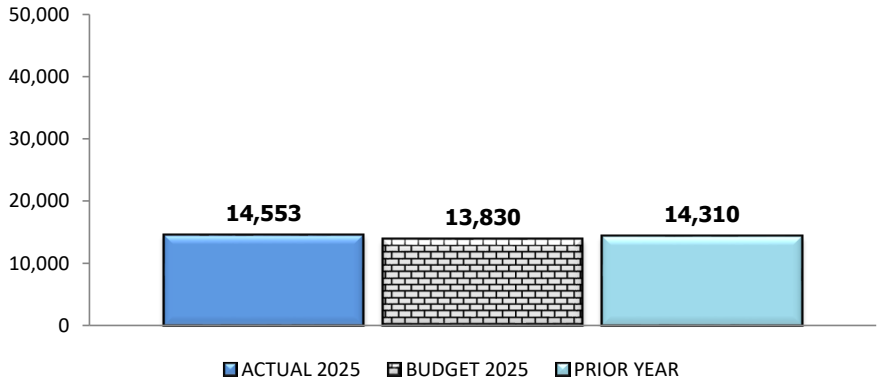
Lyndon B. Johnson APD - Current Month



Ben Taub APD - YTD



Lyndon B. Johnson APD - YTD



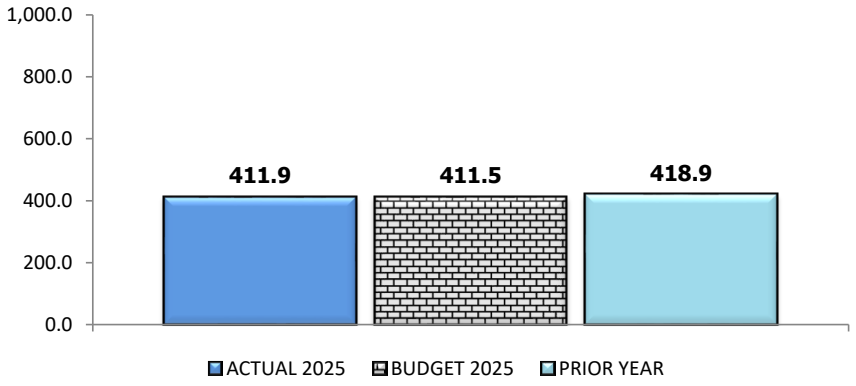
Harris Health

Statistical Highlights - Average Daily Census (ADC)

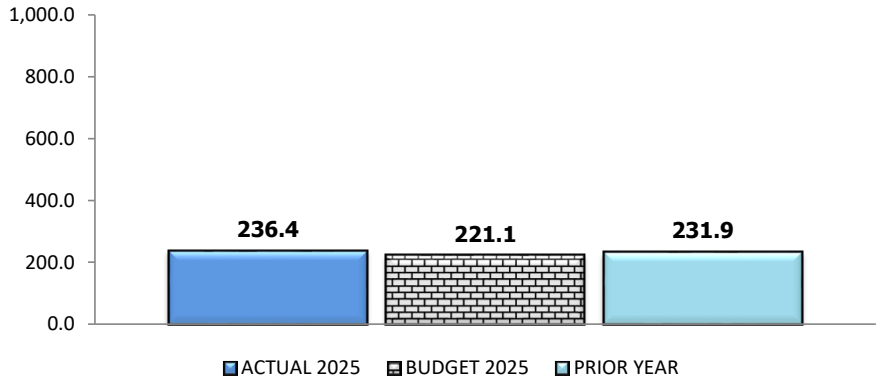
October FY 2025

BT Average Daily Census - CM	BT Average Daily Census - YTD	LBJ Average Daily Census - CM	LBJ Average Daily Census - YTD
411.9	411.9	236.4	236.4

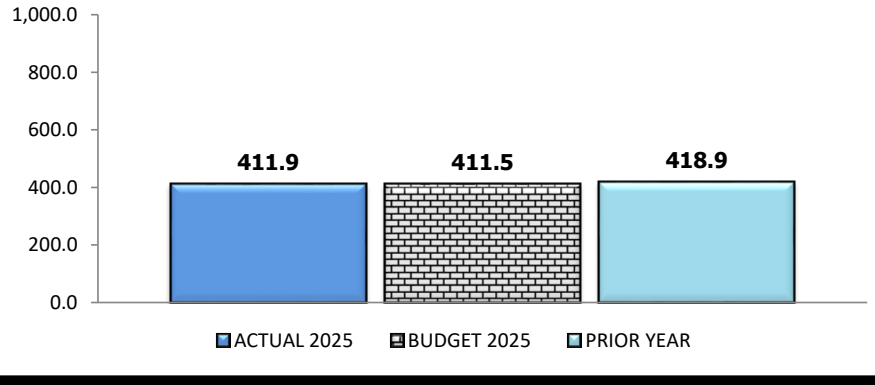
Ben Taub ADC - Current Month



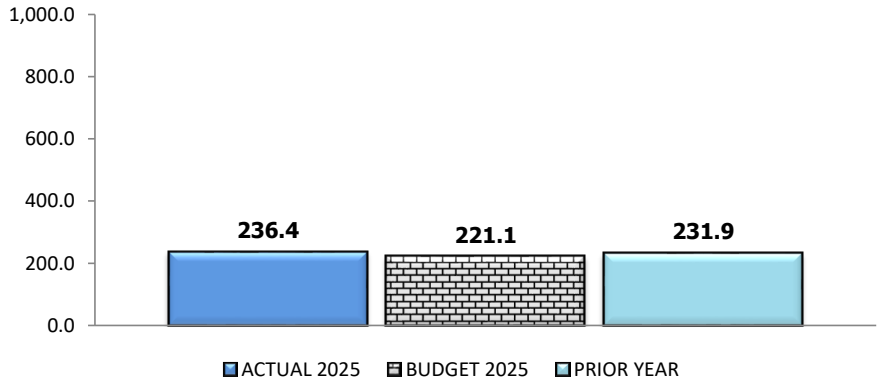
Lyndon B. Johnson ADC - Current Month



Ben Taub ADC - YTD



Lyndon B. Johnson ADC - YTD



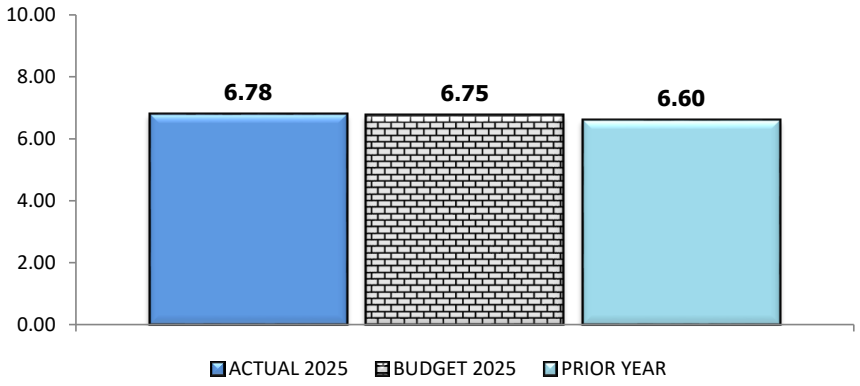
Harris Health

Statistical Highlights - Inpatient Average Length of Stay (ALOS)

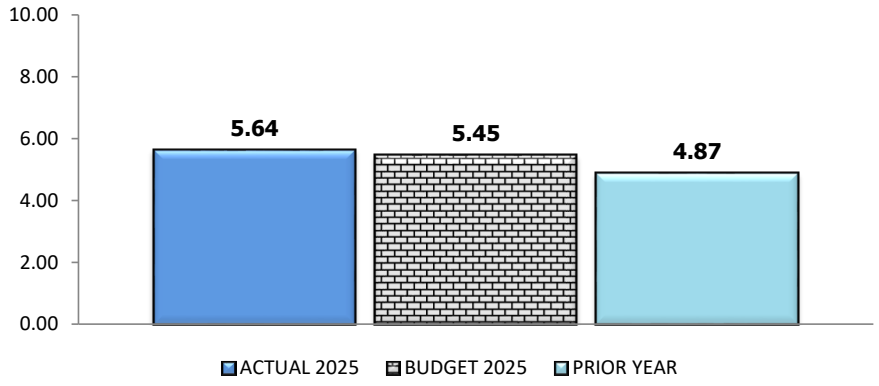
October FY 2025

BT Inpatient ALOS - CM	BT Inpatient ALOS - YTD	LBJ Inpatient ALOS - CM	LBJ Inpatient ALOS - YTD
6.78	6.78	5.64	5.64

