BOARD OF TRUSTEES

Public Meeting Agenda

HARRISHEALTH

Thursday, May 22, 2025
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 – April 30, 2025	**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 • New Member of the Harris Health Board of Trustees		*(5 min)*
IV.	**Public Comment**	**Dr. Andrea Caracostis**	**3 min**
V.	**Executive Session**	**Dr. Andrea Caracostis**	**25 min**
	A. Report Regarding Quality of Medical and Healthcare, 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 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***		*(5 min)*
	B. 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 Upon Return to Open Session ***– Dr. Kunal Sharma and Dr. Asim Shah***		*(10 min)*

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, 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. O. Reggie Egins*** *(10 min)*

VI. Reconvene to Open Meeting **Dr. Andrea Caracostis** **2 min**

VII. General Action Item(s) **Dr. Andrea Caracostis** **6 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. Kunal Sharma*** *(2 min)*
2. Consideration of Approval of Changes to the Nurse Practitioner and Physician Assistant General Clinical Privileges ***– Dr. Kunal Sharma*** *(2 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. O. Reggie Egins*** *(2 min)*

VIII. Strategic Discussion **Dr. Andrea Caracostis** **35 min**

A. Harris Health Strategic Plan Initiatives

1. Presentation Regarding Patient and Family Advisory Council (PFAC) Update ***– Dr. Jennifer Small and Mr. David Riddle*** *(10 min)*
2. Presentation Regarding the 2025 Harris Health Hurricane Preparedness and Emergency Response Update ***– Mr. Louis Smith and Ms. Monica Carbajal*** *(10 min)*

B. Committee Reports *(15 min)*

- May 8, 2025: Budget & Finance Committee ***– Dr. Andrea Caracostis***
- May 8, 2025: Compliance & Audit Committee ***– Ms. Carol Paret***
- May 8, 2025: Joint Conference Committee ***– Dr. Andrea Caracostis***

IX. New Items for Board Consideration **Dr. Andrea Caracostis** **5 min**

A. Consideration of Approval for Funding of $71,000,000 for the Calendar Year 2025 Harris County Hospital District Pension Plan ***– Ms. Victoria Nikitin*** *(5 min)*

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

A. Consent Purchasing Recommendations

1. Consideration of Approval of Purchasing Recommendations (Items A1 through A7 of the Purchasing Matrix) ***– Ms. Paige McInnis and Mr. Jack Adger, Harris County Purchasing Office***

   (See Attached Expenditure Summary: May 22, 2025)

B. Consent Committee Recommendations

1. Consideration of Acceptance of the Harris Health Second Quarter Fiscal Year 2025 Investment Report **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

2. Consideration of Acceptance of the Harris Health First Quarter Fiscal Year 2025 Pension Plan Report **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

3. Consideration of Acceptance of the Harris Health March 2025 Quarterly Financial Report Subject to Audit **– *Ms. Victoria Nikitin***
   [Budget & Finance Committee]

C. Consent Grant Recommendations

1. Consideration of Approval of Grant Recommendations (Items C1 through C3 of the Grant Matrix) **– *Dr. Jennifer Small (C1-C2) and Ms. Taylor McMillan (C3)***

   (See Attached Grant Matrix: May 22, 2025)

D. New Consent Items for Board Approval

1. Consideration of Approval of Revisions to the Harris Health Patient Safety Plan **– *Ms. Tiffani Dusang***

2. Consideration of Approval to Acquire a Portion of Harrington Street in Exchange for Consideration and the Conveyance of an Easement to the City of Houston **– *Mr. Patrick Casey***

3. Consideration of Approval to Convey a Perpetual Blanket Easement and Right of Way to CenterPoint Energy Houston Electric, LLC on Harrington Street (the "Easement Area") Adjacent to the Case de Amigos Health Center **– *Mr. Patrick Casey***

4. Consideration of Acceptance of the Harris Health April 2025 Financial Report Subject to Audit **– *Ms. Victoria Nikitin***

E. 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**

(12 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***

- HCHP May 2025 Operational Update

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

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

D. Consideration of Approval of the HCHP 2025 Carryover Budget *(1 min)*
– Dr. Jennifer Small and Ms. Tracey Burdine

XII. Executive Session — **Dr. Andrea Caracostis** — **60 min**

D. Discussion Regarding Committee Reviewed Reports, Pursuant to Tex. Gov't Code Ann. §551.085: *(5 min)*

[Budget & Finance Committee]

- Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Financial Performance for the Three Months Ending March 31, 2025, Pursuant to Tex. Gov't Code Ann. §551.085 ***– Ms. Lisa Wright, CEO and Ms. Anna Mateja, CFO, Community Health Choice***

[Compliance & Audit Committee]

- Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Audit Results and Audited Financial Statements for the Twelve Months Ending December 31, 2024, Pursuant to Tex. Gov't Code Ann. §551.085 ***– Ms. Lisa Wright, CEO, Ms. Anna Mateja, CFO, Community Health Choice and Mr. Matt Howell, FORVIS MAZARS***

E. 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 Pursuant to Tex. Gov't Code Ann. §551.071 and Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Carolynn Jones*** *(15 min)*

F. Consultation with Attorney Regarding Executive Orders, State and Federal Legislative Updates Impacting Harris Health, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action Upon Return to Open Session *(10 min)*
– Ms. Sara Thomas

G. Consultation with Attorneys Regarding Harris Health's Medical School Affiliation and Support Agreements, Pursuant to Tex. Gov't Code Ann. §551.71, and Possible Action Upon Return to Open Session *(10 min)*
– Mr. Louis Smith and Ms. Sara Thomas

H. Consultation with Attorney Regarding Deliberation of the Purchase, Exchange, Lease or Value of Real Property, Pursuant to Tex. Gov't Code Ann. §551.072, and Possible Action Upon Return to Open Session *(20 min)*
– Dr. Esmaeil Porsa and Ms. Sara Thomas

XIII. Reconvene — **Dr. Andrea Caracostis** — **2 min**

XIV. Adjournment — **Dr. Andrea Caracostis** — **1 min**

MINUTES OF THE HARRIS HEALTH BOARD OF TRUSTEES
Board Meeting
Wednesday, April 30, 2025
9:00 A.M.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 9:02 a.m. by Dr. Andrea Caracostis, Chair. It was noted that a quorum was present, and the attendance was recorded. Dr. Caracostis noted that while some Board members were present in person, others were participating via videoconference, in accordance with state law and the Harris Health Videoconferencing Policy. The meeting was accessible for public viewing 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 – March 27, 2025	**Motion No. 25.04-34** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve the minutes of March 27, 2025, Board meeting. Motion carried.**
III. Announcements/ Special Presentations	**A. CEO Report Including Special Announcements** Dr. Esmaeil Porsa, President and Chief Executive Officer (CEO), shared that Harris Health had the pleasure of hosting Dr. Bruce Siegel, President and CEO of America's Essential Hospitals. Dr. Porsa presented data from the 2022 Annual Member Characteristics Survey conducted by America's Essential Hospitals, noting that 35% of Harris Health's visits are inpatient and 53% are outpatient. He highlighted that while the average amount of uncompensated care provided by Essential Hospitals is $63 million, Harris Health provided over $720 million in uncompensated care last year. He concluded by sharing updates from the Patient and Family Advisory Councils (PFACs) at Lyndon B. Johnson and Ben Taub Hospitals. He also announced the upcoming launch of the Ambulatory Care Services (ACS) PFAC on May 14, which has already received over 300 applications, with at least one representative from each clinic location. A copy of the presentation is available in the permanent record.	**As Presented.**
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements Dr. Caracostis provided an update on the Harris Health Annual Faculty Medical Staff Event, held on April 23, which featured Dr. Jeffrey Kuhlman, former Physician to the President and Chief White House Physician, as the special guest speaker.	**As Presented.**
IV. Public Comment	Ms. Cynthia Cole, Executive Director of Local #1550 – AFSCME (American Federation of State, County,	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
	and Municipal Employees), addressed the Board on key topics related to employees, including workplace safety, cost – of – living wages, and benefits related to anxiety and mental health concerns. Mr. Josh Mica, a community member, addressed the Board regarding the transition from the Council – at – Large to the Patient and Family Advisory Council, as well as communication during this process.	
V. Executive Session	At 9:17 a.m., Dr. Caracostis stated that the Board would enter 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. 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 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	**No Action Taken.**
	B. 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 Upon Return to Open Session	**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, 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 9:45 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 Medical Staff Dr. Kunal Sharma, Chair, Medical Executive Board, presented the credentialing changes for members of the Harris Health Medical Staff. In April 2025, there were ten (10) initial appointments, seventy – one (71) reappointments, fifteen (15) changes/additions of privileges, and five (5) resignations. A copy of the credentialing report is available in the permanent record.	**Motion No. 25.04-35** **Moved by Ms. Libby Viera – Bland, seconded by Ms. Afsheen Davis, 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 Correctional Health Medical Staff Dr. Otis Egins, Chief Medical Officer, Harris Health Correctional Health, presented the credentialing changes for members of the Harris Health Correctional Health Medical Staff. In April 2025, there were no initial appointments, five (5) reappointments, and two (2) resignations. A copy of the credentialing report is available in the permanent record.	**Motion No. 25.04-36** **Moved by Mr. Jim Robinson, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda item VII.B.1. Motion carried.**
VIII. Strategic Discussion		
	A. Committee Reports • **April 8, 2025: Quality Committee** Dr. Caracostis stated that the Quality Committee met on April 8, 2025, and discussed the following topics: ○ The HRO Safety Video, "Informed Consent Done Right" was viewed. ○ Harris Health's commitment to Workplace Safety & Violence is unwavering. Current improvements and methods to get the message to people were presented, i.e., snippets from current videos demonstrating current efforts and programs. Some included Workplace Safety Briefs and the updated website.	**As Presented.**

IX. Consent Agenda Items		
	A. Consent Purchasing Recommendations	
	1. Approval of Purchasing Recommendations (Items A1 through A13 of the Purchasing Matrix) Dr. Caracostis stated that the purchasing recommendations (Items A1 through A13 of the purchasing matrix) were included in the Board packet. She noted that Agenda Item A2 is being presented for informational purposes only. A copy of the purchasing agenda is available in the permanent record.	**Motion No. 25.04-37** **Moved by Ms. Afsheen Davis, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda item IX.A.1. of the purchasing recommendations (A1 through A13 of the purchasing matrix). Motion carried.**
	2. Harris Health First Quarter of Fiscal Year 2025 Premier Spend Report for Information Only A copy of the Harris Health First Quarter of Fiscal Year 2025 Premier Spend Report is available in the permanent record.	**For Information Only**
	B. Consent Committee Recommendations	
	1. Approval of Revisions to the Board of Trustees Quality Committee Charter	**Motion No. 25.04-38** **Moved by Ms. Carol Paret, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda items IX.B – F. Motion carried.**
	C. Consent Grant Recommendations	
	1. Approval of a Grant Recommendation (Item C1 of the Grant Matrix)	**Motion No. 25.04-38** **Moved by Ms. Carol Paret, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda items IX.B – F. Motion carried.**

	D. Consent Contract Recommendations	
	1. Approval of Contract Recommendations (Items D1 through D2 of the Contract Matrix)	**Motion No. 25.04-38** **Moved by Ms. Carol Paret, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda items IX.B – F. Motion carried.**
	E. New Consent Items for Board Approval	
	1. Approval of the Appointment of Ms. Sima Ladjevardian as a Member of the Board of Trustees Governance and Budget & Finance Committees	**Motion No. 25.04-38** **Moved by Ms. Carol Paret, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda items IX.B – F. Motion carried.**
	F. Consent Reports and Updates to the Board	
	1. Updates Regarding Pending State and Federal Legislative and Policy Issues Impacting Harris Health ***{End of Consent Agenda}***	**For Information Only**
X. Item(s) Related to Thomas Street Health Center		
	A. Discussion Regarding the Grant Assurance Form from The Houston Regional HIV/AIDS Resource Group (TRG) to Harris County Hospital District d/b/a Harris Health Ms. Dawn Jenkins, Director, HIV Services, led a discussion regarding the Grant Assurance Form from The Houston Regional HIV/AIDS Resource Group (TRG) to Harris County Hospital District d/b/a Harris Health. The assurance form, provided by TRG, is required to be presented to the Harris Health Board of Trustees for discussion, and the signed form must be documented in the official meeting minutes. The grant assurance form is part of the grantor's annual form update to subrecipients, and the signing of this form ensure compliance with grantor's funding requirements. Dr. Caracostis inquired about the role Houston Regional HIV Resource Group (TRG). Dr. Jenkins clarified that TRG, Inc. is an agency which serves as the community – based administrative agency for collaborative HIV/AIDS services funding across Texas. A copy of the assurance form is available in the permanent record.	**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 April 2025 Operational Update Ms. Tracy Burdine, Director, Health Care for the Homeless Program (HCHP), presented the April 2025 Operational Update. Her report included the Productivity Report, Consumer Advisory Council Report, Risk Management Report and Service Area Analysis. She shared that HCHP has provided care to 2,641 unduplicated patients, with a total of 7,273 visits year-to-date. In March 2025, HCHP served 1,566 unduplicated patients, completing 2,629 visits, including 797 patients who received family planning services. Ms. Burdine noted that, as a health center funded by the Health Resources and Services Administration (HRSA), HCHP is required to have a governing board with appropriate oversight authority. The annual Risk Management Report informs the Board of ongoing efforts to mitigate risks, improve outcomes, and ensure the delivery of safe, efficient, and effective care. She provided an overview of 2024 risk management activities and identified areas for improvement. She also presented the 2024 Service Area Analysis, highlighting that HCHP serves the City of Houston through shelter-based clinics and mobile outreach units (medical and dental). These clinics are strategically located in areas where individuals experiencing homelessness congregate, primarily Downtown and surrounding neighborhoods.	**Motion No. 25.04-39** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda item XI.A. Motion carried.**
	B. Approval of the HCHP Consumer Advisory Council Report Dr. Jennifer Small, Chief Executive Officer, Ambulatory Care Services, presented highlights from the Consumer Advisory Council Report for the period November 2024 – January 2025. Key topics included staff vacancies, updates on mobile unit operations, and the onboard of three (3) nurse practitioners who are now actively seeing patients. She also shared information related to the Uniform Data System (UDS) report and HCHP participation in community events and health fairs. A copy of the presentation is available in the permanent record.	**Motion No. 25.04-40** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda item XI.B. Motion carried.**

	C. Approval of the HCHP 2024 Annual Risk Management Report	**Motion No. 25.04-41** **Moved by Mr. Paul Puente, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda item XI.C. Motion carried.**
	D. Approval of the HCHP 2024 Service Area Analysis Report	**Motion No. 25.04-42** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item XI.D. Motion carried.**
XII. Executive Session	At 10:04 a.m., Dr. Andrea Caracostis stated that the Board would enter Executive Session for Items XII. 'D through G' as permitted by law under Tex. Gov't Code Ann. §§§551.071, 551.072, 551.085 and Tex. Health & Safety Code Ann. §161.032.	
	D. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Financial Performance for the Month Ending February 28, 2025, Pursuant to Tex. Gov't Code Ann. §551.085	**No Action Taken.**
	E. Consultation with Attorney Regarding Litigation, Pursuant to Tex. Gov't Code Ann. §551.071, Including Consideration of Approval of a Settlement in Civil Action No. 4:17-cv-02749, U.S. District Court, Southern District of Texas Upon Return to Open Session	**Motion No. 25.04-43** **Moved by Mr. Jim Robinson, seconded by Ms. Afsheen Davis, and unanimously passed that the Board approve agenda item XII.E. Motion carried.**
	F. Consultation with Attorneys Regarding Harris Health's Medical School Affiliation and Support Agreements, Pursuant to Tex. Gov't Code Ann. §551.71, and Possible Action Upon Return to Open Session	**No Action Taken.**
	G. Consultation with Attorney Regarding Deliberation of the Purchase, Exchange, Lease or Value of Real Property, Pursuant to Tex. Gov't Code Ann. §551.072, and Possible Action Upon Return to Open Session	**No Action Taken.**
XIII. Reconvene	At 10:46 a.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. The Board took action on item XII.E of the Executive Session agenda.	
XIV. Adjournment	There being no further business to come before the Board, the meeting adjourned at 10:47 a.m.	

I certify that the foregoing are the Minutes of the Harris Health Board of Trustees Meeting held on April 30, 2025.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Carol Paret, BS, Secretary

Minutes transcribed by Cherry A. Joseph, MBA

Thursday, April 30, 2025
Harris Health Board of Trustees Board Meeting Attendance

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

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Alexander Barrie	Jeffrey Baker
Dr. Amy Smith	Dr. Jennifer Small
Anna Mateja *(Community Health Choice)*	Jennifer Zarate
Anthony Williams	Jessey Thomas
Dr. Asim Shah	John Matcek
Dr. Bradford Scott	Dr. Joseph Kunisch
Cherry Joseph	Josh Mica *(Public Speaker)*
Cynthia Cole *(Public Speaker: AFSME 1550)*	Dr. Kunal Sharma
Daniel Smith	Louis Smith
Dawn Jenkins	Maria Cowles
DeWight Dopslauf	Dr. Matasha Russell
Ebon Swofford *(Harris County Attorney's Office)*	Dr. Maureen Padilla
Dr. Esmaeil Porsa *(Harris Health System, President & CEO)*	Michael Fritz *(Harris County Attorney's Office)*
Dr. Esperanza "Hope" Galvan	Dr. Michael Nnadi
Dr. Glorimar Medina	Dr. O. Reggie Egins
Jack Adger *(Harris County Purchasing Office)*	Olga Rodriguez
Dr. Jackie Brock	Omar Reid
Jay Camp	Patrick Casey

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	
Pollie Martinez	Shawn DeCosta
Randy Manarang	Dr. Tien Ko
Sam Karim	Tracey Burdine
Dr. Sandeep Markan	Dr. Yashwant Chathampally
Sara Thomas *(Harris County's Attorney's Office)*	

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 Registration Process

Pursuant to Texas Government Code Ann. §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 or a subject related to healthcare/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 attending virtually, a meeting link will be provided within 24-48 hours of the scheduled meeting. Notice: Virtual 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**. *You must click the "Watch Live" hyperlink in the blue bar, located on the top left of the screen.*

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 Board meetings. Members of the public can contact the Board of Trustees Office during core business hours, Monday through Friday between 8:00 a.m. to 4:00 p.m. To register, members of the public must submit registration no later than 4:00 p.m. on the day before the scheduled meeting using 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/registerForm.aspx
2. Printing and completing the downloadable registration form found at https://www.harrishealth.org/about-us-hh/board/Documents/Public%20Comment%20Registration%20Form.pdf
3. Emailing a hard-copy of the completed registration form to BoardofTrustees@harrishealth.org
4. Mailing a completed registration form to 4800 Fournace Pl., Ste. E618, Bellaire, TX 77401
5. Contacting a Board of Trustees staff member at (346) 426-1524 to register verbally or by leaving a voicemail with the required information denoted on the registration form

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, May 22, 2025

Executive Session

Report Regarding Quality of Medical and Healthcare, 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 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. Yashwant Chathampally
Associate Chief Medical Officer, Senior Vice President – Quality & Patient Safety

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Thursday, May 22, 2025

Executive Session

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 Upon Return to Open Session.

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

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Thursday, May 22, 2025

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, 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, MD, CCHP-CP
Chief Medical Officer - Correctional Health

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Thursday, May 22, 2025

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

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The Harris Health Medical Executive Board approved the attached credentialing changes for the members of the Harris Health Medical Staff on May 7, 2025.

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

HARRISHEALTH

May 2025 Medical Staff Credentials Report

Medical Staff Initial Appointments: 16
BCM Medical Staff Initial Appointments - 11
UT Medical Staff Initial Appointments - 5
HCHD Medical Staff Initial Appointments - 0

Medical Staff Reappointments: 56
BCM Medical Staff Reappointments - 20
UT Medical Staff Reappointments - 35
HCHD Medical Staff Reappointments - 1

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Changes in Clinical Privileges: 6

BCM/UT/HCHD Medical Staff Resignations: 13

For Information
Temporary Privileges Awaiting Board Approval - 5
Urgent Patient Care Need Privileges Awaiting Board Approval - 3
Leave of Absence - 3

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Files for Discussion: 1
Medical Staff Initial Appointment Files for Discussion - 1
Medical Staff Reappointment Files for Discussion - 0

Thursday, May 22, 2025

Consideration of Approval of Changes to the Nurse Practitioner and Physician Assistant General Clinical Privileges

A request was made to add Radiology and Surgical Assistant Non-Core Privileges to the Nurse Practitioner and Physician Assistant General Clinical Privileges. The Chiefs of Service at BT and LBJ have reviewed and are in agreement with the addition of Radiology and Surgical Assistant privileges being presented.

The Medical Executive Board has approved the revisions to the Nurse Practitioner and Physician Assistant General Clinical Privileges and requests the approval of the Board of Trustees.

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

RADIOLOGY NON-CORE PRIVILEGES

Every individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence as deemed sufficient by the department chief/chair.

Initial:

1. Previous experience with documented evidence of the minimum number of procedures listed below performed under direct physician supervision within the last 12 months.

OR

2. Successful completion of an instructional program/course (must provide certificate and/or official transcripts) and completion of at least 3 under direct physician supervision within the last 12 months.

AND

3. Successful completion of training course in Contrast Media and Radiation Safety (must provide certificate of completion) for procedures requiring fluoroscopy.

Renewal:

Demonstrated current competency and evidence of at least 15 procedures performed successfully every three (3) years.

☐ Lumbar Puncture (minimum number of 5 for initial and 15 every 3 years)
☐ Thoracentesis (minimum number of 5 for initial and 15 every 3 years)
☐ Insertion of Chest tubes (minimum number of 5 for initial and 15 every 3 years)
☐ Insertion of Pulmonary Artery Catheters (minimum number of 5 for initial and 15 every 3 years)
☐ Insertion of Central Venous Catheters (minimum number of 5 for initial and 15 every 3 years)
☐ Insertion of Arterial Catheters (minimum number of 5 for initial and 15 every 3 years)
☐ Modified barium swallow (minimum number of 5 for initial and 15 every 3 years)
☐ Paracentesis (minimum number of 5 for initial and 15 every 3 years)
☐ Image-guided needle biopsy, organ/soft tissue (minimum number of 5 for initial and 15 every 3 years)
☐ Image-guided fluid aspiration (minimum number of 5 for initial and 15 every 3 years)
☐ Image-guided fluid collection drainage (minimum number of 5 for initial and 15 every 3 years)
☐ Image-guided musculoskeletal injections (minimum number of 5 for initial and 15 every 3 years)

☐**RADIOLOGY NON-CORE PRIVILEGES REQUESTED**

Applicant Name: _____

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

SURGICAL ASSISTANT NON-CORE PRIVILEGES

Initial:

1. Successful completion of an accredited Registered Nurse First Assistant course

OR

2. Completion of a Surgical assistant course as evidenced by a certificate of completion

OR

3. Evidence from a hospital or organization (minimum number of 5 surgical assisted cases within the last 12 months under direct physician supervision)

Renewal:

Demonstrated current competency and evidence of at least 15 surgical assisted procedures performed successfully every three (3) years under direct physician supervision.

1. Assists with patient positioning, skin preparation, and draping
2. Provides wound exposure, closure and dressing application
3. Handles tissue appropriately to reduce the potential for injury
4. Knowledge of the use of surgical instruments and equipment
5. Assists in controlling blood loss
6. Sutures tissue

☐ **SURGICAL ASSISTANT NON-CORE PRIVILEGES REQUESTED**

PRESCRIPTIVE AUTHORITY PRIVILEGES

The delegation to the NP / PA to administer or dispense drugs shall include the prescribing of controlled substances.

Harris Health System Medical Staff Bylaws requires that all practitioners maintain a current federal controlled substance registration.

☐**PRESCRIPTIVE AUTHORITY PRIVILEGES REQUESTED**

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Harris County Hospital District, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies, Rules & Regulations applicable generally and any applicable to the situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Applicant's Signature **Date**

Thursday, May 22, 2025

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

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The Harris Health Correctional Health Medical Executive Committee approved the attached credentialing changes for the members of the Harris Health Correctional Health Medical Staff on May 12, 2025.

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

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

Board of Trustees

HARRISHEALTH

May 2025 Correctional Health Credentials Report

Medical Staff Initial Appointments: 3

Medical Staff Reappointments: 2

Medical Staff Resignations: 2

Medical Staff Files for Discussion: 0

Thursday, May 22, 2025

Presentation Regarding Patient and Family Advisory Council (PFAC) Update

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Attached for your review is the Patient and Family Advisory Council (PFAC) Update.

Jennifer Small, AuD, MBA, CCC-A
CEO, Ambulatory Care Services

Patient and Family Advisory Councils Update

Jennifer Small, AuD, MBA, CCC-A
CEO, Ambulatory Care Services

David Riddle, CPXP
Administrative Director, Patient Experience

May 22, 2025

HARRISHEALTH

Patient and Family Advisory Councils (PFAC) Update

- Serves as a formal advisory capacity to Harris Health with the goal of “hearing the voice of the patient” to improve healthcare quality and outcomes, ensuring a focus on patient centered care.

- Facilitates structured opportunities for staff to learn from the patients and families that Harris Health serves.

- **ACS PFAC Kick-Off Meeting, Wednesday, May 14th**
  - **17 inaugural ACS PFAC Members,**
  - **representing 10 Health Centers and Specialty Clinics**
  - **Ongoing recruitment across ACS platform,**
  - **received over 420 referrals**

- PFAC Highlights
  - Celebrated 6th year anniversary of the Ben Taub and LBJ PFACs on April 22nd
  - Two PFAC members were featured panelists in systemwide Patient Safety Town Hall event
  - Guest speaker for Zero Preventable Harm Events
  - Interviewed by surveyors for Magnet redesignation at LBJ and BT Hospitals

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Thursday, May 22, 2025

Presentation Regarding the 2025 Harris Health Hurricane Preparedness and Emergency Response Update

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Attached for your review is the 2025 Harris Health Hurricane Preparedness and Emergency Response Update.

Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

Emergency Preparedness Update

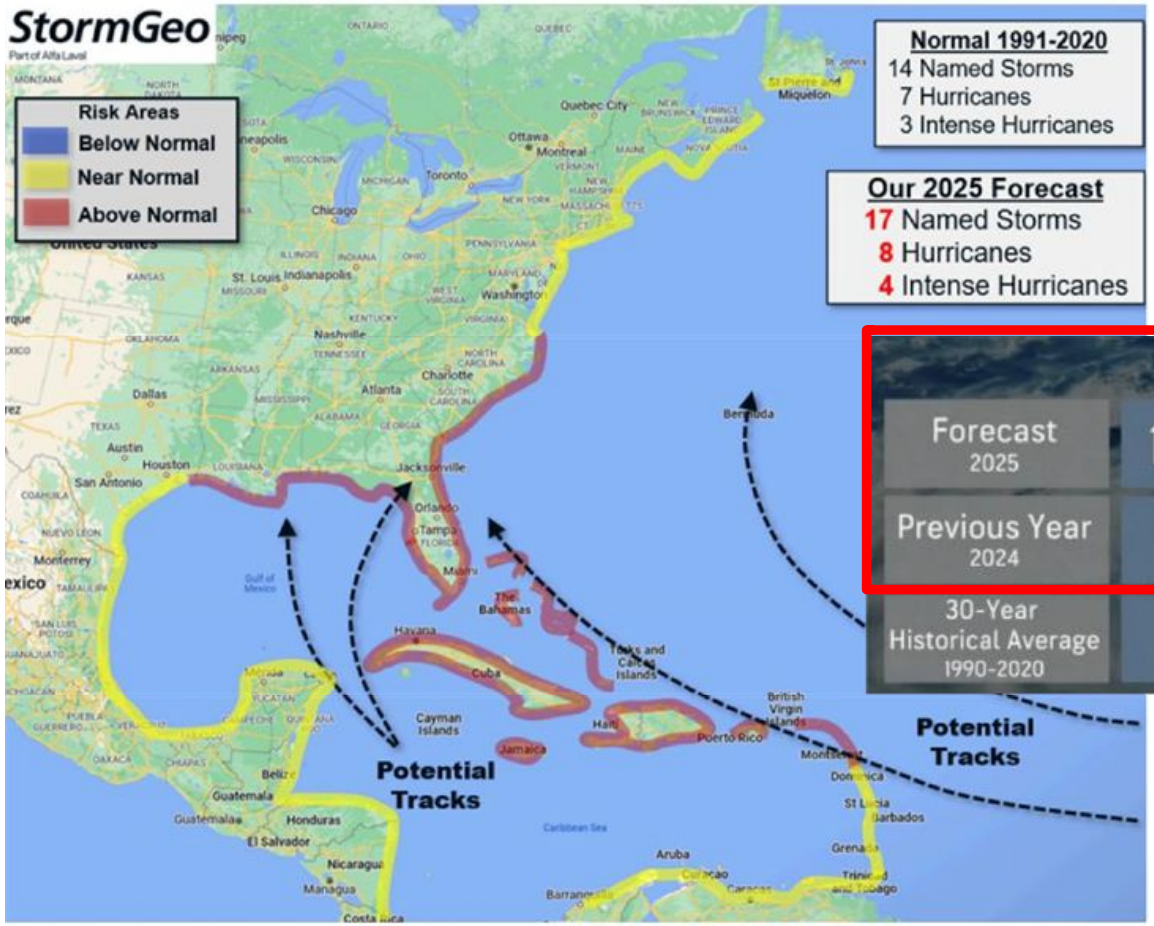
Harris Health Board of Trustees

May 22, 2025

Monica Carbajal
SVP, Chief Administrative Officer

HARRISHEALTH

2025 Hurricane Season and Outlook



Forecast is on par with or slightly below last year storm totals

	NAMED STORMS	HURRICANES	MAJOR HURRICANES	DIRECT U.S. IMPACTS
Forecast 2025	13-18	7-10	3-5	3-6
Previous Year 2024	18	11	5	6
30-Year Historical Average 1990-2020	14	7	3	4

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Learnings From Past Events

- Identified need to create additional facility resiliency
- Demand for additional services during various phases of an emergency event
- Requirement for more advanced Business Continuity Access “BCA” processes, systems and training

Additional Resiliency & Service Availability

LBJ Campus* "Whole House" Emergency Power By 6/1

Emergency Power For Smith and Quentin Mease*

Allows additional access to critical services including dialysis, Infusion and colonoscopies

Opening Community Clinics

El Franco Lee and MLK open during ride out period

Availability of Virtual Care Appointments

Review of Patient Schedules beginning as early as 72 hours before an event

- LBJ Legacy Hospital, Outpatient Center (OPC) and Ambulatory Surgery Center (ACS), and planned for new LBJ campus as well.

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Ongoing Improvements with BCA Forms + BCA Web*

System downtime, whether planned or unexpected, can significantly impact clinicians and employees by restricting access to critical information and disrupting workflows. ***BCA is the method to facilitate access to such patient information and Harris Health has further advanced our BCA processes and systems over the last year.***

Area	Status
BCA Web*	Provides ability to enter in Admissions, Discharges and Transfers during a downtime event and facilitates faster recovery post event. Went live at Harris Health 4/13 in the acute care pavilions; No reported concerns from nursing, IT or registration (*not currently available in an ambulatory setting but entered as a modification request with Epic*).
Current BCA Forms	ACS reported up to date and complete; Acute Care pavilions noting up to date in registration and patient care areas
Standardized BCA Forms	Compliance continuing to meet and review with key stakeholders to produce final 'standardized' documents by area and/or functionality.

* BCA Web helps speed up the downtime recovery process by enabling users to keep events such as admissions, discharges, and transfers up to date during a downtime.

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In Summary

- 2025 Hurricane Season Forecast is on par with or slightly below 2024
- Additional facility resiliency now in place
- Additional service offerings set to deploy
- Improved Business Continuity systems and processes are now in place. This will better assist Harris Health stakeholders with ongoing operations in a downtime environment.

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Thursday, May 22, 2025

Committee Reports

Committee Meeting:

- Budget & Finance Committee – May 8, 2025
  - Information Only
    - Annual Interest Rate Management Agreement Disclosure
    - 2024 Annual Report of the 401k and 457b Administrative Committee Activities
    - 2024 Annual Report of the Pension and Disability Committee Activities
- Compliance & Audit Committee – May 8, 2025
  - Presentation of the Harris Health Independent Auditor's Planning Communication Regarding the Harris County Hospital District 401(k) and the Harris County Hospital District Pension Benefit Plans for the Year Ended December 31, 2024
  - Information Only
    - Independent Auditor's Pre-audit Communication for the Harris County Hospital District 401(k) Plan Year Ended December 31, 2024
    - Independent Auditor's Pre-audit Communication for the Harris County Hospital District Pension Plan Year Ended December 31, 2024
  - Presentation Regarding the Harris Health Quarterly Internal Audit Update as of May 8, 2025
- Joint Conference Committee – May 8, 2025
  - Physician Leadership Reports

Thursday, May 22, 2025

Consideration of Approval for Funding of $71,000,000 for the Harris County Hospital District Pension Plan for Calendar Year 2025

It is the policy of Harris Health to fully fund the Annual Required Contribution for each plan year, based on the actuarial methods and assumptions defined in the annual Actuarial Valuation Funding Report for the Pension Plan. The required contribution includes the normal cost for new benefits being earned during the year, plus an amortization to cover any unfunded accrued liability over a period of 20 years or less. The targeted funded ratio of the Pension Plan is one hundred percent (100%) by the end of the amortization period. In order to accelerate the full funding of the Pension Plan, the Board of Trustees may authorize additional funding in excess of the Annual Required Contribution from current funds for any plan year (Policy 6.28 Retirement Plans for Eligible Employees).