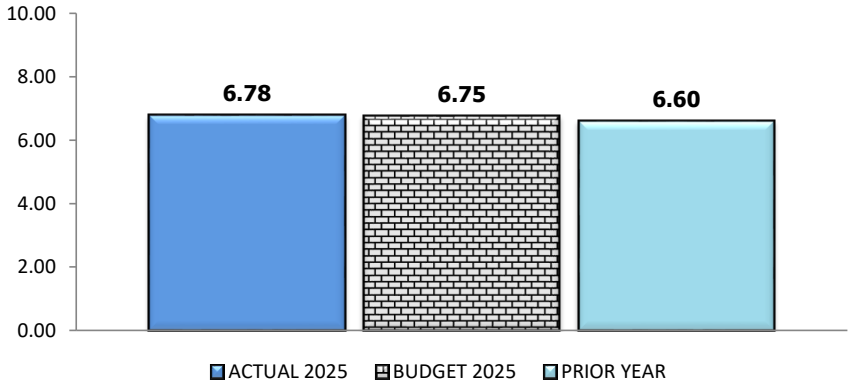
Ben Taub ALOS - Current Month



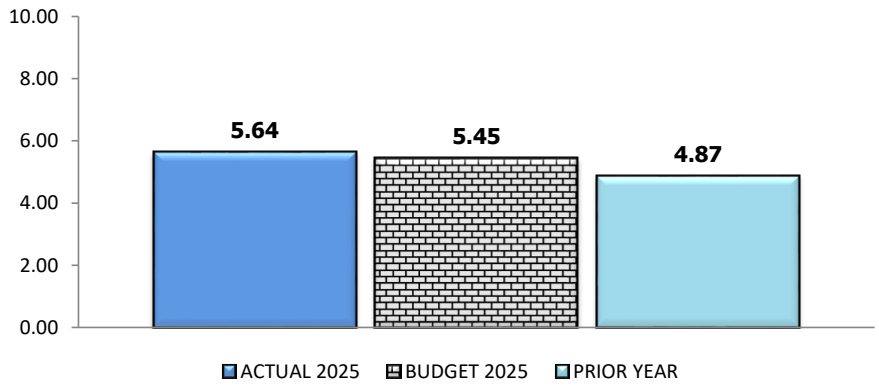
Lyndon B. Johnson ALOS - Current Month



Ben Taub ALOS - YTD



Lyndon B. Johnson ALOS - YTD



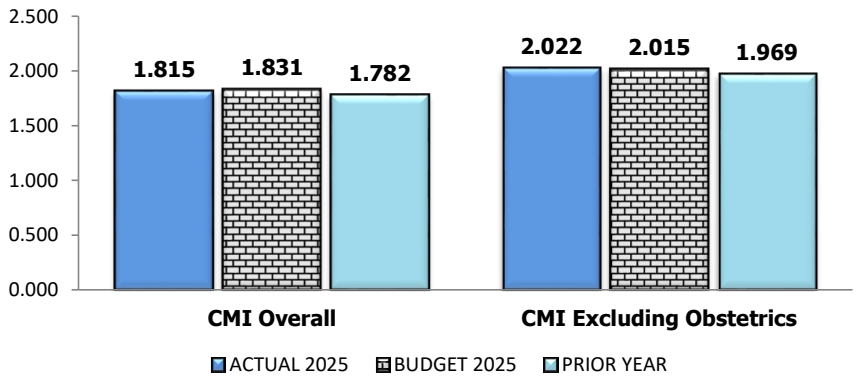
Harris Health

Statistical Highlights - Case Mix Index (CMI)

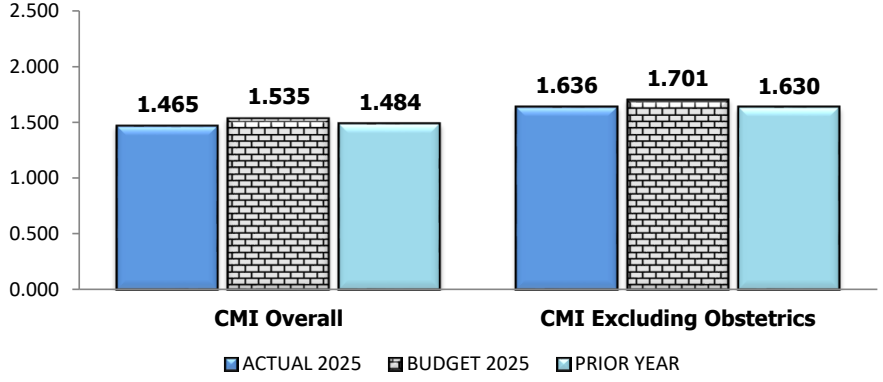
October FY 2025

BT Case Mix Index (CMI) - CM		BT Case Mix Index (CMI) - YTD		LBJ Case Mix Index (CMI) - CM		LBJ Case Mix Index (CMI) - YTD	
Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
1.815	2.022	1.815	2.022	1.465	1.636	1.465	1.636

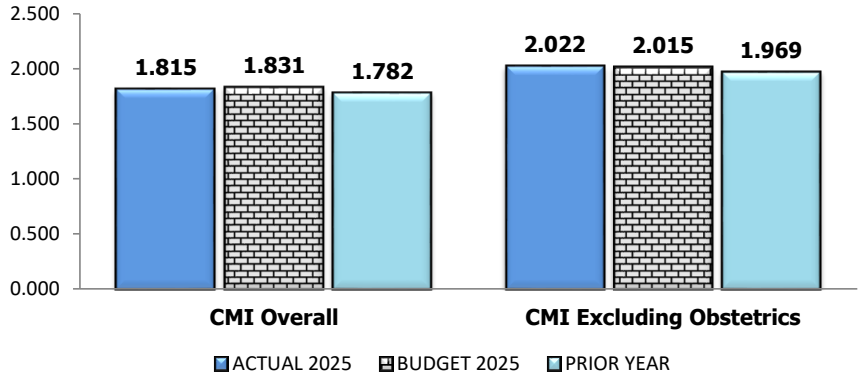
Ben Taub CMI - Current Month



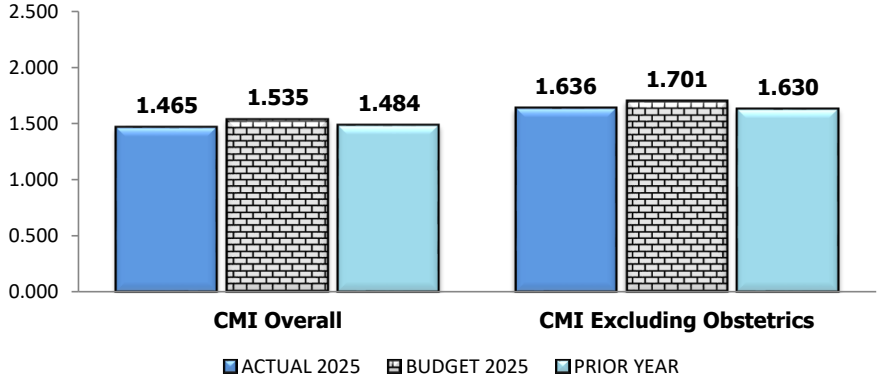
Lyndon B. Johnson CMI - Current Month



Ben Taub CMI - YTD



Lyndon B. Johnson CMI - YTD



Thursday, December 12, 2024

Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health

---

R. King Hillier
SVP, Public Policy & Government Relations

Harris Health P.O. Box 66769, Houston, Texas 77266-6769 | harrishealth.org

December 12, 2024
Board of Trustees Monthly Report

Federal Update

340B Update: After Members of Congress weighed in aggressively with the Health Resource Services Administration (HRSA) last August, Johnson and Johnson pulled down its drug rebate proposal. Johnson & Johnson (J&J) filed suit against HRSA on Nov. 12, alleging the agency illegally prohibited the manufacturer from implementing a rebate model. Eli Lilly also sued HRSA on Nov. 14, alleging the agency violated the Administrative Review Act when it prohibited implementation of a separate, previously unknown, proposed 340B rebate model.

With the Supreme Court's recent Chevron ruling and the incoming Trump Administration, we may see a very different outcome and playing field that could favor drug manufacturers.

Front Line Hospital Alliance (FLHA) Update:

The week of Nov. 18th, Dr. Porsa and King Hillier along with Eskinazi Health in Indianapolis and University Medical Center Lubbock participated in a FLHA CEO fly-in. We visited with the following leadership staff and offices:

- Charlie Chapman and Mimi Bair with House Budget Committee Republican Majority Staff – End of Year Funding and DSH Reform FLHA Definition
- Matt Fuente with Senate Majority Leader Schumer (D-NY) – DSH Reform FLHA Definition
- Stephanie Parks with Senate Minority Leader McConnell (R-KY) – DSH Reform FLHA Definition
- Kripa Sreepada and Marielle Kress with Senate Finance Committee Majority Staff – DSH Reform FLHA Definition
- Charlotte Rock with Senate Finance Committee Minority Staff – DSH Reform FLHA Definition
- Parker Reynolds with Senator Cassidy (R-LA) and Jasmine Marsand with Senator Hassen (D-NH)- Site Neutral and DSH Reform FLHA Definition
- Jeff Last with Senator Cornyn (R-TX) – DSH Reform and FLHA Definition
- Beth Nelson with Senator Young (R-IN) – DSH Reform and FLHA Definition
- Alex Stepahin and Luke Blanchat (R-NC) – Mental Health Comorbidities Legislation
- Hannah Anderson with the America First Policy Institute – Health Policy Initiatives Under New Administration

In meetings with Senate staff, it was very clear that there were still ongoing leadership discussions regarding the size and scope of the end of year Continuing Resolution (CR), Health Care Extenders, and the Emergency Supplemental Funding bills. Congress must act before Dec. 20 to fund government operations and programs. There is a developing consensus in both chambers around a CR to extend funding into March 2025.