The Annual Required Contribution to the Pension Plan for Calendar Year 2025 is estimated to be $32.9 million utilizing data from prior year Actuarial Valuation Funding Reports. The final funding report for the current year was received in April. Total Plan benefits for Calendar Year 2025 are estimated to be $70.7 million.

In accordance with the policy provision allowing additional funding, Management recommends that Harris Health increase the Pension Plan funding for Calendar Year 2025 from the estimated Annual Required Contribution of $32.9 million to the projected total benefit amount of $71.0 million. The purpose of the increased funding is cover in full the estimated benefit expense of $70.7 million in 2025.

Management recommends that the Board of Trustees approve the funding of $71.0 million for the Harris County Hospital District Pension Plan for Calendar Year 2025.

Victoria Nikitin
EVP - CFO

Paige McInnis
Harris County Purchasing Agent

May 05, 2025

Board of Trustees Office
Harris Health

RE: Board of Trustees Meeting – May 22, 2025
Budget and Finance Agenda Items

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

Approvals - matrix

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: May 22, 2025 (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: 30.90%	**Construction Manager at Risk for the Construction of the Lyndon B. Johnson Hospital Replacement Project for Harris Health** - To provide construction services for the Lyndon B. Johnson replacement project. ***Job No. 230368, Board Motion 24.05-105***	Additional Funds	Babak Zare	$ 998,504,379	**$ 183,819,802**
A2	**O'Donnell Snider Construction, LLC** MWBE Goal: TBD	**Construction of New Parking Garage at Lyndon B. Johnson Hospital for Harris Health** - Additional funds are to design and construct three (3) additional levels (600 parking spots) at LBJ Hospital. The Board of Trustees approved the award on 2/29/24. The owner contingency provides for coverage on unanticipated costs throughout the construction project. ***Job No. 230500***	Additional Funds	Babak Zare	$ 35,975,624	**$ 19,779,619**
A3	**Multiple (see attached)** MWBE Goal: 0% Non-Divisible	**Construction Manager-Agent for Harris Health** - To provide consulting and project management services on construction projects for Harris Health. ***Job No. 240343***	Award Most qualified vendor(s) meeting requirements One (1) year initial term with four (4) one-year renewal options	Erica Sims-Lavergne		**$ 14,500,000**
A4	**Best Care EMS, LTD (HCHD-715)** MWBE Goal: 100%	**Ground Ambulance Services for Harris Health** - To continue ambulance services for patients to and from various Harris Health facilities, clinics, and other locations. ***Public Health or Safety Exemption, Board Motion 25.01-07***	Ratify Renewal Public Health or Safety Exemption April 01, 2025 through March 31, 2026	Alyssa Davis	$ 1,300,000	**$ 1,300,000**
A5	**Vantive US Healthcare LLC (HCHD-1268)** MWBE Goal: Exempt Public Health or Safety	**Dialysis Equipment and Fluids for Harris Health** - Additional funds are needed to pay outstanding invoices due to an increase in peritoneal dialysis patients. ***Public Health or Safety Exemption, Board Motion 24.05-72***	Ratify Additional Funds Public Health or Safety Exemption July 12, 2024 through June 30, 2025	Charles Motley	$ 2,471,214	**$ 850,000**
A6	**Whitecap Health Advisors, LLC** MWBE Goal: 12%	**Strategic Financial Planning Consulting Services for Harris Health** - To provide consulting services to facilitate and develop a strategic financial plan for Harris Health. ***Job No. 250019***	Award Best proposal meeting requirements One (1) year initial term with five (5) one-year renewal options	Maria Cowles		*
A7	**Engage2Excel, Inc.** MWBE Goal: 0% Non-Divisible	**Employee Service Recognition and Rewards Program for Harris Health** - To provide a central reward system for employee recognition programs accessible to all Harris Health employees. ***Job No. 240437***	Award Best proposal meeting requirements One (1) year initial term with four (4) one-year renewal options	Omar Reid		*
					Total Expenditures	$ 219,802,175
					Total Revenue	$ (0)

Thursday, May 22, 2025

Consideration of Approval of Grant Recommendations
(Items C1 through C3 of the Grant Matrix)

Grant Recommendations:

C1. Grant Award

- Grantor: The City of Houston Department of Health
  Funded by the Centers for Disease Control and Prevention
- Term: January 1, 2025 – December 31, 2025
- Award Amount: $125,000.00
- Project Owner: Dr. Jennifer Small

C2. Interlocal Agreement

- Grantor: Harris County Public Health
  Funded by Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A
- Term: March 1, 2025 – February 28, 2026
- Award Amount: $11,024,445.80
- Project Owner: Dr. Jennifer Small

C3. Grant Award

- Grantor: Harris Health Strategic Fund
- Term: One Year
  Funds to be distributed May 2025
- Award Amount: $2,000,000.00
- Project Owner: Patrick Casey

Grant Agenda Items for the Harris County Hospital District dba Harris Health, Board of Trustees Report
Grant Matrix: May 22, 2025

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 a Grant Award from The City of Houston Department of Health Funded by the Centers for Disease Control and Prevention to Harris Health for **Routine HIV Screening Services** at Harris Health.	**Grant Award**	January 1, 2025 through December 31, 2025	Dr. Jennifer Small	$ 125,000.00
C2	Harris County Public Health *Funded by Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A*	Consideration of Approval of an Interlocal Agreement Between Harris Health and Harris County Public Health Funded by Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A to Provide **Primary Medical Care, Psychiatric Services, Obstetric and Gynecological Care, and Local Pharmacy Assistance Program to HIV Positive Patients** of Harris Health.	**Interlocal Agreement**	March 1, 2025 through February 28, 2026	Dr. Jennifer Small	$ 11,024,445.80
C3	Harris Health Strategic Fund	Consideration of Approval of a Grant Award from the Harris Health Strategic Fund to Implement the Strategic Facilities Plan Described in the Harris Health Strategic Fund's Healthier Harris County Capital Campaign.	**Grant Award**	One Year *(funds to be distributed May 2025)*	Patrick Casey	$ 2,000,000.00
					TOTAL AMOUNT:	**$ 13,149,445.80**

Thursday, May 22, 2025

Consideration of Recommendation for Approval of Revisions to the Harris Health Patient Safety Plan

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

Patient Safety Plan

Tiffani Dusang MSN, RN, CPPS, NEA-BC, AFN-BC
Vice President of Patient Safety & Risk Management

Board of Trustees Board Meeting
May 22, 2025

HARRISHEALTH

Summary of Changes

- Section I- Introduction
  - Highlights Plan is a component of Harris Health's Patient Safety Evaluation System
- Section II- Purpose
  - Updated to reflect Harris Health's commitment to zero harm through a Just and Accountable culture that promotes psychological safety
- Section IV- Privilege and Confidentiality of Patient Safety Activities
  - Replaced QGC with Patient Safety Collaborative as the committee who oversees Plan and directs actions
- Section V- Definitions
  - Added Workforce, High Risk Event, and One Harris Health Platform RCA
  - Updated Incident and all Event types

Summary of Changes

- Section VIII- Incident Reporting and Investigation Process
  - Added all communication surrounding the investigation of an incident is performed at the direction of Patient Safety and Risk Management
- Section IX- Event Report Escalation
  - Added Section B on Tiered Huddles as well as new Appendices F & G to highlight Leadership Escalation Guidelines
- Section XIII- Variance Management Filter Council (“Filter”)
  - New section with Definition and Objectives (Highlighted in Appendix M)
- Section XIV- Patient Safety Collaborative
  - Added PSC acts at the direction of the BOT and regularly reports to the QBOT
  - Charter added as Appendix N
- Appendices A-N
  - All references/guides added as an Appendices and referenced throughout Plan

HARRISHEALTH

Patient Safety Plan

~~June 2024~~

~~I. Introduction~~

~~The Harris Health System ("Harris Health")~~ April ~~March~~ 2025

Contents

I. Introduction

Harris Health's Patient Safety Plan ("Plan") is a description of the Harris Health system-wide strategy to support Harris Health's mission, vision, and values ~~and~~, as well as the strategic plan, through the patient safety process. The Plan defines how the organization will focus on an uncompromising commitment to high-quality, safe, and efficient care by reducing risk, preventing harm, and promoting optimal patient safety through a systematic and data-driven approach that reflects the complexity of the services provided by Harris Health.

The Plan is a ~~component of the~~counterpart to Harris Health's Quality Manual, which outlines Harris Health's organizational approach to monitoring and improving quality, patient safety, and performance. Additionally, this Plan is a component of Harris Health's Patient Safety Evaluation System under the federal Patient Safety and Quality Improvement Act of 2005 (PSQIA) and Patient Safety Rule.

II. Purpose

The purpose of the ~~Patient Safety~~ Plan is to provide a framework for fostering a culture of safety and high reliability within ~~our organization~~Harris Health where zero patient harm is not only a possibility but an expectation. ~~Our~~The goals include eliminating preventable harm through standardization and robust process improvements ~~while~~and proactively identifying and managing risks and opportunities. ~~Committed~~Harris Health's commitment to ~~establishing~~ a Just and Accountable Culture~~, we empower~~ (JAC), empowers every workforce member to prioritize patient safety. By promoting ~~Psychological Safety, we ensure~~psychological safety, workforce members can voice concerns and share insights without fear of ~~retribution, fostering~~reprisal, as well as foster continuous improvement and shared accountability. Through these principles, ~~we strive~~Harris Health strives to deliver the highest standards of care, minimizing risks and enhancing outcomes for ~~our~~all patients.

III. Governance

The Senior Vice President (SVP) of Quality and Patient Safety is the designated Patent Safety Officer (PSO) who oversees initiatives related to patient safety and quality improvement. The PSO is the primary contact ~~of~~for the patient safety program.

The Harris Health Board of Trustees (BOT) and the Patient Safety Collaborative

Committee (PSC) ~~oversees~~oversee the ~~Patient Safety~~ Plan. The BOT and PSC ~~delegates and directs~~~~delegate~~ delegate ~~direct~~s the Patient Safety and Risk Management department to carry out the patient safety duties ~~of patient safety~~ within Harris Health and coordinate the Plan with support from the pavilion-based Quality Management departments and system-level Quality Programs department.

IV. Privilege and Confidentiality of Patient Safety Activities

All actions taken and documents developed by the Patient Safety and Risk Management department or at the direction of the Patient Safety and Risk Management department during the patient safety process are at the direction of the PSC and are privileged, confidential, and not subject to disclosure pursuant to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code. Actions and documents include, but are not limited to, reports, investigations, analysis, data aggregation, summaries, and documentation of patient safety events. ~~-~~Actions ~~are~~ taken and documents ~~are~~ developed at the direction of the ~~Quality Governance Council, which is both~~PSC, a medical peer review committee and/or medical committee as those terms are defined in Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code~~.~~, are privileged, confidential and not subject to disclosure pursuant to those statutes. Confidential information maintained by the Patient Safety and Risk Management department includes, but is not limited to, committee minutes, organizational risk management and/or patient safety reports, electronic data gathering and reporting, and incident reports. ~~The Harris Health Quality Manual contains further description of the privilege and confidentiality of patient safety activities.~~

In order to safeguard protected health information and to maintain the privileged nature of this data, the following must be observed:

- Electronic Incident Reporting System ("eIRS") reports must not be printed, copied, or copied and pasted into a document or email;
- No reference to the eIRS system, an incident report, or communication with Risk Management should be made in a patient's medical record; and
- Information contained in eIRS should be extracted and shared with other departments only as needed for furtherance of patient safety functions.

Failure to follow these procedures may result in disciplinary action, up to and including termination.

V. Definitions

A. Workforce: ~~Harris Health~~ All employees, trainees, ~~Medical Staff, contractors, including consultants,~~ volunteers, affiliated healthcare providers, and ~~vendors. This definition includes President~~contractors, who perform work and ~~Chief Executive Officer (CEO).~~/or clinical care under the direct control of Harris Health and may need to access PSWP to carry out any employment or other duty/responsibility.

~~a.~~B. Electronic Incident Reporting System (eIRS): A real-time electronic reporting tool used to increase awareness of patient, visitor, or Workforce safety concerns throughout the organization.

~~b.~~

C. ~~c.~~Incident ("Event"): A circumstance that is not consistent with the standard care of a patient or routine operations, and does not follow established policy, procedure or guideline, and results in or has the potential to result in harm or injury to a person, patient or property. Events may be considered unsafe conditions, near misses, incident, adverse event, preventable adverse event, serious reportable event, and high-risk event. Events may or may not result in an error.

D. Event Types:

1. Unsafe (or Hazardous") Condition: Circumstances or events that have the capacity to cause error.

2. Pre-Patient Event/Near Miss (also known as a close call): An event or circumstance where an error occurred and could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention.

    a. Good Catch: Recognition of an event or circumstance where an error occurred that had the potential to cause an accident, injury, or illness, but did not occur thanks to a corrective action and/or timely intervention.

3. Adverse Event: An event or circumstance that reached a patient that may have contributed to or resulted in harm. Adverse events may or may not be a result of a deviation from expected practice.

    a. Safety Event ("SE"): A deviation from expected from expected practice that results in minimal harm or no detectable harm.

b. Preventable Adverse Event (PAE): A list of adverse events that must be reported to the Texas Department of State Health Services in accordance with 25 Tex. Admin. Code §§ 200.2, 133.49, 135.26.

c. Serious Reportable Event ("SRE") (or "Never Event"): As defined by the National Quality Forum (NQF), Serious Reportable Events are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers for purposes of public accounting.

d. Serious Safety Event ("SSE"): A deviation from expected practice that resulted in results in death, permanent harm, or severe temporary harm.

~~B.~~e. High Risk Event ("HRE"): Deviation or error that has the potential to cause severe harm or death to a future patient but did not necessarily harm a patient related to the incident. The severity of the potential risk will generally supersede the outcome-based safety event score.

~~B.~~E. Root Cause Analysis (RCA): A process for identifying causal factor(s) that lead to performance gaps, including the occurrence or possible occurrence of an SSE1, SSE2, HRE, or reportable event. Includes an assessment of the problem, identification of opportunities to implement improvement strategies, and creation of a quality improvement plan for sustained improvement.

~~a.~~1. One Harris Health ~~Risk~~Platform (OHHP) Root Cause Analysis ~~Platform a~~(RCA)- A system service line forum to conduct an RCA where improvement strategies will have a one system comprehensive approach.

VI. Preventable Adverse Events (PAE)

Preventable Adverse Events are defined by the Texas Department of State Health Services and must be reported every six months.
https://www.dshs.texas.gov/sites/default/files/IDCU/HSU/Files/Definitions-and-Guidance-2018.pdf
These events as well as those events described by Harris Health policy 3.63, "Incident Reporting," must be reported into the eIRS system. (**Appendix A).**

VII. Serious Reportable Events (Never Events):

Serious Reportable Events are defined by the National Quality Forum (http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx)

These events as well as those events described by Harris Health policy 3.63, "Incident Reporting," must be reported into ~~the~~ eIRS ~~system~~. (**Appendix B)**.

VIII. Incident Reporting and Investigation Process:

~~The~~A Workforce Member, ~~or~~ assigned delegate (e.g. designated leader), who observes, discovers, or is directly involved in an ~~event~~Event shall notify their supervisor (if applicable- refer to section IX- Event Escalation Reporting) and enter a report in e~~E~~IRS before they leave at the end of their shift. An eIRS report must be completed for all ~~events~~Events regardless of severity using ~~the Harris Health Electronic Incident Reporting System ("~~eIRS~~").~~ See Policy 3.63, "Incident Reporting."

Patient grievances concerning the quality of care received by a patient, or the abuse, neglect, or exploitation of a patient occurring on Harris Health property will be reported in ~~the~~ eIRS ~~system~~ for investigation and response by the Risk Management department. See Policy 4200, "Patient Complaints and Grievances."

If a Harris Health Workforce member, or assigned delegate (e.g. designated leader), does not timely report an event into the eIRS system, the Workforce member's supervisor will be notified, and the employee will be addressed according to ~~our~~Harris Health's JAC algorithm.

Once an eIRS report is filed, an email notification of the report is automatically delivered to the ~~administrator or the administrator's designee~~leadership team member of the clinical area where the ~~event was reported to have~~Event occurred. The administrator or their designee is responsible for reviewing ~~events~~Events that occur in their areas, performing an initial investigation, and documenting their findings within 7 days of the event. All Serious Reportable Event investigations must be initiated by the involved areas within 24 hours of becoming aware of the ~~event.~~ Event. All communication surrounding the investigation of an incident is performed at the direction of patient safety and risk management.

Team members of the Patient Safety and Risk Management department will review all eIRS reports to determine what, if any, further action and/or analysis is warranted based on the information provided in the report (**Appendix C**).
The Patient Safety and Risk Management team assigns a harm severity level to each ~~event~~Event to uniformly evaluate the degree of harm caused by the ~~event~~Event. The Harm Severity Level~~,~~ is assigned using the NCC MERP Index

(**Appendix D**).
All Serious Reportable Events, Serious Safety Events, High Risk Events, and other significant ~~events~~Events will proceed to the pavilion Variance Management Filter Council for a review and determination of next steps to include a One Harris Health Risk Analysis (RCA) or referral to the Performance Improvement Council, Nursing Peer Review, or Human Resources. The findings of the RCA and the risk reduction strategies (RRS) for SSE1s, SSE2s and HREs will be presented at the Harris Health Patient Safety Collaborative Committee. Other serious ~~events~~Events, close calls, and near misses may proceed as a pavilion -level clinical case review and/or OHHP RCA as requested by pavilion administration (**Appendix E**).

The findings of each ~~event~~Event investigation and the risk reduction strategies are maintained in eIRS in accordance with Harris Health policy 8.03, "Records Retention and Destruction." Event investigations are to be completed within 45 days. When necessary, extensions may be approved by the System Patient Safety and Risk Management Leadership.

IX. Event Reporting Escalation

A. Escalation Guiding Principles

1. Err in favor of timely escalation if any doubt.
2. Welcome and own the escalation – offload frontline staff.
3. Create a list of unit specific risks front of mind for team as part of daily standard work.
4. Share escalation experiences with the team to refine process with real examples in safety huddles.
5. Patient ~~safety, Legal~~Safety, ~~the~~ Harris Health Legal~~County Attorney's Office~~, and Corporate Compliance are available to help 24/7.

We should work to create safer systems following a safety event that was prevented by team member rather than a safety event that could have been prevented.

B. The Tiered Huddle System allows teams to share and make real time decisions that positively impact patient care, identify risks, address issues, and escalate safety events and/or concerns. Harris Health has a dedicated meeting free zone to allow frontline leaders to focus on patient safety through rounding, attending Tier 1 and 2 huddles, reviewing daily incident reports, and preparing to escalate any ~~their~~ safety findings or concerns in the pavilion Tier 3 huddle. Safety issues

and concerns identified in the Tier 3 huddle are the escalated and reported at Harris Health's Tier 4 huddle. ~~Pavilion leaders will then escalate in the system's Tier 4 huddle.~~

C. Harris Health ~~System~~Leadership Event Notification and Escalation ~~Flow Chart~~Guidelines (**Appendix F**)

D. ~~C~~. Harris Health ~~System~~Leadership Event~~/Risk~~ Notification ~~-~~and Escalation ~~Policy~~Flow Chart
(**Appendix G**)

X. Scale for Harm and Risk Classification

Scale for Harm Classifications (**Appendix H**)

1. SSE1: Death
2. SSE2: Severe permanent or temporary harm
3. HRE: Deviation or error that has potential to cause major harm or death
4. SE3: Moderate harm
5. SE4: Mild harm
6. SE5: No harm
7. SE-U: Harm Unknown
8. PPE/Near Miss: Did not reach the patient

The One Harris Health Risk Analysis Platform will first utilize a revised Healthcare Performance Improvement Safety Event Classification (SEC) Levels of Harm with a *Determining Deviation* and *Known Complication* checklist to accurately determine Safety Events, Serious Safety Events, or Near Misses. Next, the platform participants will determine if the safety event or near miss is high, medium or low risk to a future patient (based on worst case scenario) by utilizing a 5X5 risk matrix for severity and probability. (**Appendix E, I & J**).

XI. Standardized Scoring

The Patient Safety Collaborative Committee will utilize the revised Healthcare Performance Improvement Safety Event Classification (SEC) Levels of Harm as an approach to~~,~~ accurately screen safety events to determine if they are Serious Safety Events or High-Risk Events. The Serious Safety Event Rate (SSER) provides a consistent methodology for measuring patient harm and improvement in patient harm

reduction. The SSER is calculated monthly as the number of Serious Safety Events for the previous 12 months per 10,000 adjusted patient days. The Safety Event Classification (SEC) provides common definitions and an algorithm for the classification of safety events. The classification is based on the degree of harm that results from the error, injury, harm or death not related to the natural course of the patient's condition. The Safety Event Classification (SEC) serves as the foundation for identification and scoring of Serious Safety Events. The committee members of the Patient Safety Collaborative shall use the algorithm to score deviations from expected performance (**Appendix K**)

XII. Preventative, Proactive, and Corrective Actions to Reduce Risk

A. Risk Based Thinking (Preventative Action)

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

1. Severity – Seriousness of the harm
2. Probability – Probability that harm will occur

B. Proactive Risk Assessment

A comprehensive systematic analysis where the system proactively evaluates the process to see how it could potentially fail, to understand the consequences of such failure and to identify parts of the process that need improvement. Determining why the breakdown or failures occurred and designing/re-designing ~~of~~ the process or underlying systems minimizes the risk of the effect on patients. Proactive risk reduction prevents harm before it reaches the patient.

C. Failure Mode Effectiveness Analysis ("FMEA")

~~Conducted~~FMEAs are conducted to proactively identify and assess potential failures, prioritize corrective efforts, and evaluate the effectiveness of process and system changes. Harris Health identifies the need for FMEA through point of service engagement. FMEA may be conducted by the Risk Management

department or the Quality Management department. As potential risk concerns are identified within the Risk Management or Quality Management departments, FMEA criteria are applied to determine whether FMEA is warranted. Areas of high risk or error-prone processes are selected for concentrated activity, ongoing measurement, and periodic analysis.

The process in question is assessed to determine the steps where there is or may be undesirable variation (failure modes). Information from internal or external sources will be used to minimize risks to patients affected by the new or redesigned process. For each failure mode, the possible effects on patients, as well as the seriousness of the effect, will be identified. The process will be redesigned to minimize the risk of failure modes, and the redesigned process will be tested and implemented. Measures to determine the effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time will be identified.

D. Root cause analysis ("RCA")

An RCA is an investigation of a patient safety event scored as an SSE1, SSE2, or HRE. This may involve several levels of investigation which may include timelines, interviews, process mapping, observations, policy and best practice review, and data evaluation. All events ~~scored with SSE 1, SSE2, or HRE with a system design concern will~~that progress to the One Harris Health Risk Analysis Platform for a one system comprehensive approach to analyze the case, determine causal factors, identify root causes and develop an action plan to address identified failure modes.

During the One Harris Health Risk Analysis, Patient Safety and Risk Management will collaborate with leaders for a presentation of the event timeline to a preidentified team of leaders, frontline workforce members, and ad hoc experts from the involved/affected service lines to identify the root causes and develop and action plan with risk reduction strategies (RRS). The RRS will be implemented by the responsible parties in the affected areas. Patient Safety and Risk Management team will present the findings of the RCA investigation to the Patient Safety Collaborative for review and approval of the RRS.

See *Risk Reduction Strategy and Action Hierarchy Levels and Categories* (**Appendix L**)

XIII. ~~ilPatient~~Variance Management Filter Council ("Filter")

The Council is a pavilion-based multidisciplinary group comprised of pavilion and system leadership as well as hospital quality personnel who provide guidance in determining the appropriate review process for all referrals relating to patient safety, quality of care, medical error, professionalism, grievances and other types of variances.

A. Objectives (Appendix M)

1. Create transparency and consistency in the review, investigation, and remediation process such that all participants will have confidence in an efficient, effective, and equitable management of variances or professionalism concerns.

2. Ensure that all components of the case related to system failures and process deficiencies are identified and remediated prior to focusing on individual performance.

3. Assist Office of Patient Safety and Risk Management in engaging stakeholders and key personnel to ensure timely and appropriate review and analysis of each case.

4. Filter and distribute cases to appropriate committees and venues for further analysis and/or remediation.

5. Track and trend incidents to provide longitudinal event analysis

~~XII.~~XIV. Patient Safety Collaborative ~~Committee~~

The Patient Safety Collaborative ~~Committee~~ is an interdisciplinary ~~Committee~~committee that aims to promote a culture of transparency to provide a multidisciplinary objective review and analysis of patient safety events and ~~functions as~~is a medical committee/medical peer review committee that acts at the direction of the ~~QGC~~BOT and regularly reports to the BOT Quality Committee. All functions of the Patient Safety Collaborative Committee are confidential, privileged and protected from disclosure pursuant to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code~~.~~

The Patient Safety Collaborative Committee shall use a consistent scoring system to determine and/or approve the final severity level of patient safety events. The ~~workgroup~~committee will review and approve Serious Safety Event and High-Risk Event

root causes, recommendations, developed risk reduction strategies, and the severity level plus risk score determined in the One Harris Health Platform Risk Analysis Platform.

A review of eIRS trends and near misses will be completed to prioritize risk for process improvement, education, and awareness initiative. Voting members will provide physician and nursing peer review recommendation to the pavilion chief nursing officer and/or chief of staff.

The impact of the Patient Safety Collaborative is to optimize a rapid system-wide response to patient safety with intent to drive Harris Health ~~System~~ towards becoming a high reliability organization where zero harm is expected for patients served.

The Patient Safety Collaborative Committee meets bi-weekly (second and fourth Monday) and is comprised of system executive leadership, pavilion leadership, physician and nurse experts, physician residents, Risk and Patient Safety, Quality, Corporate Compliance, Accreditation, County Attorney's Office, and ad hoc members as applicable to specific safety events- *Refer to The Patient Safety Collaborative Committee Charter*~~:~~ *in* Appendix N

~~XIV.~~XV. Data Collection and Use

Information and data collected by eIRS and the Patient Safety and Risk Management department is shared with pavilion-level administrators and system-level administrators on an as needed basis. Patient Safety and Risk Management analyzes data obtained from eIRS and reports the findings quarterly at QRC meetings and biannually at QGC meetings. Aggregate data derived from the RCA process is reviewed annually at the Patient Safety Collaborative Committee.

The VP of Patient Safety and Risk Management and Patient Safety~~/ Patient Safety~~ Officer (or designee) reports Preventable Adverse Events to the Texas Department of State Health Services ("TDSHS") as required by state law. Other significant events are reported to TDSHS and other regulatory agencies as required with the assistance of the Harris Health Accreditation and Regulatory Affairs department.

Patient Safety and Risk Management facilitates ~~the AHRQ Patient~~a reviewed and approved ~~Leapfrog~~ Culture of Safety ~~Culture survey~~Survey, which is conducted biennial to evaluate the

culture of patient safety at all levels of Harris Health. Pavilion-level leadership is responsible for evaluating the findings and developing a CAP to address areas of concern.

~~XV.~~XVI. Disclosure of Adverse Events

Harris Health communicates Adverse Events to patients and/or their Legal Representative in accordance with the process set forth in Harris Health policy 3.64, "Disclosure of Adverse Events."

~~XVI.~~XVII. References/Bibliography:

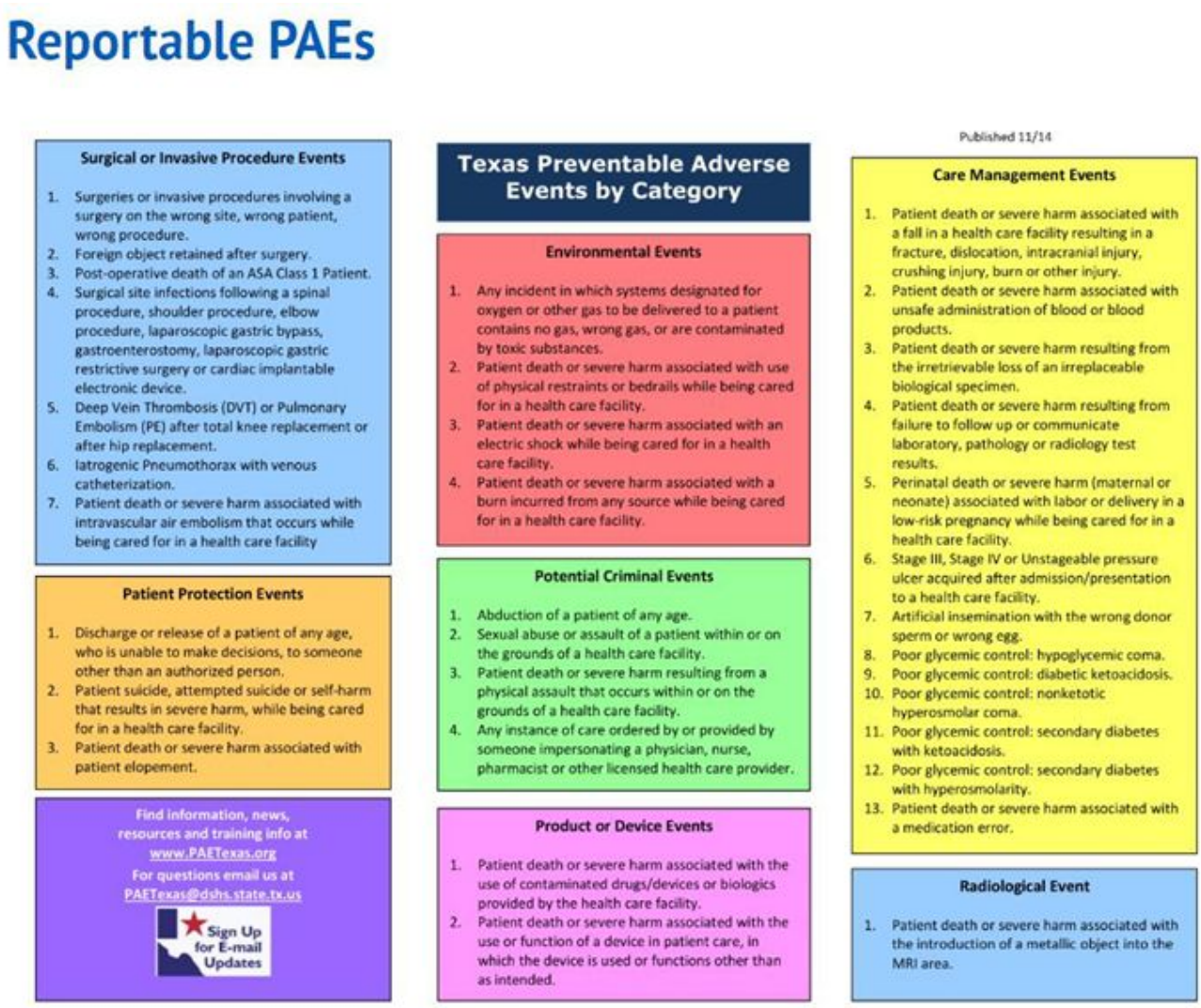
Harris Health System Quality Manual
National Quality Forum- http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx
25 Tex. Admin. Code § 133.48
Texas Health & Safety Code § 161.
Texas Occupations Code § 151 and 160.
DNV Standard QM.8 Patient Safety System.
Harris Health Policy 3.63, "Incident Reporting."
Harris Health Policy 3.64, "Disclosure of Adverse Events."
Harris Health Policy 8.03, "Records Retention and Destruction."
Harris Health Policy 4200, "Patient Complaints and Grievances."
Harris Health Policy 6000, "Preventive Action."
Harris Health Policy 7000, "Corrective Action."
Harris Health Medical Staff Bylaws, May 2015
ASHRM, "Serious Safety Event."
IHI Serious Safety Events and RCA

~~XVII.~~XVIII. Revision History:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers, and Stakeholders etc.)
5/1/2016		5/1/2016	Approved by Harris Health System Patient Safety Committee
4/11/2019		04/11/2019	Approved by Harris Health System Quality Governance Council
5/30/2019		5/30/2019	Approved by Harris Health System Board of Trustees

3/10/2020		3/10/2020	Approved by Harris Health System Quality Governance Council
3/10/2020		3/12/2020	Approved by Harris Health System Board of Trustees
5/17/2022		5/17/2022	Approved by Harris Health System Quality Governance Council
6/23/2022		6/23/2022	Approved by Harris Health System Board of Trustees

APPENDIX A
PREVENTABLE ADVERSE EVENTS



APPENDIX B
SERIOUS REPORTABLE EVENTS

SURGICAL OR INVASIVE PROCEDURE EVENTS

1. Surgery or other invasive procedure performed on the wrong site;
2. Surgery or other invasive procedure performed on the wrong patient;
3. Wrong surgical or other invasive procedure performed on a patient;
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure;
5. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient.