In the Emergency Supplemental and Health Extenders package telehealth, physician provider fees, and possibly a much-needed Medicaid Disproportionate Share Hospital fix. The latter is where we are hoping that the FLHA definition can find a home. The larger issues of 340B reform and Site Neutral Hospital Outpatient Fee reform will take place in 2025. Those discussions present another opportunity to address the FLHA designation language.

As a side note, we heard from the Senate side that Repeal and Replace of the ACA, Medicaid Block Grants and Per Capita Caps were off the table due to the impact those issues had in the 2018 mid-term elections. The House on the other hand is suggesting that everything is on the table as it relates to the ACA and Medicaid.

Without a continuing resolution and legislative action, the ACA Medicaid DSH reductions of approximately $2.4 billion for Texas will be implemented over a 3-year period beginning in FY 2025.

Congress will return after the Thanksgiving holiday and will have only 15 legislative days to finalize the CR and determine the size and scope of the Emergency Supplemental and Health Extenders.

Attached is the FLHA strategic priorities for 2025 in a new Congress and Administration.

State Update

Harris Health Engages with Agency and Legislative Leadership on Myers & Stauffer Charity Care Report: Pursuant to a Texas General Appropriations Act budget rider, the Health and Human Services Commission (HHSC) contracted with auditing firm, Myers and Stauffer, to report on the financial and utilization data of Texas hospitals.

Officially due to be released December 1, 2024, Harris Health and others in the hospital industry have reviewed an advanced copy and identified numerous factual inaccuracies and accounting errors.

Working with similarly situated Texas public health systems and the Teaching Hospitals of Texas, Harris Health's CEO and senior government relations staff met with HHSC's Executive Commissioner and senior staff to communicate our concerns. Likewise, senior government relations staff has met with legislative leadership offices and other critical legislative offices to communicate the report's inaccuracies. We'll have more meetings on this issue, but so far everyone we've spoken to has been receptive and understands our concerns.

Harris Health staff will also attend and participate in larger legislative staff briefings at the Texas Capitol in December on the Myers and Stauffer report as well as the broader issue of hospital charity care.

2024 General Election Results: Republicans expanded their majority in the Texas House by flipping two formerly Democratic seats—meaning when lawmakers convene in January of next year, the party breakdown will be 88 Republicans to 62 Democrats.

In the Texas Senate, Republicans expanded their majority by one, bringing the balance of power to 20 Republicans and 11 Democrats.

Harris Health P.O. Box 66769, Houston, Texas 77266-6769 | harrishealth.org

Statewide elected officials were not up for reelection this year, meaning the political dynamic in terms of numbers will remain relatively unchanged—though with 26 members newly elected in the House and 2 in the Senate, there will be a significant number of unfamiliar faces.

Speaker's Race: Texas House members will officially choose their next Speaker on the first day of session in January 2025. But the race to obtain—or retain—the Speaker's Gavel is continuing to play out before lawmakers are officially sworn in.

Texas House GOP members and members-elect seeking an alternative to current Speaker Dade Phelan (R-Beaumont) have seemingly coalesced behind Rep. David Cook (R-Mansfield) as their candidate of choice, though other members have officially filed for the leadership role and continue to court their colleagues' support.

With 150 members, a candidate must obtain a simple majority of 76 votes to prevail in a Speaker's Race. Complicating matters, however, is a House Republican Caucus rule stating members of the caucus must support the Speaker candidate who first obtains the support of 3/5 of the caucus. The caucus will meet in early December 2024 to vote on its preferred Speaker candidate.

In addition, House Democrats with 62 seats can also be influential in the Speaker's race if they vote as a bloc.

Until the 89th Legislature convenes in January 2025 and representatives cast their vote for Speaker, it remains uncertain who will lead the Texas House for the next biennium.

Early Bill Filing: Starting November 12, 2024, lawmakers could begin filing bills early in anticipation of the upcoming Texas Legislative Session. By day's end over 1,000 pieces of legislation had been filed.

Lawmakers typically file thousands of bills throughout the course of session, though the vast majority of them fail to become law, and lawmakers cannot even begin to formally debate any piece of legislation till session has started and committees have been formed.

Thus far bills filed touch on a wide array of subjects, including some critical to Harris Health, such as property taxes, behavioral health, and workforce.

Representative Jolanda Jones and Senator Boris Miles have pre-filed their respective bills that would give Harris Health the ability to hire peace officers.

Attached is the Texas Hospital Association's comment letter regarding the Health and Human Services Legislative Appropriations Request (LAR). More details on the budget will be coming early next year.

PRIORITIES FOR YEAR END 2024 AND 119TH CONGRESS

WHO WE ARE

The Front Line Hospital Alliance (FLHA) is a coalition of "super" safety-net hospitals that form the backbone of our nation's health care safety-net. We share a commitment to providing care for an exceptionally high amount of medically complex, socially at-risk, and vulnerable patients. As a result of this commitment, Front Line hospitals face severe financial distress. We are eager to work with Congress to find reasonable solutions. We believe there is a pathway to modernizing payment that strengthens the health care safety-net that will improve access to the highest quality of care for the vulnerable patient populations we serve.

2024 YEAR END FOCUS

***Secure H.R. 7327, the Protecting Front Line Multimission Hospitals Act -- Rep. Diana DeGette (D-CO) – in Any Year-End Package*.** H.R. 7327 is narrowly tailored to recognize hospitals that are truly on the front lines of care and are truly financially challenged. The qualifying criteria reflects high disproportionate share, tertiary and teaching, which in combination leads to financial instability. The bill also empowers states to protect our financially vulnerable hospitals. In accordance with that federal requirement on states, H.R. 7327 requires states to provide for a public process for determination of rates of payment that take into account the short and long-term financial viability of Front Line Multimission hospitals within their state, and within 100 miles of the state border that are serving substantial numbers of tertiary care patients across state lines. The legislation enables states to meaningful and substantive financial assistance to maintain their financial viability and ensure access for low-income patients to the broad spectrum of primary through life-saving care they provide.

The FLHA proposes a revised version of Rep. Diana DeGette's bill to make the following changes. First, In addition to recognizing the unique situation of Front Line Multimission hospitals as "***Hospitals Dedicated to the Underserved (HDU)***," the bill would add two other categories of HDUs -- Endangered Rural, and Vulnerable Community Hospitals -- that are also financially distressed, although for different reasons. Second, the revised bill would require states to consider all three types of HDUs when setting Medicaid rates, including "stranded uncompensated care costs," but not within the disproportionate share program specifically. Third, the proposal deems all of these qualifying front line, rural and community hospitals eligible for the 97th percentile exception to the Medicaid shortfall definition in Section 1923(g) of the Social Security Act. The revised bill provides a narrowly tailored approach to the Medicaid shortfall issue that addresses the concerns of most affected hospitals without changing the Medicaid shortfall definition itself, and it does not eliminate the 97th percentile exception.

We urge enactment of an updated version of H.R. 7327 the bill that recognizes all HDUs, and provides a "fix" for qualifying HDU hospitals that are losing substantial amounts under the Section 203 Medicaid shortfall definition. *The Front Line Hospital Alliance strongly supports Rep. DeGette's legislation with the updated language and urges Congress to consider the bill for any year-end package.*

119th CONGRESS PRIORITIES

Protect and Strengthen Urban, Rural and Community Hospitals Dedicated to the Underserved (HDUs). The FHLA recognizes the need to modernize health care delivery, reform hospital financing and reduce the costs

of care, particularly for the most medically and socially vulnerable we serve. Since our inception, FLHA has consistently provided thoughtful solutions to pressing issues, and data to support them. We have recently expanded our focus beyond only Front Line Multimission hospitals, to recognize and define Endangered Rural and Vulnerable Community hospitals, that also form the backbone of health in their communities and are financially distressed. As the 119th Congress considers potential changes to financing of hospital care, we will continue to offer practical and policy concepts that will protect and strengthen HDUs in expanding access and delivering value to patients and taxpayers. ***We urge the 119th Congress to focus critical resources on HDUs, that are truly in need.***

Modernize 340B Drug Discount Program. When the 340B Discount Program was enacted in 1992, the legislative record is clear. Congress was alarmed by the dramatically escalating drug prices affecting public and public-equivalent hospitals following the Medicaid Drug Rebate Program enactment in 1990. The Congress estimated that only approximately 90 public and public-equivalent hospitals DSH would be eligible for the 340B Program. There are nearly 1000 DSH hospitals in 340B today. While 340B adds to the bottom line of some hospitals in the program, for us, it is a life-preserver and our survival depends on it. We support comprehensive 340B reform using the following five pillars, and we welcome the opportunity to work with the Congress on modernizing the 340B program, and have developed legislative language, building off of the draft Senate SUSTAIN 340B Act.