PRODUCT OR DEVICE EVENTS

1. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting;
2. Patient death or serious injury associated with the use of function of a device in patient care, in which the device is used or functions other than as intended;
3. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

PATIENT PROTECTION EVENTS

1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person;
2. Patient death or serious injury associated with patient elopement (disappearance);
3. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a healthcare setting.

CARE MANAGEMENT EVENTS

1. Patient death, serious injury, or close call associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);
2. Patient death, serious injury, or close call associated with unsafe administration of blood products;
3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting;
4. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
5. Patient death or serious injury associated with a fall while being cared for in a

healthcare setting;

6. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting;
7. Artificial insemination with the wrong donor sperm or wrong egg;
8. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;
9. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test reports.

ENVIRONMENTAL EVENTS

1. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting;
2. Any incident in which systems designed for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
3. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting;
4. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

RADIOLOGIC EVENTS

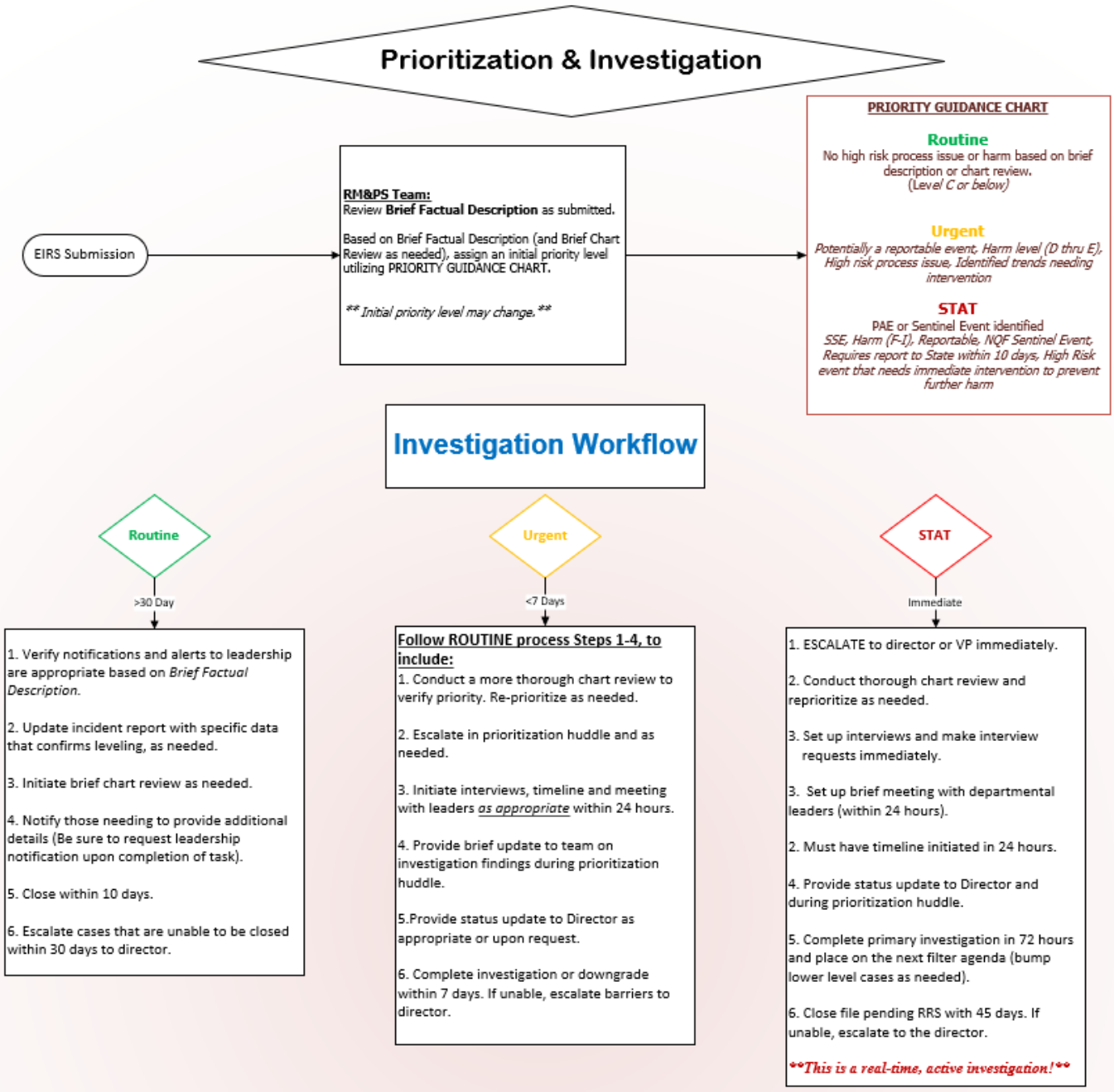
1. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

POTENTIAL CRIMINAL EVENTS

1. An instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
2. Abduction of a patient/resident of any age;
3. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting;
4. Death or serious injury of a patient or staff member resulting from physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

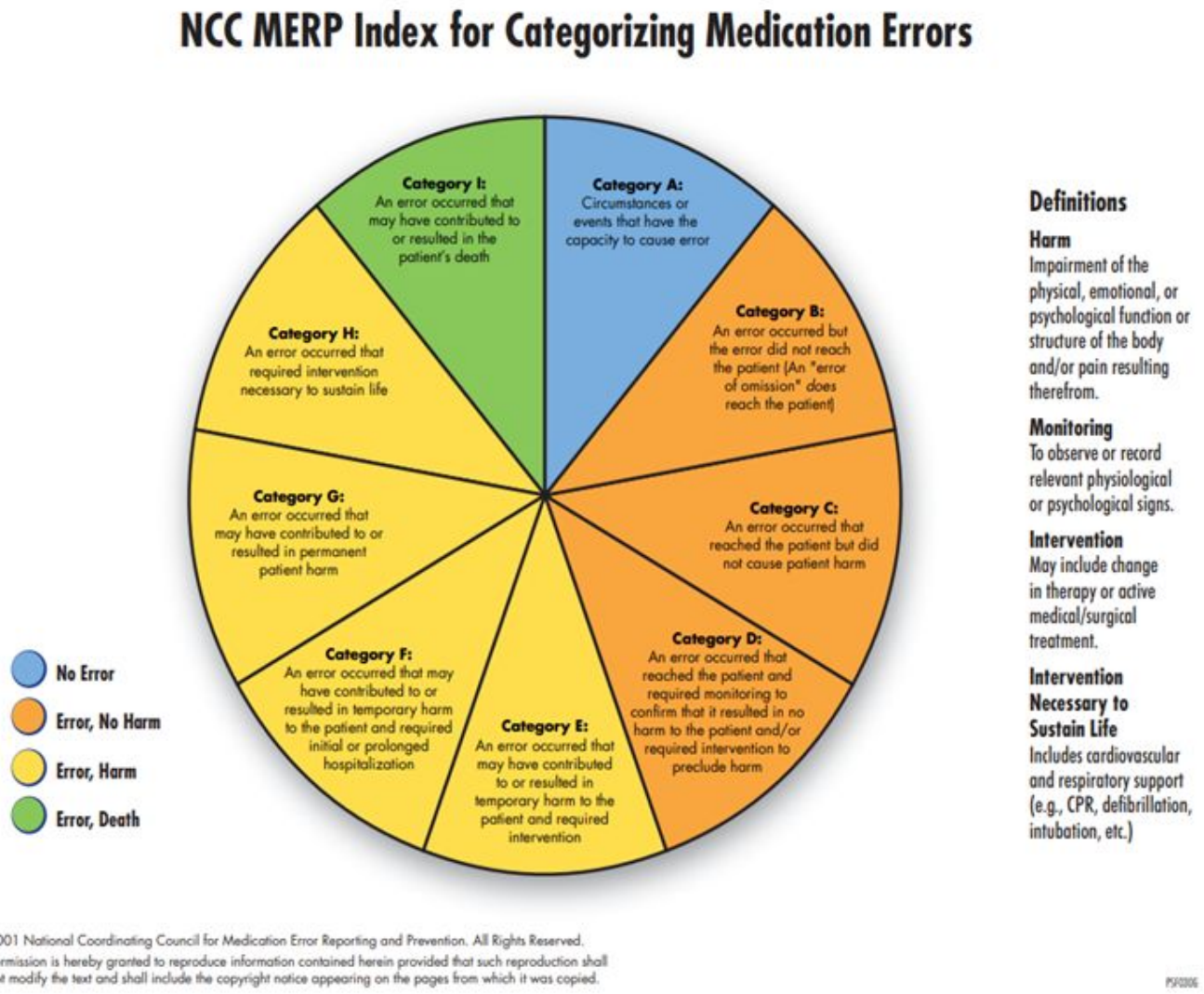
APPENDIX C

Incident Reporting, Prioritization, and Investigation



APPENDIX D

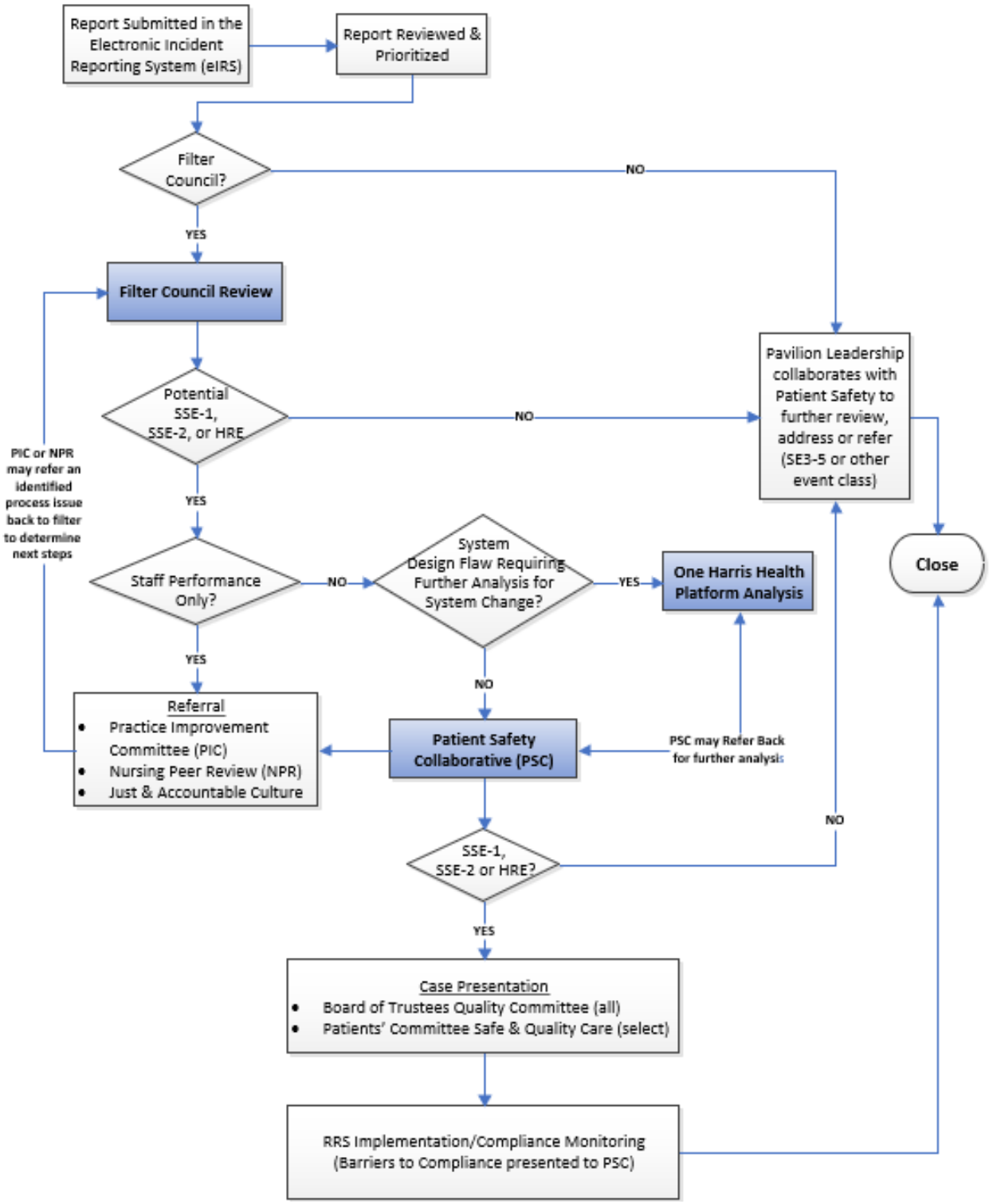
NCC MERP Index



APPENDIX E

Red Alert Post-Event Notification	Red Alert Actions
A serious safety or high-risk event has occurred that requires immediate leadership awareness and/or timely decision support / action to prevent / mitigate harm and recurrence. (*Never Event, Sentinel Event, Reportable Event, Serious Safety Event*)	
Criteria: **1. Injury, Morbidity or Mortality** • Concern for unexpected death or cardiac arrest • Required significant additional treatment (ICU, major surgery/invasive procedure) • Significant loss of function (movement, vision, wrong site major surgery) • Wrong surgery OR procedure involving wrong site, wrong patient OR performing an A list procedure without consent • Retained foreign object requiring re-operation or additional surgical procedures • Patient death or severe harm as a result of: o An irretrievable loss or irreplaceable biological specimen o Failure to follow up or communicate laboratory, pathology or radiology test results o A medication error o A fall o The use or function of a device in patient car in which the device is used or functions other than as intended o The introduction of a metallic object into the MRI area • Maternal or infant death in a low-risk pregnancy • Patient death or severe injury associated with unsafe administration of blood products • Actual or potential patient harm from contaminated drug, device, or biologics • Suicide attempt or self- harm of a patient resulting in serious harm • Patient or staff allegation of abuse (physical or sexual), neglect, exploitation, or unprofessional conduct by a Harris Health Staff member or another patient within any Harris Health Facility or facility where Harris Health workforce are employed **(Page Forensic Nursing Immediately for sexual assault or rape)** • Serious staff or visitor related safety event (Staff injury or assault or visitor creating a disturbance including potential damage to facility) • Significant threats of violence or harm by a patient, visitor, or workforce member that requires immediate intervention by the pavilion and system **2. Significant Regulatory, Compliance, Legal Risk:** • Death while in restraints or seclusion, OR within 24 hours of removal of 4-point restraints or seclusion, OR within 7 days of removal of restraints or seclusion if restraint is determined to be the contributing factor of the death • Concern for EMTALA violation • Patient Elopement without Decision Making Capacity • Unsafe Discharge of a patient of any age who is unable to make decisions • Abduction of a patient of any age • Any morgue related issue where human bodies or fetal remains are mismanaged and/or released inappropriately (i.e., wrong entity, wrong temperature storage). Includes complications related to autopsies (or autopsy orders) • Impersonation of a Health Care Provider **3. Unanticipated Internal / External Disaster Events** **4. Serious concern for imminent negative media, social media or regulatory party exposure**	**Once Escalated** ***(See Appendix A)*:** **Department Leadership:** 1. Notify House Supervisor who will notify AOC and Pavilion Exec Team 2. Notify Patient Safety/Risk Management (if not already aware) 3. Call for a Safety Huddle as needed (See Safety Huddle instructions in orange column). **4. Report in Tier 3** **Pavilion Exec Team:** 1. Place WebEx Alert and notify system leader 2. Call for a Safety Huddle (as needed) **3. Report in Tier 4** **Patient Safety/Risk Management:** 1. Create an SBAR for Pavilion and System Leaders 2. Verify appropriate notifications (i.e. Compliance, Legal) 3. Initiate an immediate investigation (in collaboration with department leaders) 4. Follow the High-Level SSE Event Process (Appendix B & C)

High Level SSE/HRE Review Flow



APPENDIX F
Harris Health Leadership Event Notification and Escalation Guidelines

Red Alert Post-Event Notification	Red Alert Actions
A serious safety or high-risk event has occurred that requires immediate leadership awareness and/or timely decision support / action to prevent / mitigate harm and recurrence. (*Never Event, Sentinel Event, Reportable Event, Serious Safety Event*)	