1. **Ensure the benefit of the discount to patients most in need.** We support modernizing 340B to ensure that patients are benefiting from the discounted drugs.
2. **Ensure the benefit of the discount to hospitals most in need.** We believe that we are the primary urban DSH hospitals Congress originally intended to benefit from 340B.
3. **Enhance transparency.** We support reasonable and workable reporting requirements and are happy to demonstrate why the program is vital to our survival.
4. **Improve program integrity.** We support fixing the definition of patient and ensuring accountability for the value of the discount we receive.
5. **Simplify and reduce program complexity.** We support changing the child site registration rubric which does not align with hospital operations and unnecessarily complicates our ability to comply with program requirements without adding any value.

Support Comorbidities Collaboration Between Physical and Mental Health Providers. We urge reintroduction of S. 3450 sponsored by Senator Michael Bennet (D-CO), the **Mental and Physical Health Care Comorbidities Collaborative Act**, which would a demonstration program enabling front line and other high-DSH rural and urban hospitals to enter into cooperative agreements with the Secretary of HHS to address the comorbidities of serious mental illness, accompanying physical challenges, and social risk factors on a community specific basis.

Establish a Site-Neutral Alternative Payment Model for Hospitals Dedicated to the Underserved. Our hospitals serve the highest need and highest cost patients every day, and are perfectly positioned as incubators to modernize delivery of services to them, with payment aligned to patient need, not clinical location. We know who the high-need, high-cost patients are – we lack investments and payment flexibility to address their needs on an individual basis, and test and evaluate interventions that really work and can be replicated. We have developed a concept for an alternative payment model for urban and rural Hospitals Dedicated to the Underserved. Qualifying hospitals could voluntarily elect to enter into one or both tracks, that have ten year spans to enable meaningful improvement to access, smarter health care utilization, better outcomes and lower costs.

Texas Hospital Association

1108 Lavaca Street, Suite 700, Austin, Texas 78701
512/465-1000
www.tha.org

November 22, 2023

Texas Health and Human Services Commission
Cecile Erwin Young, Executive Commissioner
P.O. Box 13247
Austin, TX 78711-3247

Via electronic submission to
CFOStakeholderFeedback@hhs.texas.gov

Texas Hospital Association Recommendations for Texas HHSC Legislative Appropriations Request, 2026-2027

Dear Commissioner Young:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching, specialty hospitals and private psychiatric facilities, the Texas Hospital Association is pleased to submit these comments on the Texas Health and Human Services Commission's (HHSC) forthcoming legislative appropriations request for the 89th Legislature.

We respectfully ask HHSC to consider the following items in its budget request:

1. Fully fund Medicaid inpatient hospital rates and standard dollar amount add-on payments commensurate with current costs
2. Fully fund improvements to HHSC's eligibility system and workforce
3. Fully fund HHSC's better birth outcomes strategies, including the full array of Medicaid and women's health programs
4. Increase reimbursement for inpatient behavioral health hospital care
5. Maintain dedicated funding for the state's trauma hospital network
6. Increase oversight and transparency of Medicaid managed care organizations (MCOs)

Fully fund Medicaid inpatient hospital rates and add-on payments commensurate with current costs

Trauma, Safety-net and Rural Add-on Payments

The 88th Texas Legislature appropriated $404.9 million in state revenues for the 2024-2025 biennium to fund enhanced Medicaid standard dollar amount add-on payments to trauma, safety-net and rural hospitals. These included an additional $36 million annually in general revenue (GR) over the prior fiscal biennium to fund cost-based reimbursement for rural hospitals' payment rates. The 88th Texas Legislature also tripled the Medicaid rural labor and delivery add on payment from $500 to $1,500 per delivery, at a total cost of $47 million. Labor and delivery services are costly to provide in rural areas and can be vulnerable to reductions when financially distressed rural hospitals make operational changes necessary to keep their doors open.

We encourage HHSC to request funding to maintain all current standard dollar amount add-on payments and rural labor and delivery add-on payments, and include the $1,500 per delivery add-on amount in the base budget for the next biennium. These funding enhancements will financially sustain the hospitals that continue to provide this care, and the enhanced labor and delivery add-on payment will reinforce access to maternal health care in rural areas.

Inpatient Rate Rebasing

Beginning in early 2024, HHSC will perform an inpatient Medicaid rate rebasing for rural, urban and children's hospitals. Implementation is planned for Sept. 1, 2026. An inpatient rate rebasing recalculates all standard dollar amounts, add-ons, diagnosis-related group relative weights, mean length of stay and day outlier thresholds to align to costs in a selected base year. This long-overdue exercise has not occurred in Texas since FY 2013.[1]

Failing to adjust Medicaid base rates for inflation and cost growth in the last ten years has meant that even "fully funded" Medicaid rates are increasingly distant from hospitals' costs of care. Today, Texas Medicaid base rates only reimburse hospitals 72% of inpatient costs on average.[2] Texas has applied piecemeal rate increases to preserve access in distressed markets and services, such as rural health and maternal care, but has not addressed generally flagging reimbursements that underpin the entire safety net. Hospitals' reliance on self-financed supplemental payments has also increased. From 2013 to 2023, the share of total Medicaid payments in Texas made through supplemental programs has grown from 13% to 31%.[3] Furthermore, Texas uses its Medicaid 1115 waiver to partially offset over $7 billion in uninsured charity care costs incurred by hospitals each year from delivering care to 5 million uninsured Texans.[4] In short, safety net hospitals must depend on a patchwork of targeted and temporary rate increases, add-on payments, and supplemental payments to compensate for underfunded base rates and a heavy uninsured burden.

Reliance on supplemental payments leaves Texas with less control over its safety net and carries significant administrative complexity. The Medicaid 1115 waiver and directed payment programs are subject to periodic federal government reapproval. Since 2020, HHSC has endured repeated challenges, protracted negotiations, and multiple rounds of litigation with the federal government to preserve the 1115 waiver, Delivery System Reform Incentive Payment (DSRIP) successor programs and their underlying method of finance. The Centers for Medicare & Medicaid Services (CMS) has made multiple attempts to increase regulatory authority over non-GR-funded supplemental payments and has proposed spending and finance limits that could keep the state from continuing to operate its current programs. HHSC has also incurred millions of dollars in administrative and legal costs related to the 1115 waiver and directed payments that it has charged hospitals additional fees to cover.[5] THA unequivocally supports HHSC's comprehensive legal and policy defense of its programs. However, the financial stakes of such challenges in the future could be lowered if Medicaid base rates were updated to reflect current costs and funded with state GR.

We are pleased HHSC recognizes the threat that stagnant base rates present to the safety net and will be taking action to rebase most hospitals. THA urges HHSC to request full funding in its 2026-2027 base budget for rural, urban and children's Medicaid inpatient hospital base rates aligned to costs in the most recent available

[1] Texas Health and Human Services Commission. (January 2023). 2024-2025 PFD Hospitals Rate Table.
[2] Texas Health and Human Services Commission. (January 2023). 2024-2025 PFD Hospitals Rate Table.
[3] Texas Health and Human Services Commission. CMS-37 Medicaid History Reports.
[4] Texas Health and Human Services Commission. (June 2023). DY 12 Uncompensated Care Pool Final Rule Modeling.
[5] Texas Health and Human Services Commission. (November 2022). Annual Revenue and Expenditure Report.

data year at the time of FY 2025 rebasing. We note that a budget-neutral inpatient rebasing could lead to harm for certain hospitals in Medicaid. Our support is specifically for a funding request that seeks the full amount necessary to fund rates rebased to current costs. THA looks forward to strongly supporting the commission's full funding request.

Furthermore, we hope HHSC will agree that rate adjustments should occur on a defined, more frequent cadence. We encourage HHSC to recommend that the 89th Texas Legislature follow the lead of other state legislatures and install a standardized annual or biennial Medicaid inflation adjustment that tracks with commonly accepted inflators, such as those used in the Medicare inpatient prospective payment system (IPPS). This would ensure Medicaid payment rates track more closely with costs and reduces gaps in access that can be caused by interruptions in non-GR-financed payments.

Fully fund improvements to the HHSC eligibility system and workforce

Over the past year, HHSC has taken on the unprecedented Medicaid continuous eligibility unwinding project. We appreciate the diligent effort and collaboration the agency has invested to date. Close communication with stakeholders and advocates helped to inform Texans of the changes. However, as with any large project, the Medicaid unwinding implementation shed light on areas for improvement within the system. The state's eligibility workforce and information technology systems were stretched to the brink, making it even more difficult to address unanticipated issues timely.

Texas has disenrolled 1,250,063 people as of October 2023,[6] about 500,000 more than were projected to be disenrolled by this time.[7] Most lost coverage due to procedural denials, meaning recipients were not able to submit all necessary information for a renewal. Given that the legislature only partially funded HHSC's initial eligibility system and workforce funding request to support Medicaid unwinding, we urge the agency to assess remaining needs, and factor those activities and costs into their appropriation request. This is an opportunity to act on lessons learned and remove unintended barriers by investing in Texas 2-1-1 call centers, modernizing the YourTexasBenefits website and app, and the eligibility workforce.

Fully fund HHSC's better birth outcomes strategies, including the full array of Medicaid and women's health programs

In its last published report, the Texas Maternal Mortality and Morbidity Review Committee (MMMRC) repeated its number one recommendation: "Increase access to comprehensive health services during pregnancy, the year after pregnancy, and throughout the preconception and interpregnancy periods."[8] House Bill 12 passed in the 88th Legislature extending Medicaid coverage to 12 months postpartum. HB 12 is a major step in fulfilling the recommendations of the MMMRC and improving health outcomes for women across the state. We look forward to full implementation in early 2024.

[6] Texas Health and Human Services Commission. (October 2023). End of Continuous Medicaid Coverage Dashboard.
[7] HMA. (November 2023). Unwinding Medicaid Data: A Real-Time 50-State Assessment as Redeterminations Approach the Midpoint.
[8] Texas Department of State Health Services. (2022). Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022.

Coverage is the first step in making the necessary postpartum health services accessible and affordable. Next, HHSC should request funds to fully implement and maximize the policy, such as outreach to pregnant Medicaid participants, monitoring utilization to ensure services are accessible, and incentivizing managed care plans that coordinate care for pregnant women on Medicaid. HHSC should also request funds for patient advocates to navigate women through postpartum services. Furthermore, we encourage HHSC to request funding sufficient to maintain the 6% Medicaid rate increases for birth and women's health related surgeries introduced in the 2023-2024 budget. These rate increases will ensure reproductive health care delivered in hospitals remains accessible to Medicaid enrollees, including amniocentesis, cerclage and hysterectomies.

The 88th Legislature also substantially increased funding for HHSC's women's health programs, consistent with MMMRC recommendations. Access to preventive and preconception care – including health screenings and contraception – means healthy, planned pregnancies and early detection of cancers and other treatable conditions. While the women's health programs do not provide comprehensive care like Medicaid, they form a safety net that many Texas women rely on during preconception and interpregnancy periods. Providing women access to preventive care prior to pregnancy promotes better birth outcomes for mothers and babies. THA urges HHSC to request funding in its base budget request at the new funding levels to support the increased caseload due to the state's growing population, as well as enrollees losing coverage during the Medicaid unwinding.

Increase reimbursement for inpatient behavioral health hospital care

Pursue an IMD Exclusion Waiver

Today, patients otherwise eligible for Medicaid coverage are prohibited from receiving Medicaid benefits in freestanding psychiatric hospitals beyond 15 days. This creates a gap in the continuum of care. Patients in acute psychiatric distress may present to hospital emergency departments, and without an available transition to the inpatient psychiatric setting, preventable emergency department boarding can result. The exclusion also obstructs mental health parity and discourages investment in community mental health hospitals. Securing an IMD exclusion waiver could boost rates for psychiatric hospitals by closing the Medicaid gap, encourage investment in the community, save the state boarding costs and, most importantly, lead to better outcomes for patients. THA encourages HHSC to request any appropriation necessary to fund the IMD exclusion waiver.

Implement Behavioral Health Hospital Rate Increases

The need for behavioral health inpatient services continues to rise across the state, even as society returns to a new normal from the COVID-19 pandemic. Even before the pandemic, inpatient psychiatric beds were hard to come by and that has only been exacerbated in the past few years. Despite the increase in demand for these services, reimbursement rates for behavioral health providers in the Medicaid program have not increased since 2008. These low rates blunt psychiatric hospitals' ability to expand capacity, hire necessary staff and meet the demand for services for both adults and children.

Additionally, while THA applauds the funding dedicated to purchased psychiatric beds in the 2024-2025 General Appropriations Act, there is no consistency guaranteed in the rate hospitals will receive when they contract with local mental health authorities (LMHAs) to make those beds available. Historically, the rates provided do not cover the actual cost of the bed and services, meaning hospitals operate at a loss, which can be destabilizing and impact an entity's ability to serve its community.

As described in 1 TAC §355.8060, HHSC reimburses freestanding psychiatric facilities for inpatient care using a different methodology than for children's, urban and rural hospitals. The latter are scheduled to be rebased in FY 2025. To ensure behavioral health hospitals are not left behind after other hospitals are rebased, boosting behavioral health inpatient rates will take on added urgency. To bolster access to much-needed inpatient behavioral health services, THA urges HHSC to (1) re-examine Medicaid rates for behavioral health services; (2) update those rates to better reflect the cost of delivering services; and (3) ensure funding for purchased psychiatric beds reflects both an increase in the number of beds and a rate commensurate with the cost of providing those beds.

Maintain dedicated funding for the state's trauma hospital network

A robust and effective trauma care system ensures Texans receive the appropriate level of care in emergencies. Hospitals' capacity to manage stroke, cardiac arrest, maternal and perinatal care is layered on top of the state's trauma system. Uncompensated trauma care payments are vital for Texas hospitals, as they are used to help offset a portion of the cost of providing unreimbursed trauma care to Medicaid and other low-income patients ordinarily written off as bad debt or charitable care. Uncompensated care trauma payments are funded out of GR and GR-dedicated appropriations from the state's designated trauma and EMS accounts. Because of the payment sequence prescribed in rule, shortfalls in these accounts necessarily reduce uncompensated trauma care payments to Level 3 and Level 4 trauma facilities first. Level 3 and Level 4 facilities comprise most of the rural trauma system.

Texas must ensure dedicated funding for the state's trauma network keeps pace with utilization. During the interim, HHSC is charged with issuing a report on uncompensated trauma care. If the report identifies any threats to maintaining current funding levels supported by designated trauma funding accounts, or an increased volume of uncompensated care, THA recommends HHSC request increased appropriations or recommend modifications to its underlying financing to preserve a consistent and sustainable source of funds for the state's trauma program.

Increase oversight and transparency of Medicaid MCOs

Reduce overuse and misuse of utilization management practices

Today, 97% of Texas' Medicaid beneficiaries are enrolled in managed care.[9] Ensuring Medicaid managed care enrollees have the same access to medically necessary care as commercially insured patients is a key administrative responsibility of HHSC. A recent audit by the federal Health and Human Services Office of Inspector General (OIG) finds that in some cases, Medicaid beneficiaries are prevented from accessing covered services because of MCO misuse and overuse of utilization management practices, including prior authorization denials.[10]

In the seven Texas Medicaid MCOs sampled, OIG found high variance in prior authorization denial rates, including one plan that denied prior authorization requests at a rate nearly three times the national average

[9] Texas HHSC. (2022). Texas Medicaid and CHIP Reference Guide, 14th ed.
[10] U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

(Table 1). OIG also noted Texas does not offer external medical reviews as an option for enrollees when MCOs uphold a prior authorization denial at the first level of appeal.

Table 1: Prior Authorization Request Denial Rates, Select Texas Medicaid MCOs, 2019

MCO	Enrollment	Denial Rate
Molina Healthcare of Texas, Inc.	178,509	34.2%
Amerigroup Texas, Inc.	593,798	17.0%
Amerigroup Insurance Co.	150,159	14.6%
Superior Health Plan	838,407	13.0%
NATIONAL AVERAGE		*12.5%*
United Healthcare Community Plan of TX	296,898	10.9%
Aetna Better Health of Texas	75,617	10.0%
Aetna Parkland Community Health Plan, Inc.	154,219	6.4%

Source: U.S. Health and Human Services Office of Inspector General. (July 2023). High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care.

THA urges HHSC to request any resources needed to enhance state oversight of Medicaid MCOs as recommended in the OIG audit, including (1) enhancing reviews of prior authorization denial rates; (2) delivering technical assistance or corrective action to plans when warranted; and (3) establishing a process for external medical reviews.

HHSC should also use its oversight of Medicaid MCOs to improve transparency, speed and clarity of Medicaid prior authorizations to adhere to new expectations communicated by CMS. In December 2022, CMS proposed a rule (CMS-0057-P) that, if finalized, would require Medicaid managed care plans to publicly report the percentage of standard prior authorization requests that were approved, denied, or approved after appeal. HHSC would be required to report related metrics to CMS annually. The rule proposes additional requirements for managed care plans to electronically automate certain elements of the prior authorization request process, adhere to new minimum response times for prior authorization requests and provide a specific reason for all denied requests.

THA strongly supported CMS's proposals in public comment, and they reflect goals the Texas Medicaid program should pursue. HHSC should seek funding from the legislature for administrative support necessary to deliver new or enhanced technical assistance and oversight of MCOs' prior authorization practices that are likely to become required.

Transparency of payments in supplemental payment programs

Texas hospitals have repeatedly advocated for – and both CMS and HHSC have acknowledged – the need for improved transparency of dollars flowing through MCOs to providers in directed payments. We believe HHSC, the legislature, providers and the public have an interest in understanding what portion of directed payment funding is reaching providers as payments for care, and what portion is retained by the MCO.