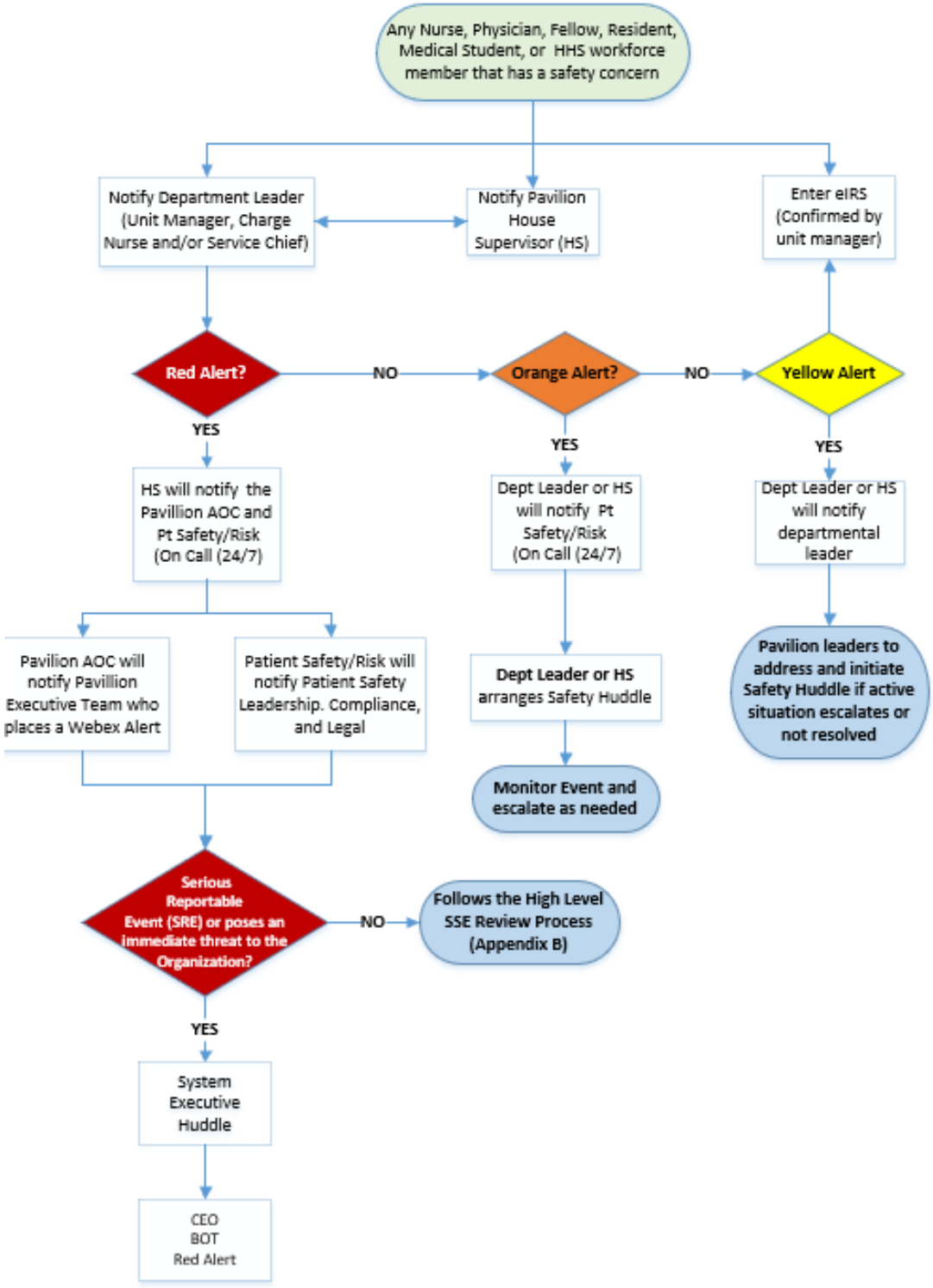
Criteria:
1. Injury, Morbidity or Mortality
• Concern for unexpected death or cardiac arrest
• Required significant additional treatment (ICU, major surgery/invasive procedure)
• Significant loss of function (movement, vision, wrong site major surgery)
• Wrong surgery OR procedure involving wrong site, wrong patient OR performing an A list procedure without consent
• Retained foreign object requiring re-operation or additional surgical procedures
• Patient death or severe harm as a result of:
  o An irretrievable loss or irreplaceable biological specimen
  o Failure to follow up or communicate laboratory, pathology or radiology test results
  o A medication error
  o A fall
  o The use or function of a device in patient car in which the device is used or functions other than as intended
  o The introduction of a metallic object into the MRI area
• Maternal or infant death in a low-risk pregnancy
• Patient death or severe injury associated with unsafe administration of blood products
• Actual or potential patient harm from contaminated drug, device, or biologics
• Suicide attempt or self- harm of a patient resulting in serious harm
• Patient or staff allegation of abuse (physical or sexual), neglect, exploitation, or unprofessional conduct by a Harris Health Staff member or another patient within any Harris Health Facility or facility where Harris Health workforce are employed **(Page Forensic Nursing Immediately for sexual assault or rape)**
• Serious staff or visitor related safety event (Staff injury or assault or visitor creating a disturbance including potential damage to facility)
• Significant threats of violence or harm by a patient, visitor, or workforce member that requires immediate intervention by the pavilion and system
2. Significant Regulatory, Compliance, Legal Risk:
• Death while in restraints or seclusion, OR within 24 hours of removal of 4-point restraints or seclusion, OR within 7 days of removal of restraints or seclusion if restraint is determined to be the contributing factor of the death
• Concern for EMTALA violation
• Patient Elopement without Decision Making Capacity
• Unsafe Discharge of a patient of any age who is unable to make decisions
• Abduction of a patient of any age
• Any morgue related issue where human bodies or fetal remains are mismanaged and/or released inappropriately (i.e., wrong entity, wrong temperature storage). Includes complications related to autopsies (or autopsy orders)
• Impersonation of a Health Care Provider
3. Unanticipated Internal / External Disaster Events
4. Serious concern for imminent negative media, social media or regulatory party exposure
	Once Escalated *(See Appendix A)*:
	Department Leadership:
	1. Notify House Supervisor who will notify AOC and Pavilion Exec Team
	2. Notify Patient Safety/Risk Management (if not already aware)
	3. Call for a Safety Huddle as needed (See Safety Huddle instructions in orange column).
	4. Report in Tier 3
	Pavilion Exec Team:
	1. Place WebEx Alert and notify system leader
	2. Call for a Safety Huddle (as needed)
	3. Report in Tier 4
	Patient Safety/Risk Management:
	1. Create an SBAR for Pavilion and System Leaders
	2. Verify appropriate notifications (i.e Compliance, Legal)
	3. Initiate an immediate investigation (in collaboration with department leaders)
	4. Follow the High-Level SSE Event Process (Appendix B & C)

Orange Alert Escalation For Safety Huddle	Orange Alert Actions
A serious safety event may occur if an identified unsafe condition or hazard is not urgently escalated.	
Criteria: 1. **Potential for Injury, Morbidity or Mortality (clinically significant care concerns or delays)** • Care delay needing immediate intervention • Complex care decision support to prevent harm to patient, visitors and/or workforce members • Decision-making capacity concern • Time sensitive transfer delay • Time sensitive safe discharge concern • Time Sensitive OR Unresolved Issues (despite dept/pavilion internal escalation) 2. **Delay in or potential disruption in care or operations related to:** • Unanticipated high risk equipment failure • Time Sensitive Equipment or Medication Recall 3. **Regulatory, Compliance or Legal Risk:** • Concern for or awareness of complaint to State/CMS • Concern for or awareness of complaint or other state agency (Disability Rights, Elderly Advocacy) • Concern for negative media exposure o Patient or patient's representative raises concern claiming or intimating that they will report to the media o During a sensitive event (i.e., CIT, CPR) a patient, visitor or staff appears to have recorded some or all of the event. • Concern for a significant deviation from an existing Harris Health policy or procedure ***IMPORTANT NOTE:*** **A Safety Huddle may be called for any concern and is not limited to the above criteria.**	**Need For Safety Huddle Has Been Identified:** **Departmental Leadership:** 1. Notify Patient Safety and Risk Management (24/7 on call) as well as additional departments involved of the situation and proposed time of safety huddle 2. Arrange a Safety Huddle by following the below: a. Create a Webex meeting b. Choose below pavilion email group from address book (includes pavilion triad, legal, risk, corporate compliance) • *Safety Huddle- BT* • *Safety Huddle- LBJ* • *Safety Huddle- ACS* c. Add to invite all of the below who are involved or key decision makers: • Nursing, Provider, and/or Ancillary Department Leaders • Involved Provider and Nurse who can best speak to the situation (if applicable) • House Supervisor • Specialty Service (i.e., Psychiatry, Forensic Nursing) • Security • Social Work d. Send invite

Yellow Alert Pre or Post Event	Yellow Alert Actions
A safety event has occurred that requires leadership awareness *OR* a safety event that may occur if an identified unsafe condition or hazard is not escalated and resolved (*does not meet any of the red alert criteria*).	
Criteria: 1. **Injury, Morbidity or Mortality** • High Risk Red Rule Violation • Any care management event that results in minor to moderate harm • Suicide or self-harm attempt (no harm) 2. **Delay in or potential disruption in care or operations related to:** • Treatment, admission, consultation (unable to reach), ancillary services, transfer, administrative approval • Unanticipated staff shortage (call in or illness mid-shift) • Interpersonal or professional issues that interfere with the delivery of care (i.e., incivility, retaliation) 3. **Regulatory, Compliance or Legal Risk:** • Concern for or awareness of complaint to State/CMS • Concern for or awareness of complaint or other state agency (Disability Rights, Elderly Advocacy) • Patient or patient representative has sought or is seeking legal council • Patient, visitor or other party is injured in or near HH property • Significant deviation from an existing Harris Health policy or procedure 4. **High Risk Events Requiring Reporting** • Ambulatory Surgery Center (ASC) transfer of any patient to a higher level of care • Suspected drug diversion by patient, visitor, or workforce • Suspected impairment by workforce member, medical provider, or third parties that participate in care, supervision, transport or escort of Harris Heath patients (EMS, Law enforcement, shared ride drivers) • Suspected controlled substance overdose • Death from communicable disease or infection 5. **Concern for negative media exposure** • Patient or patient's representative raises concern claiming or intimating that they will report to the media • During a sensitive event (i.e., CIT, CPR) a patient, visitor or staff appears to have recorded some or all of the event. 6. **Unanticipated equipment failure**	**Once Escalated (See Appendix A):** **Pavilion Departmental Leadership:** • Enter eIRS • Notify departments who need to be involved in addressing/resolving the issue (i.e. Human Resources, Pharmacy, etc.) • Work with pavilion leaders to address/resolve • Report in Tier 3 Huddle **Pavilion Executive Team:** 1. Call for a Safety Huddle if there is an active situation that is escalating or not resolved 2. Report in Tier 4 **Patient Safety/Risk Management:** 1. Review eIRS for leadership resolution and action items.

APPENDIX G

Harris Health Leadership System Event Notification and Escalation Flow Chart

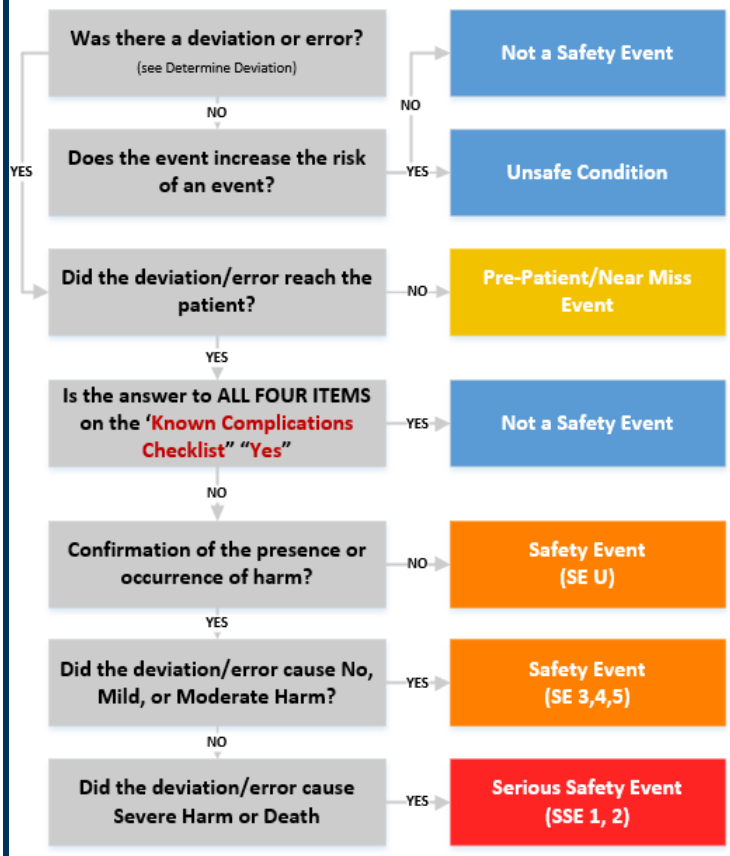


APPENDIX H
Scale for Harm Classification

Safety Event Class	Level of Harm	Code	Patient Outcome
Serious Safety Event (Reaches the patient)	**Death**	**SSE-1**	Unexpected death not related to the natural or expected course of the patient's illness or underlying condition. On balance of probabilities, was caused by or brought forward in the short term by the incident.
	Severe **Permanent or Temporary Harm**	**SSE-2**	Patient outcome is symptomatic, requiring life-saving intervention or major medical-surgical intervention, shortening life expectancy or causing major, permanent or temporary harm or loss of function.
High Risk Error	**Deviation or error that has potential to cause major harm or death**	**HRE**	Deviation or error that has the potential to cause major harm or death to a future patient but did not harm a patient related to the incident. In addition to future harm (impact), the risk assessment should include likelihood of recurrence ranging from high (frequent) to remote (rare). Examples of "high risk - no harm" events include dangerous actions, EMTALA, Red Rule and other policy violations.
Safety Event (Reaches the patient)	***Moderate*** **Permanent or Temporary Harm**	**SE-3**	Patient outcome is symptomatic, requiring intervention (e.g. additional operative procedure, additional therapeutic treatment) an increased length of stay, or causing permanent or temporary harm, or loss of function.
	Mild **Temporary Harm or None**	**SE-4**	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate, but short-term, and minimal or intervention (e.g. Extra observation, investigation, review, or minor treatment), is required.
	No Detectable Harm/No Harm	**SE-5**	Patient outcome is asymptomatic. No symptoms are detected and no treatment is required. Not able to discover or ascertain the existence, presence, or fact of harm, but harm may exist: Insufficient information is available, or unable to determine any harm. Harm may appear later.
	Unknown	**SEU**	Unknown if harm reached a patient
Pre-Patient Event/Near Miss (Does not reach the patient)	**Almost Happened**	**PPE**	Did not reach the patient. Error or capacity to cause harm was caught by an error by an error detection barrier prior to reaching the patient. √ The system worked.

APPENDIX I
One Harris Health Risk Analysis Platform

Patient Safety & Risk Management Safety Event Classification



DETERMINE DEVIATION

- Internal policies, procedures, or protocols
- Nationally recognized best practices and standards of care
- Industry-imposed practice mandates and requirements
- Professional practice standards
- Objective review by other experts
- Organization obligation to best protect the patient from harm

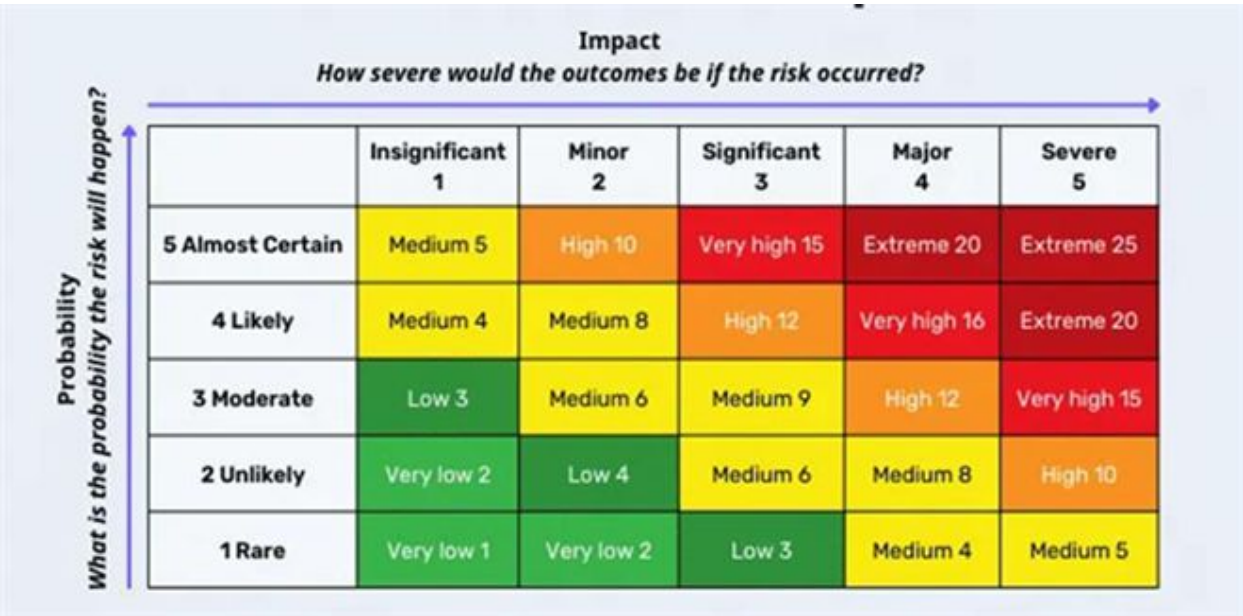
If any of the above are answered YES, proceed with safety events classification

KNOWN COMPLICATION CHECKLIST

1. Was the procedure, treatment, or test appropriate and warranted based on nationally recognized standards of care?
2. If patient experienced a "complication": Was the complication a known risk AND it was anticipated AND the care team planned ahead to take steps to prevent it?
3. Was the complication identified in a timely manner?
4. Was the complication treated according to evidence based standards in a timely manner?

REMINDER TO VIEW FROM THE PATIENT'S PERSPECTIVE:
WOULD WE HAVE EXPECTED OR WANTED THIS LEVEL OF CARE FOR OURSELVES OR OUR LOVED ONE?

APPENDIX J
Risk Matrix



	Insignificant 1	Minor 2	Significant 3	Major 4	Severe 5
5 Almost Certain	Medium 5	High 10	Very high 15	Extreme 20	Extreme 25
4 Likely	Medium 4	Medium 8	High 12	Very high 16	Extreme 20
3 Moderate	Low 3	Medium 6	Medium 9	High 12	Very high 15
2 Unlikely	Very low 2	Low 4	Medium 6	Medium 8	High 10
1 Rare	Very low 1	Very low 2	Low 3	Medium 4	Medium 5

Impact

Also called severity or consequences, the Impact (y-axis) aims to determine the level of effects that the hazard can cause to workplace health and safety.

While a 5×5 risk matrix can be tailored to the needs of an organization, the following represent the general terms used to describe the 5 levels to determine the risk's impact:

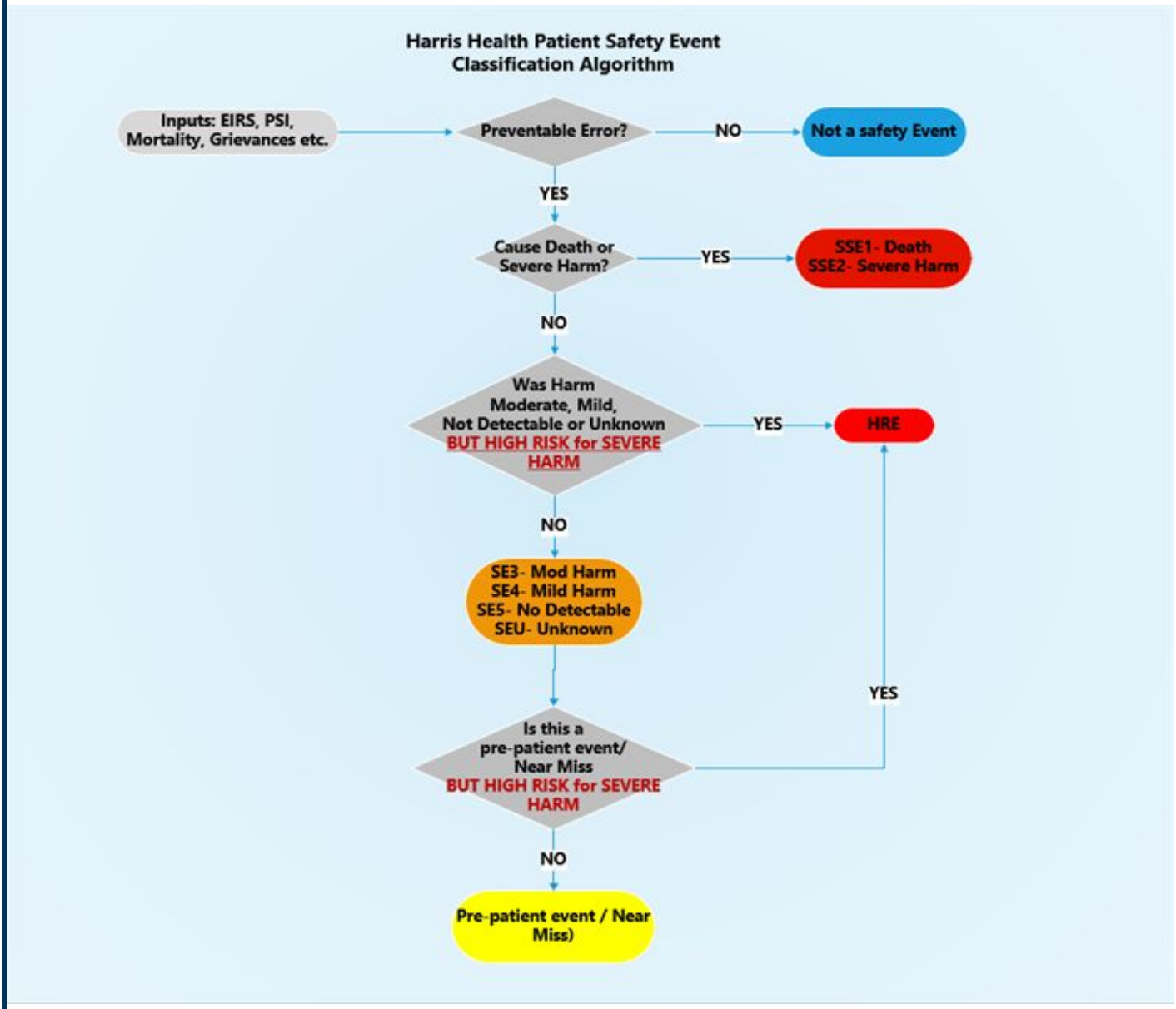
1. **Insignificant** – won't cause serious injuries or illnesses
2. **Minor** – can cause injuries or illnesses, only to a mild extent
3. **Significant** – can cause injuries or illnesses that may require medical attention but limited treatment
4. **Major** – can cause irreversible injuries or illnesses that require constant medical attention
5. **Severe** – can result in fatality

Probability

Also called likelihood, the Probability (x-axis) pertains to the extent of how likely it is for the risk to occur. The 5 risk rating levels under this component are as follows:

1. **Rare** – unlikely to happen and/or have minor or negligible consequences
2. **Unlikely** – possible to happen and/or to have moderate consequences
3. **Moderate** – likely to happen and/or to have serious consequences
4. **Likely** – almost sure to happen and/or to have major consequences
5. **Almost certain** – sure to happen and/or have major consequences

APPENDIX K
Patient Safety Collaborative Revised Healthcare Performance Improvement Safety Event Classification (SEC) Levels of Harm for Standardized Scoring



Appendix L
Risk Reduction Strategy and Action Hierarchy Levels and Categories

	Action Category	Example
Stronger Actions	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building with powered sliding or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose, meters, and test strips with selection of the most appropriate for the patient population being served.
	Engineering control (forcing function)	Eliminate the use of universal adaptors and peripheral devices for medical equipment and use tubing/fitting that can only be connected the correct way (e.g. IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process.
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluation and interact with staff; support the RCA^2 process; ensure staffing and workload are balanced.
Intermediate Actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages.
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day.
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation–based training with periodic refresher sessions and observations	Conduct patient handoffs in a simulation lab/environment with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operating rooms. Use a checklist when reprocessing flexible fiber optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use read-back or repeat-back for all verbal medication orders. Use a standardized patient handoff format.
	Enhanced documentation, communication	Highlight medication name and dose on IV bags.
Weaker Actions	Double checks	One person calculates dosage, another person reviews their calculations.
	Warnings	Add audible alarms or caution labels.
	New procedure/ memorandum policy	Remember to check IV sites every 2 hours.
	Training	Demonstrate the hand-to-use defibrillator with hidden door during an in-service training.

APPENDIX M
Variance Management Filter Council Leadership ~~Guidance~~Guidelines

HARRISHEALTH SYSTEM

Filter Council

The Filter Council is a pavilion based multidisciplinary patient safety meeting with leaders and system colleagues that provides for the transparent initial review of safety and quality of care events or trends to collectively determine next steps for further analysis and/or remediation (i.e., follow-up to the Filter Council, a One Harris Health Platform (OHHP) or Pavilion RCA, or a referral to another committee such as PIC or nursing peer review).

General Safety Event Review Process

- Always initiate an immediate investigation when your unit experiences a potential error that may have reached a patient, caused harm, OR is high risk for harming a patient if the event were to a recur.
- Patient Safety will support and collaborate with your investigation. We may reach out to speak to staff members involved. Please ensure workforce members understand that if a patient safety representative would like to speak with a workforce member, it is because we are looking for ways to improve the process to better support all workforce members (human factors) and prevent a recurrence.
- As part of the investigation into the event, an individual performance issue may be identified and will be referred to the departmental leadership to make recommendations for additional review including peer review.

Filter Council Preparation Instructions

The Patient Safety Team will notify you when a specific event is scheduled to present to the Filter Council. ***The following are next steps:***

- Use the filter template provided in the notification email.
- All involved departments/service lines should contribute to the presentation (i.e., radiology, social work, guest transportation).
- The format helps you communicate your analysis by utilizing an SBAR technique (examples follow below).
  - The **SITUATION** is a simple overview of the care concern.
  - The **BACKGROUND** is a timeline of the event.
  - The **ASSESSMENT** is where you will be introduced you to the "5 whys." You do not have to get this perfect or even reach 5 whys. This is simply a great tool to help you as a leader think at a deeper level to identify holes in the process (Swiss cheese) to identify the most possible root cause to your care concern (what occurred). We have placed several examples of utilizing 5 whys below. Please note, this is an initial 5 why exercise. If this case goes to an OHHP analysis, Patient Safety will lead a deeper analysis to determine causal factors, 5 whys, root causes, and contributing factors. See video Example of "5 Whys"- Watch VIDEO- https://www.youtube.com/watch?v=N7cR2gArCFE
    - During your investigation, if it is identified that a process or expected performance was not followed, please make further attempts to determine the ***why*** behind the staff member failure. This will help in identifying whether there are opportunities in the process or obstacles/barriers that may impact other staff members.
  - The **RECOMMENDATIONS** should address your root causes. (Recommendations by strength plus examples are provided below)
    - Recommendations should include an owner and targeted completion date
- The filter presentation **will be due to Patient Safety 48 hours prior to Filter (Monday by 2:30 pm).** If not submitted, an escalation email will be sent to the one up leadership. Please note the 48 hours is an expectation set by your pavilion leadership as it allows for review and opportunity for additional support if needed. We are here to partner with you!

Appendix N
Patient Safety Collaborative Charter

Harris Health System's Board of Trustees ("BOT") & the Board of Trustees – Quality Committee ("BOT-QC"), through the Quality Manual, has authorized the formation of the Patient Safety Collaborative ("The Collaborative

Title: Harris Health System Patient Safety Collaborative (the "Collaborative")

Purpose: The Patient Safety Collaborative Committee is an interdisciplinary Committee that aims to promote a culture of transparency to provide a multidisciplinary objective review and analysis of patient safety events and functions as a medical committee/medical peer review committee at the direction of the QGC. All functions of the Patient Safety Collaborative Committee are confidential, privileged and protected from disclosure pursuant to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code. The Patient Safety Collaborative is an interdisciplinary team that consists of system and pavilion leaders that collaborate to review events related to patient safety. The goal of the Collaborative is to partner together to achieve zero harm at Harris Health System.

RESPONSIBILITIES

The Collaborative has the following broad sets of responsibilities:

- Supports the overall mission, vision, and values of Harris Health System.
- Review safety events and all risk reduction strategy development to reduce harm and improve patient safety outcomes within the organization.
- Score safety events brought forth for review using the Harris Health approved Serious Safety Event Classification System.
- Conduct data analysis using performance indicators, the Patient Safety Event Rate, Incident Reporting Data, etc. as it may deem necessary or appropriate.
- Monitor risk reduction strategy development.
- Deliberate, discuss, and approve recommendations from the Patients' Collaborative for Safe & Quality Care
- Provide physician and nursing peer review recommendations when applicable.
- Make recommendations related to patient safety and quality that pertains to policy and procedure development.

OVERSIGHT: The Harris Health System Board of Trustees and the Harris Health System Board of Trustees Quality Committee

MEMBERSHIP

Membership for the Collaborative is based on roles, not individuals. Co-chair of the Collaborative will be the Associate Chief Medical Officer/Senior Vice President Quality and Patient Safety and Vice President of Patient Safety and Risk Management. Each member of The Collaborative shall be appointed for a one-year term. The Collaborative members may be removed and/or replaced by the Chair.

Membership on The Collaborative will broadly include the following workforce member's roles:

System	Pavilion
Board Member	Executive Vice President
Chief Executive Officer	Chief Medical Officer
Chief Quality & Patient Safety Officer	Chief Nursing Officer
Chief Operating Officer	Vice President, Operations
Chief Compliance & Risk Officer	Administrative Director of Nursing
Chief Medical Executive	Director, Patient Safety
Chief Nursing Executive	Director, Quality & Patient Safety
Chief Pharmacy & Laboratory Officer	Patient Safety Specialist
Chief Strategy & Integration Officer	Senior Patient Safety Specialist, Controlled
Senior Vice President, Medical Affairs & Utilization	Substances
Senior Vice President, Transitions & Post-Acute Care	Chief of Staff
Senior Vice President, Nursing Affairs & Support Services	Baylor Physician

Senior Vice President, Human Resources Vice President, Transformation & Operational Excellence Vice President, Risk Management & Patient Safety Vice President, Quality Programs Medication Safety Officer Administrative Director, Pharmacy System Operations Administrative Director, Nursing Strategic Initiatives Director, Nursing Quality & Patient Safety Director, Medical Peer Review Director, Lean Six Sigma Program Consultant, Harris County District Attorney	UT Physician

MEETINGS

The Collaborative strives to meet bimonthly and/or at such times, it deems appropriate. Special meetings may be convened, as the Collaborative deems necessary. When additional expertise is needed, Harris Health Workforce Members may be invited by the Patient Safety and Risk Management Department to address specific issues.

PROCEDURE

The Collaborative meetings will have a standard agenda, which will include:

- Confidentiality Statement
- Old Business/Unresolved Issues
- Patient Safety Priorities
- Patient Safety Performance Indicators
- Risk Reduction Strategy and Monitoring Tracking
- Event Summary

A patient safety event summary will include at a minimum:

- Case Summary
- Root Causes
- Incidental Findings (If Applicable)
- Contributing Factors
- Risk Reduction Strategy Table, which will include at a minimum:
    - Strategy
    - Associated Root Cause/Contributing Factor
    - Owner
    - Measurement Strategy
    - Implementation Deadline

The following entities/ roles may refer events for the Collaborative to review:

Role	Entity
Board Member Chief Executive Officer Chief Quality & Patient Safety Officer Chief Medical Executive Chief Compliance & Risk Officer Chief Nursing Executive Executive Vice President Pavilion Triads	Variance Management Filter Council

Events will be scored using Harris Health System's approved Serious Safety Event Classification System, which is adapted from the HPI Safety Event Classification & Serious Safety Event Rate Patient Safety Measurement System.

When deemed necessary and at its discretion, the Collaborative may review a previously scored event to update a patient safety event summary or score that may not have been identified during the original case presentation or to change the score

on a previously reviewed patient safety event when additional information is presented that suggests a change or update is warranted.

As often as is necessary or appropriate in its judgment, the Collaborative shall report a patient safety summary, as applicable, at each scheduled BOT-QC meeting.

RECORDS

The Collaborative decisions and actions are documented through minutes as recorded by Patient Safety and Risk Management Department. The meeting minutes are disseminated within ten business days from the meeting.