There is often an assumption that the entire dollar value of a directed payment program reaches providers (less the taxes and fees MCOs withhold). Texas hospitals know and have experienced firsthand that in a utilization-dependent risk-based arrangement, that does not always occur. Capitation is paid to the MCO based on caseload but only reaches the provider if enrollees use care. The overall stability of the safety net can suffer

for this reason during periods of aberrant caseloads and utilization, such as recently occurred in the public health emergency when caseloads soared, but utilization did not.

Currently Texas makes no information available on the amount of directed payment funds that MCOs pay providers because the necessary reporting does not exist. MCOs do not separate out the base payments from directed payments on Financial Statistical Reports they submit to the state. This makes it difficult for the state to know what portion of aggregate program funds are spent on patient care.

In the case of directed payment programs operating under the authority of 42 CFR §438.6(c), HHSC can direct an MCO when, why and how much to pay a Medicaid provider. In the case of a 42 CFR §438.6(b) quality incentive program, which HHSC plans to establish for FY 2025, HHSC pays an MCO based on achieving quality metrics, and any payments distributed to providers participating in that arrangement occur on a negotiated basis. Going forward, transparency on aggregate or class-specific amounts paid from MCOs to providers should be an expectation in both program types, regardless of whether HHSC directs the payment. Aggregate or class-level reporting would not require HHSC to seek information on private contracts between individual providers and MCOs.

THA recommends HHSC amend current Rider 15: Supplemental Payment Programs Reporting to include requirements for HHSC to publish periodic expenditure reporting by MCOs on supplemental provider payments. Any additional reporting that cannot be accomplished with existing resources should be funded from legislative appropriations and not from additional fees on hospitals.

THA thoroughly appreciates HHSC's effective stewardship of the Medicaid program and other dollars. We look forward to working with HHSC to ensure the agency's funding needs are addressed during the legislative session and that the state's obligation to sustain essential health services to Medicaid clients is fully met. Please contact astelter@tha.org with any questions.

Respectfully submitted,

/s/

Anna Stelter
Vice President, Policy
Texas Hospital Association

Thursday, December 12, 2024

Review and Acceptance of the Following Report for the Healthcare for the Homeless Program as Required by the United States Department of Health and Human Services Which Provides Funding to the Harris County Hospital District d/b/a/Harris Health System to Provide Health Services to Persons Experiencing Homelessness under Section 330(h) of the Public Health Service Act

---

Attached for review and acceptance:

- **HCHP December Operational Updates**

Administration recommends that the Board accept the Healthcare for the Homeless Program Report as required by the United States Department of Health and Human Services which provides funding to the Harris County Hospital District d/b/a/ Harris Health System to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.

Jennifer Small
Executive Vice President – Ambulatory Care Services

Health Care for the Homeless Monthly Update Report – December 2024

Jennifer Small AuD, MBA, CCC-A, Executive Vice President, Ambulatory Care Services

Tracey Burdine, Director, Health Care for the Homeless Program

HARRISHEALTH

Agenda

- Operational Update
  - Productivity Report
  - Budget Summary Report
  - H80 Notice of Grant Award

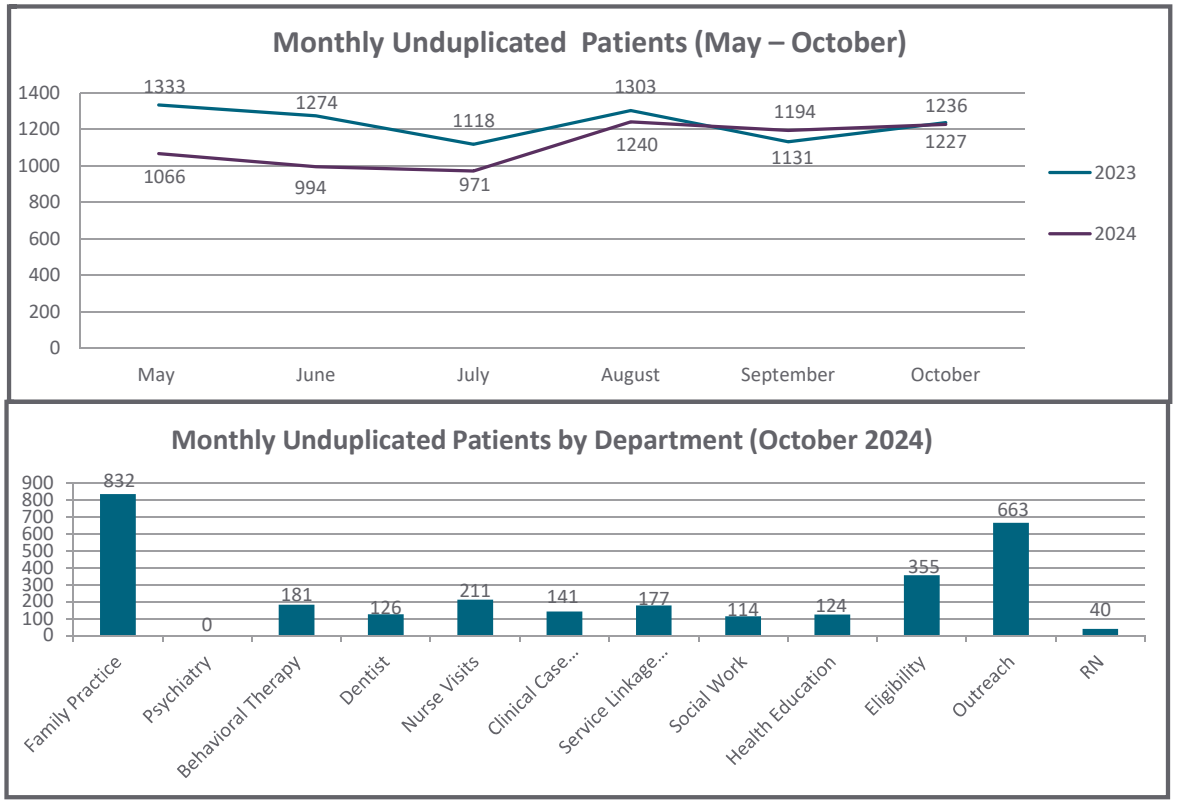
HARRISHEALTH

Patients Served

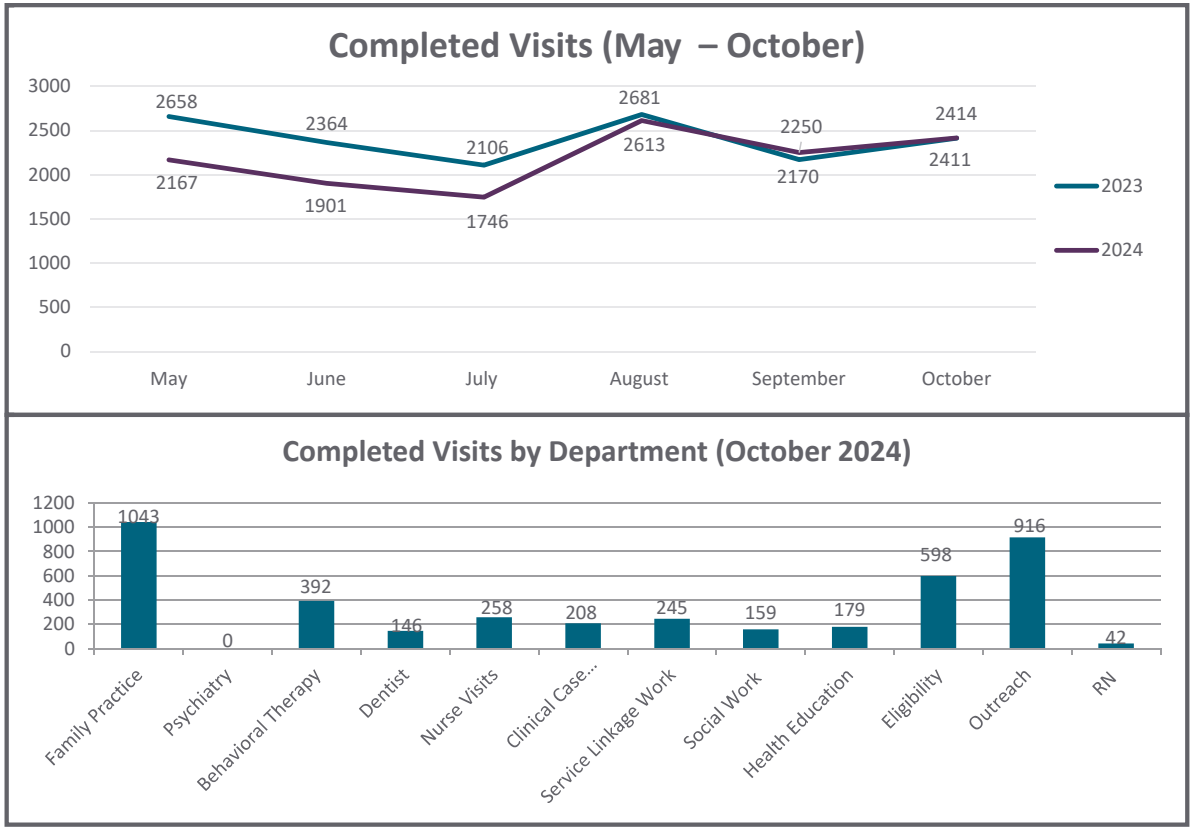
HRSA Unduplicated Patients Target:	HRSA Completed Visit Patients Target:
7,250	**22,500**
YTD Unduplicated Patients:	YTD Total Completed Visits:
5,775	23,149

HARRISHEALTH

Operational Update



Operational Update



Budget Summary Report

Homeless -Primary Grants and Harris Health Funding					
	Period: January 1, 2024 – December 31, 2024				
	Reporting Period: January 1, 2024 – September 30, 2024				
	Line Item	Multiple Award Year Budget	YTD Total Expense	Remaining Balance (budget-projected expense)	%Used YTD
Operating	Personnel/Fringe	$6,357,306	$3,176,034	$3,181,272	49.89%
	Travel	$22,758	$10,175	$12,583	44.7%
	Supplies	$584,941	$149,892	$435,049	25.6%
	Equipment	$120,679	$0	$120,679	0%
	Contractual	$834,645	$163,702	$670,943	19.6%
	Other	$218,789	$89,107	$129,682	40.7%
	Total	**$8,139,118**	**$3,588,910**	**$4,550,208**	**44%**

HARRISHEALTH

Operational Update

- H80 Notice of Grant Award
  - Pending Board Approval of New Award
  - Funding Amount: **$21,768,609**
  - Focus: Existing grant, extended for a 3 year-period to provide patient-centered services based on the service area competition application. Must meet HRSA requirements, including board requirements, for continued funding. Includes waiver from having a 51% patient-majority board.

  - Services Provided
    - Primary care
    - Eligibility and registration services
    - Health education
    - Prevention services
    - Dental care
    - Case management
    - Mental health care
    - Substance use disorder services
    - Class D pharmacy

H80 Budget

HARRIS HEALTH

HEALTH CARE FOR THE HOMELESS PROGRAM

HARRIS COUNTY HOSPITAL DISTRICT dba Harris Health

January 1, 2025 through December 31, 2027

REVENUE	Year 1 Federal Resources	Year 1 Non-Federal Resources	Total - Year 1	Total - Year 2	Total - Year 3
SAC Grant Request	$4,412,560	$0	$4,412,560	$4,412,560	$4,412,560
Applicant Organization	$0	$2,317,033	$2,317,033	$2,666,473	$3,036,880
Local Funds	$0	$0	$0	$0	$0
Other Support	$0	$0	$0	$0	$0
Program Income	$0	$170,181	$170,181	$170,181	$170,181
TOTAL REVENUE	$4,412,560	$2,487,214	$6,899,774	$7,249,214	$7,619,621

Thursday, December 12, 2024

Consideration of Approval of the HCHP Budget Summary Report

Attached for review and approval:

- **HCHP Budget Summary Report**

Administration recommends that the Board approve the Healthcare for the Homeless Program Report as required by the United States Department of Health and Human Services which provides funding to the Harris County Hospital District d/b/a/ Harris Health System to provide health services to persons experiencing homelessness under Section 330 (h) of the Public Health Service Act.

Jennifer Small
Executive Vice President – Ambulatory Care Services

ACS Grants -Homeless
Through September 2024

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2023	Budget/Balance Remaining as of Jan 1, 2024
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	3,179,078.00	-	$ 3,179,078.00
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Benefits	762,978.00	-	$ 762,978.00
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Travel	6,000.00	-	$ 6,000.00
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Supplies	-	-	$ -
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Equipment	-	-	$ -
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Contractual	172,260.00	-	$ 172,260.00
Homeless	Homeless-Primary GYE 12/24	2936	HRSA Grant			Other	-	-	$ -
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	98,624.00	-	$ 98,624.00
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Benefits	23,670.00	-	$ 23,670.00
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Travel	270.00	-	$ 270.00
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Supplies		-	$ -
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Equipment		-	$ -
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Contractual	169,680.00	-	$ 169,680.00
Homeless	Homeless-Dental GYE 12/24	2937	HRSA Grant			Other	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant	**1/1/2024**	**12/31/2024**	Salary	852,422.00	-	$ 852,422.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Benefits	204,581.00	-	$ 204,581.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Travel	10,063.00	-	$ 10,063.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Supplies	393,401.00	-	$ 393,401.00
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Equipment	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Contractual	-	-	$ -
Homeless	Homeless-Carryover GYE 2024	2987	HRSA Grant			Other	79,213.00	-	$ 79,213.00
Homeless	ARP - Capital	1760	HRSA Grant	**9/15/2021**	**9/14/2024**	Salary	-	-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Benefits		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Travel		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Supplies		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Equipment	120,679.00	-	$ 120,679.00
Homeless	ARP - Capital	1760	HRSA Grant			Contractual	471,800.00	-	$ 471,800.00
Homeless	ARP - Capital	1760	HRSA Grant			Other	21,000.00	-	$ 21,000.00
Homeless	Bridge Access Program	2689	HRSA Grant	**9/1/2023**	**12/31/2024**	Salary	31,126.00	1,917.88	$ 29,208.12
Homeless	Bridge Access Program	2689	HRSA Grant			Benefits	9,961.00	365.82	$ 9,595.18
Homeless	Bridge Access Program	2689	HRSA Grant			Travel	800.00	-	$ 800.00
Homeless	Bridge Access Program	2689	HRSA Grant			Supplies	14,361.00	-	$ 14,361.00
Homeless	Bridge Access Program	2689	HRSA Grant			Equipment	0.00	-	$ -
Homeless	Bridge Access Program	2689	HRSA Grant			Contractual	0.00	-	$ -
Homeless	Bridge Access Program	2689	HRSA Grant			Other	11,200.00	-	$ 11,200.00
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant	**9/1/2023**	**12/31/2024**	Salary	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Benefits	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Travel	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Supplies	45,000.00	-	$ 45,000.00
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Equipment	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Contractual	0.00	-	$ -
Homeless	Homeless Ending the HIV Epidemic	2675	HRSA Grant			Other	12,114.00	-	$ 12,114.00
Homeless	Homeless-QIA:UDS	3013	HRSA Grant	**5/30/2024**	**12/31/2024**	Salary	27,117.00		$ 27,117.00
Homeless	Homeless-QIA:UDS	3013	HRSA Grant			Benefits	6,508.00		$ 6,508.00

ACS Grants -Homeless
Through September 2024

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2023	Budget/Balance Remaining as of Jan 1, 2024
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation	**8/1/2017**	**7/31/2024**	Salary	-	-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Benefits		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Travel		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Supplies	10,000.00	5,270.52	$ 4,729.48
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Equipment	164,305.00	164,305.00	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Contractual		-	$ -
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation			Other	25,769.09	705.12	$ 25,063.97
Homeless Support	Shelter Support Dental	2939	Harris Health	**1/1/2024**	**12/31/2024**	Salary	11,000.00	-	$ 11,000.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Benefits	2,640.00	-	$ 2,640.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Travel	0.00	-	$ -
Homeless Support	Shelter Support Dental	2939	Harris Health			Supplies	15,000.00	-	$ 15,000.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Equipment	0.00	-	$ -
Homeless Support	Shelter Support Dental	2939	Harris Health			Contractual	7,165.00	-	$ 7,165.00
Homeless Support	Shelter Support Dental	2939	Harris Health			Other	200.00	-	$ 200.00
Homeless Support	Shelter Support Medical	2938	Harris Health	**1/1/2024**	**12/31/2024**	Salary	927,328.00	-	$ 927,328.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Benefits	222,557.00	-	$ 222,557.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Travel	5,625.00	-	$ 5,625.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Supplies	109,800.00	-	$ 109,800.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Equipment	0.00	-	$ -
Homeless Support	Shelter Support Medical	2938	Harris Health			Contractual	13,740.00	-	$ 13,740.00
Homeless Support	Shelter Support Medical	2938	Harris Health			Other	70,000.00	-	$ 70,000.00
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation	**10/13/2023**	**10/12/2025**	Salary	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Benefits	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Travel	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Supplies	5,000.00	2,350.62	$ 2,649.38
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Equipment	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Contractual	-	-	$ -
Homeless Support	Glucometers For The Homeless	2741	HCHD Foundation			Other	-	2.07	$ (2.07)

Homeless Primary Grant & Non-Federal Funding Period: January 1, 2024 - December 31, 2024 Reporting Period: January 1, 2024 - September 30,2024							
	Line Item	**Annual Budget**	**YTD Total Expense**	**Annualized Expenses**	**Remaining balance(Budget-YTD Expenses)**	**% Used YTD**	**% Used Annualized**
Federal	Salary	$ 4,186,449.12	$ 2,258,995.05	$ 3,011,993.40	$ 1,927,454.07	54.0%	71.9%
	Benefits	$ 1,007,332.18	$ 595,685.76	$ 794,247.68	$ 411,646.42	59.1%	78.8%
	Travel	$ 17,133.00	$ 7,791.56	$ 10,388.75	$ 9,341.44	45.5%	60.6%
	Supplies	$ 452,762.00	$ 121,796.75	$ 162,395.67	$ 330,965.25	26.9%	35.9%
	Equipment	$ 120,679.00	$ -	$ -	$ 120,679.00	0.0%	0.0%
	Contractual	$ 813,740.00	$ 134,336.76	$ 179,115.68	$ 679,403.24	16.5%	22.0%
	Other	$ 123,527.00	$ 24,690.60	$ 32,920.80	$ 98,836.40	20.0%	26.7%
	Total	**$ 6,721,622.30**	**$ 3,143,296.48**	**$ 4,191,061.97**	**$ 3,578,325.82**	**46.8%**	**62.4%**
Non-Federal	Salary	$ 938,328.00	$ 261,658.83	$ 348,878.44	$ 676,669.17	27.9%	37.2%
	Benefits	$ 225,197.00	$ 59,694.05	$ 79,592.07	$ 165,502.95	26.5%	35.3%
	Travel	$ 5,625.00	$ 2,383.90	$ 3,178.53	$ 3,241.10	42.4%	56.5%
	Supplies	$ 132,178.86	$ 28,095.09	$ 37,460.12	$ 104,083.77	21.3%	28.3%
	Equipment	$ -	$ -	$ -	$ -	0.0%	0.0%
	Contractual	$ 20,905.00	$ 29,365.08	$ 39,153.44	$ (8,460.08)	0.0%	187.3%
	Other	$ 95,261.90	$ 64,416.52	$ 85,888.69	$ 30,845.38	67.6%	90.2%
	Total	**$ 1,417,495.76**	**$ 445,613.47**	**$ 594,151.29**	**$ 971,882.29**	**31.4%**	**41.9%**
Grand Total	Salary	$ 5,124,777.12	$ 2,520,653.88	$ 3,360,871.84	$ 2,604,123.24	49.2%	65.6%
	Benefits	$ 1,232,529.18	$ 655,379.81	$ 873,839.75	$ 577,149.37	53.2%	70.9%
	Travel	$ 22,758.00	$ 10,175.46	$ 13,567.28	$ 12,582.54	44.7%	59.6%
	Supplies	$ 584,940.86	$ 149,891.84	$ 199,855.79	$ 435,049.02	25.6%	34.2%
	Equipment	$ 120,679.00	$ -	$ -	$ 120,679.00	0.0%	0.0%
	Contractual	$ 834,645.00	$ 163,701.84	$ 218,269.12	$ 670,943.16	19.6%	26.2%
	Other	$ 218,788.90	$ 89,107.12	$ 118,809.49	$ 129,681.78	40.7%	54.3%
	Total	**$ 8,139,118.06**	**$ 3,588,909.95**	**$ 4,785,213.27**	**$ 4,550,208.11**	**44.1%**	**58.8%**

Project 2936- Homeless Medical

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	1,996,901.59	$ -	$ 1,996,901.59
Benefits	542,697.35		$ 542,697.35
Travel	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Equipment	$ -	$ -	$ -
Contractual	26,250.00		$ 26,250.00
Other	$ -	$ -	$ -
Total	**$ 2,565,848.94**	**$ -**	**$ 2,565,848.94**

Project 1760 - ARP Capital

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	$ -	$ -	$ -
Benefits	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Supplies	$ 33,417.00	$ -	$ 33,417.00
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	19,053.58	$ -	$ 19,053.58
Total	**$ 52,470.58**	**$ -**	**$ 52,470.58**

Project 2937 -Homeless Dental

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	65,478.85		$ 65,478.85
Benefits	20,153.32	$ -	$ 20,153.32
Travel	$ -		$ -
Supplies	$ -		$ -
Equipment	$ -		$ -
Contractual	108,086.76	$ -	$ 108,086.76
Other	$ -		$ -
Total	**$ 193,718.93**	**$ -**	**$ 193,718.93**

Project 0002689 - Homeless FY 2023 Bridge Access Program

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	19,397.75	$ 1,917.88	$ 17,479.87
Benefits	5,140.81	$ 365.82	$ 4,774.99
Travel	$ -	$ -	$ -
Supplies	8,362.38	$ -	$ 8,362.38
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	365.22	$ -	$ 365.22
Total	**$ 33,266.16**	**$ 2,283.70**	**$ 30,982.46**

Project 0002987 -Homeless Carryover GYE 2024

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	165,460.56		$ 165,460.56
Benefits	27,014.03		$ 27,014.03
Travel	7,791.56		$ 7,791.56
Supplies	38,776.37		$ 38,776.37
Equipment	$ -		$ -
Contractual	$ -		$ -
Other	3,426.26		$ 3,426.26
Total	**$ 242,468.78**		**$ 242,468.78**

Project 0002675-Homeless Ending the HIV Epidemic

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary		$ -	$ -
Benefits		$ -	$ -
Travel	$ -	$ -	$ -
Supplies	41,241.00	$ -	$ 41,241.00
Equipment		$ -	$ -
Contractual	$ -	$ -	$ -
Other	1,845.54	$ -	$ 1,845.54
Total	**$ 43,086.54**	**$ -**	**$ 43,086.54**

Project 0003013-Homeless QIA:UDS+

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	13,674.18	$ -	$ 13,674.18
Benefits	1,046.07	$ -	$ 1,046.07
Travel	$ -	$ -	$ -
Supplies	$ -	$ -	$ -
Equipment	$ -	$ -	$ -
Contractual	$ -	$ -	$ -
Other	$ -	$ -	$ -
Total	**$ 14,720.25**	**$ -**	**$ 14,720.25**

Mobile Unit Purchase Support -793

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	$ -		$ -
Benefits	$ -		$ -
Travel	$ -		$ -
Supplies	$ 5,270.52	$ 5,270.52	$ -
Equipment	$ 164,305.00	$ 164,305.00	$ -
Contractual			$ -
Other	$ 2,124.07	$ 705.12	$ 1,418.95
Total	**$ 171,699.59**	**$ 170,280.64**	**$ 1,418.95**

Shelter Support dental-2939

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	$ 3,627.11		$ 3,627.11
Benefits	$ 1,035.26		$ 1,035.26
Travel	$ -		$ -
Supplies	7,853.60	$ -	$ 7,853.60
Equipment			$ -
Contractual	$ -	$ -	$ -
Other	1,453.99	$ -	$ 1,453.99
Total	**$ 13,969.96**	**$ -**	**$ 13,969.96**

Shelter Support Medical-2938

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	258,031.72	$ -	$ 258,031.72
Benefits	58,658.79		$ 58,658.79
Travel	2,383.90		$ 2,383.90
Supplies	18,489.78	$ -	$ 18,489.78
Equipment	$ -	$ -	$ -
Contractual	$ 29,365.08		$ 29,365.08
Other	61,540.72	$ -	$ 61,540.72
Total	**$ 428,469.99**	**$ -**	**$ 428,469.99**

Glucometers for the Homeless-2741

	Expenses through current year September 2024	Expenses through 12/31/2023	Expenses 01/2024 to 09/2024
Salary	$ -		$ -
Benefits	$ -		$ -
Travel	$ -		$ -
Supplies	4,102.33	$ 2,350.62	$ 1,751.71
Equipment	$ -	$ -	$ -
Contractual	$ -		$ -
Other	$ 4.93	$ 2.07	$ 2.86
Total	**$ 4,107.26**	**$ 2,352.69**	**$ 1,754.57**

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, December 12, 2024

Executive Session

Consultation with Attorney Regarding Opioid Litigation, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action for Approval to Participate in the Settlement with Kroger in the Texas Opioid Multi-District Litigation Upon Return to Open Session.

Sara Thomas
Chief Legal Officer/Division Director
Harris County Attorney's Office
Harris Health System

- Pages 240-241 Were Intentionally Left Blank -

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH SYSTEM

Thursday, December 12, 2024

Executive Session

Consultation with Attorney Regarding Settlement of Claims Brought by or on Behalf of David Clark, Pursuant to Tex. Gov't Code Ann. §551.071 and Possible Action Upon Return to Open Session.

Sara Thomas
Chief Legal Officer/Division Director
Harris County Attorney's Office
Harris Health System

- Pages 243-244 Were Intentionally Left Blank -

Thursday, December 12, 2024

Executive Session

Review of the Community Health Choice, Inc. (CHCI) and Community Health Choice Texas, Inc. (CHCT) 2025 Insurance Renewals and Consideration of Approval Upon Return to Open Session, pursuant to Tex. Gov't Code Ann. §551.085.

Anna Mateja
Chief Financial Officer
Community Health Choice, Inc.
Community Health Choice Texas, Inc.

Victoria Nikitin
EVP & Chief Financial Officer
Harris Health

- Pages 246-248 Were Intentionally Left Blank -