Meeting minutes are reviewed and approved by the Collaborative members. Agendas and meeting minutes are retained by the Patient Safety and Risk Management Department and approved by all members.

QUORUM

Includes a minimum of one operational and nursing executive (or their appointed delegate) from Ben Taub, Lyndon B Johnson, and the System. Ambulatory Care Services and Hospital at Home will require an executive leader (or their delegate) to be present when a summary from their pavilion is presented. The Collaborative may take no action without the consent of a majority of the members.

REPORTS

The Collaborative will report to the BOT-QC routinely to include:

- Data derived from the electronic Incident Reporting System (eIRS)/Patient safety event analysis/trending.
- Progress on Risk Reduction Strategies
- Event Summary
- Patient Safety Event Rate

SUBCOMMITTEE

Subcommittees may be established by the Collaborative. Any subcommittee shall be composed of members of the Collaborative (or the designees of such members) and a minimum of three patients or family members of patients. A subcommittee charter will be included as a sub-section of the Collaborative Charter. The subcommittee will require the same quorum requirement as the Collaborative. The subcommittee will report recommendations and advice to the Collaborative for deliberation and discussion. The Collaborative will document the subcommittee's recommendations and advice and present them to the BOT-QC.

Title: The Patients' Committee for Safe & Quality Care

The Patients' Committee for Safe & Quality Care is a subcommittee of the Patient Safety Collaborative. The purpose of the Patients' Committee for Safe & Quality Care is to provide awareness on patient safety events and quality of care concerns to promote patient involvement, input, and engagement in preventing future harm. The Patients' Committee for Safe and Quality Care, as a subcommittee of the Collaborative, is a medical committee/medical peer review committee that functions at the direction of the Collaborative and the QGC. All functions of the Patients' Committee for Safe and Quality Care are confidential, privileged and protected from disclosure pursuant to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code.

RESPONSIBILITIES

The Patients' Committee for Safe & Quality Care has the following broad sets of responsibilities:

- Supports the overall mission, vision, and values of Harris Health System.
- Review safety events and quality of care issues
- Provide recommendations on strategies and/or process improvements to prevent harm and improve quality of care delivery.
- Provide recommendations related to patient safety and quality that pertains to policy and procedure development.

MEETINGS

The Patients' Committee for Safe & Quality Care strives to meet quarterly. Special meetings may be convened, as deemed necessary. When additional expertise is needed, Harris Health Workforce Members may be invited by the Risk & Patient Safety Department to address specific issues.

PROCEDURE

1. The Committee's meetings will have a standard agenda, which will include:
    - Confidentiality Statement
    - Old Business/Unresolved Issues
    - Patient Safety and Quality of Care Concerns
    - Strategy and Process recommendations
    - Open Forum
2. Meeting will be held virtually.
3. The chair shall create the meeting agenda. The agenda is distributed electronically to members at least two days in advance of scheduled meetings. PCSQC members may request that items be considered for the agenda by contacting the chair.
4. Members should confirm attendance prior to meetings.

MEMBERSHIP

The PCSQC shall be comprised of the following:

- Chair: Vice President for Patient Safety & Risk Management
- Minimum of three patients
- Patient Relations
- Minimum of three Harris Health workforce members
- Ad hoc/quest members as needed/appropriate

The Committee shall review and assess the adequacy of this charter periodically and recommend any proposed changes to the BOT.

Thursday, May 22, 2025

Consideration of Approval to Acquire a Portion of Harrington Street in Exchange for Consideration and the Conveyance of an Easement to the City of Houston

---

Administration recommends Board of Trustees approval of the acquisition of real property and the conveyance of an easement to the City of Houston as follows:

Harris Health shall acquire from the City of Houston:

1) Harrington Street from the corner of North Main Street going southwest ±284 feet ("Harrington Segment")

Harris Health will convey to the City of Houston:

1) A utility easement the full width of the Harrington Segment

All real property to be acquired and/or conveyed through this approval is within the Marian Addition No. 1 and/or Mrs A C Allen's addition, out of the John Austin Survey, Abstract 1. Parcel SY124-063 and VY25-001.

Harris Health has provisionally accepted the City of Houston's request for additional consideration in the amount of $324,311.00 as the appraised value for the acquired Harrington Segment, subject to completion of the transaction requirements and approval of the Houston City Council, Harris Health Board of Trustees and Harris County Commissioner's Court.

Patrick Casey
SVP, Facilities Construction & Systems Engineering

Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

HOUSTON PUBLIC WORKS

April 23, 2025

Mr. Chuck Davis
C.L. Davis and Company
1500 Winding Way
Friendswood, Texas 77546

OFFER LETTER

Subject: Abandonment and sale of Harrington Street, from North Main Street southwest ±284 feet, in exchange for the conveyance to the City of a full-width utility easement, both being within the Marlan Addition No. 1 and/or Mrs A.C. Allen's Addition, out of the John Austin Survey, Abstract 1. **Parcel SY24-063 and VY25-001**

Dear Mr. Davis:

This letter is the City's offer to conclude the captioned transaction for a consideration of $324,311.00 subject to your completion of the outstanding transaction requirements and City Council approval.

1. A letter from Harris County Hospital District, accepting the City's offer.

2. A cashier's check payable to the City of Houston for the $321,511.00 balance of the consideration. We will hold these funds with your $2,800.00 nonrefundable deposit.

3. An original statement of ownership letter from an attorney-at-law (Attachment 1).

4. A letter of no objection from CenterPoint Energy for the street being abandoned and sold (Attachment 2).

Should you not be able to accept the offer within the fifteen-day period, this offer will be considered withdrawn and the file will be canceled without further communication. To pursue the transaction thereafter might require either: (1) you to initiate the process anew OR (2) an appraisal update. If, at the City's sole discretion, the latter alternative is possible, you will be required to submit a written request and an additional nonrefundable deposit equal to the cost of updating the appraisal. This additional nonrefundable deposit will not be applied toward the consideration. The City's updated offer will be for the higher of the original appraised value or the updated appraised value.

Upon your completing these requirements, we will request our Legal Department to prepare the conveyance instrument.

HOUSTON PUBLIC WORKS

Attached for your information are copies of the approved field notes and Drawing No. 78979 (Attachment 3).

Should you have any questions, please contact Tiffany Cano, Senior Real Estate Analyst, Real Estate Services- Asset Management, at (832) 395-3169.

Sincerely,

DocuSigned by:
Al Jackson
5E1D621925F944C...

Addie L. Jackson Esq.
Assistant Director-Real Estate Services
Houston Public Works

ALJ:WSB:tdc

Attachments: 1. Attorney Statement of Ownership
2. Letter of no objection from private utility companies
3. Survey and Field Notes for Drawing No.78979

File: tdc\sy24-063

PARCEL NO. SY24-063
PROJECT NO.
DWG NO 78979

PARCEL SY24-063
0.2713 ACRE BEING A PORTION OF HARRINGTON STREET BETWEEN KEENE STREET AND NORTH MAIN STREET JOHN AUSTIN SURVEY, ABSTRACT 1 HOUSTON, HARRIS COUNTY, TEXAS

All that certain 0.2713 acre (11,817 square feet) being a portion of Harrington Street (width varies) between Keene Street and North Main Street as dedicated by Marlan Addition No. 1 according to the plat thereof as filed in Volume 01, Page 48 Harris County Map Records, John Austin Survey, Abstract 1, Houston, Harris County, Texas and being more particularly described by metes and bounds as follows (Coordinates and Bearings shown are based on the Texas Coordinate System of 1983, South Central Zone 4204. Distances shown are surface and can be converted to grid by multiplying by a combined scale factor of 0.9998941);

Commencing at Harris County Floodplain Reference Marker No. 050005 having published grid coordinates of N: 13,846,999.60, E: 3,121,067.23 and from which Harris County Floodplain Reference Mark No. 050010 bears N 51° 30' 23" W – 2,544.91' for reference; Thence S 89° 26' 14" E – 1,693.32' to a point (unable to set due to construction) marking the most northerly corner of Restricted Reserve "A", Block 1, Harris Health System Casa de Amigos according to the plat thereof as filed in Film Code Number 706085 Harris County Map Records and being located on the southeasterly right-of-way line of said Harrington Street and marking the POINT OF BEGINNING of herein described tract, having grid coordinates of N: 13,846,983.18, E: 3,122,760.34;

1. Thence S 42° 57' 08" W – 241.14' with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to a set 5/8" iron rod with cap (stamped C.L. DAVIS RPLS 4464) for corner, from which a found 3/4" iron rod marking the most westerly corner of said Restricted Reserve "A", Block 1 bears S 42° 57' 08" W – 17.89' for reference;

2. Thence N 49° 07' 11" W – 40.03' to a found 2" iron pipe for corner;

3. Thence N 42° 57' 08" E – 240.63' with the common northwesterly right-of-way line of said Harrington Street and the southeast line of Lots 1-4 of said Marlan Addition No. 1 to a set 5/8" iron rod with cap (stamped C.L. DAVIS RPLS 4464) for corner marking east corner of said Lot 1, Marlan Addition No. 1;

4. Thence N 50° 02' 52" W – 15.40' with northeasterly line of said Lot 1, Marlan Addition No. 1 to a set 5/8" iron rod with cap (stamped C.L. DAVIS RPLS 4464) for corner;

5. Thence N 65° 33' 08" E – 50.54' with southeasterly line of Lot 7, Block 23, Mrs. A.C. Allen's Addition according to the plat thereof as filed in Volume Z, Page 518 Harris County Deed Records to a point (unable to set) for corner marking the intersection of the northwesterly right-of-way line of said Harrington Street and the westerly right-of-way line of North Main Street (80' wide) as dedicated by said plat of Mrs. A.C. Allen's Addition;

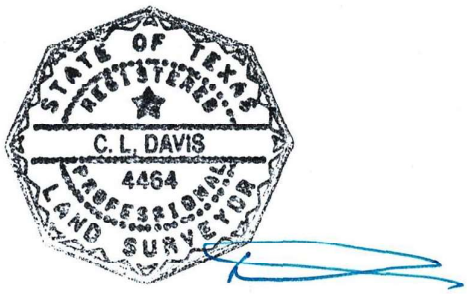
6. Thence S 24° 26' 52" E – 60.30' to a point (unable to set due to construction) for corner;

7. Thence S 65° 37' 08" W – 21.86' with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to a point for corner (unable to set due to construction);

8. Thence N 49° 50' 52" W – 11.30' continuing with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to the POINT OF BEGINNING and containing 0.2713 acre (11,817 square feet) of land more or less.

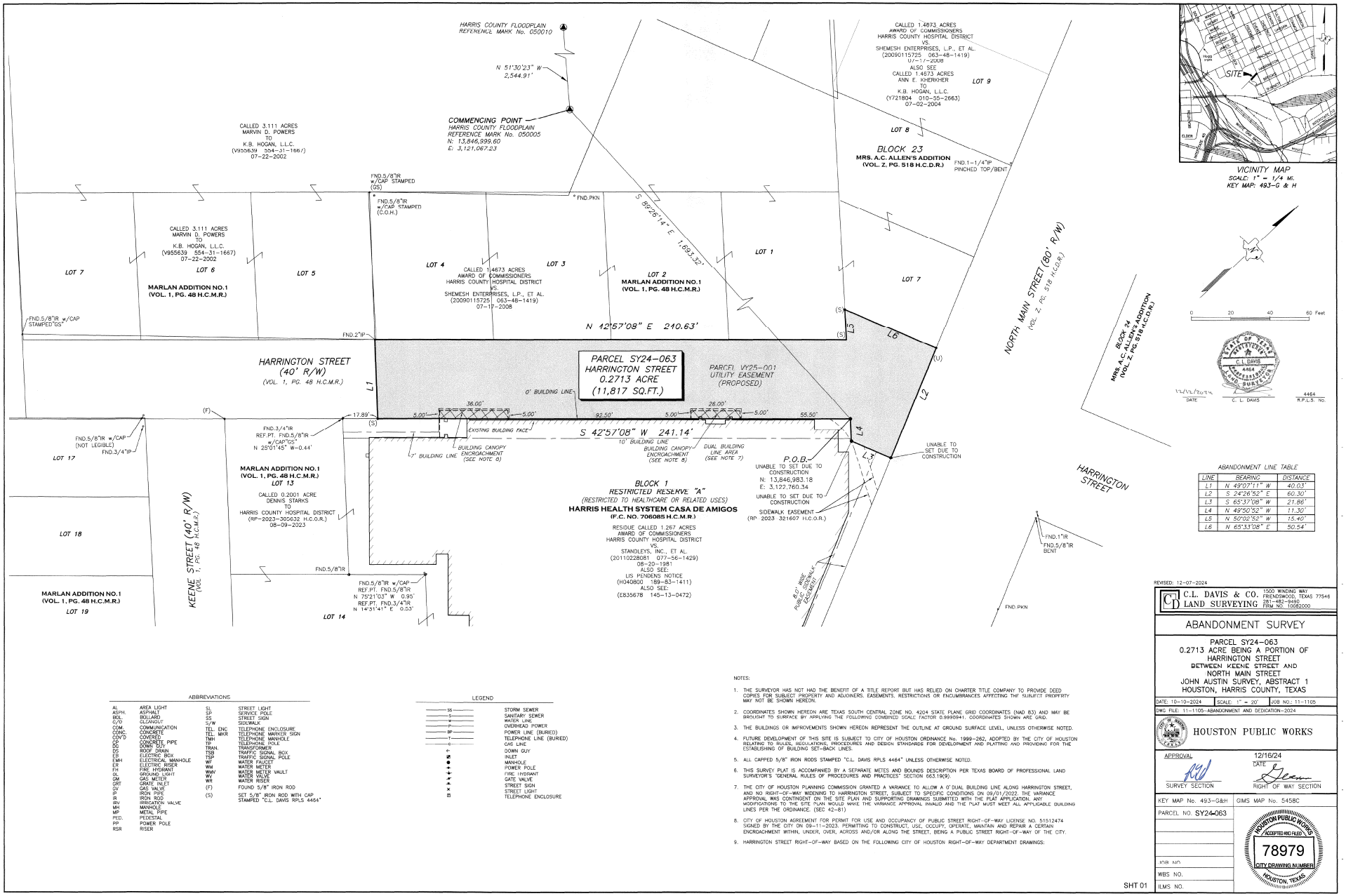
This metes and bounds description is accompanied by a separate plat, drawing or exhibit per Texas Board of Professional Land Surveyor's "General Rules of Procedures and Practices" Section 663.19(9).

Compiled by: C.L. Davis & Company
Firm No. 10082000
Job Number: 11-1105-SY24-063 REV.doc
10-10-2024
Revised 12-11-2024



PARCEL NO. SY24-063
PROJECT NO.
DWG NO 78979

CHECKED
DATE 12/16/24
APPROVED



ABANDONMENT LINE TABLE		
LINE	BEARING	DISTANCE
L1	N 49°07'11" W	40.03'
L2	S 24°26'52" E	60.30'
L3	S 65°37'08" W	21.86'
L4	N 49°50'52" W	11.30'
L5	N 50°02'52" W	15.40'
L6	N 65°33'08" E	50.54'

ABBREVIATIONS

AL	AREA LIGHT	SL	STREET LIGHT
ASPH.	ASPHALT	SP	SERVICE POLE
BOL.	BOLLARD	SS	STREET SIGN
C/O	CLEANOUT	S/W	SIDEWALK
COM.	COMMUNICATION	TEL. ENC.	TELEPHONE ENCLOSURE
CONC.	CONCRETE	TEL. MKR	TELEPHONE MARKER SIGN
COV'D	COVERED	TMH	TELEPHONE MANHOLE
CP	CONCRETE PIPE	TP	TELEPHONE POLE
DG	DOWN GUY	TRANS.	TRANSFORMER
DS	ROOF DRAIN	TSB	TRAFFIC SIGNAL BOX
EB	ELECTRIC BOX	TSP	TRAFFIC SIGNAL POLE
EMH	ELECTRICAL MANHOLE	WF	WATER FAUCET
ER	ELECTRIC RISER	WM	WATER METER
FH	FIRE HYDRANT	WMV	WATER METER VAULT
GL	GROUND LIGHT	WV	WATER VALVE
GM	GAS METER	WR	WATER RISER
GRT	GRATE INLET	(F)	FOUND 5/8" IRON ROD
GV	GAS VALVE		
IP	IRON PIPE	(S)	SET 5/8" IRON ROD WITH CAP STAMPED "C.L. DAVIS RPLS 4464"
IR	IRON ROD		
IRV	IRRIGATION VALVE		
MH	MANHOLE		
MP	METAL PIPE		
PED.	PEDESTAL		
PP	POWER POLE		
RSR	RISER		

LEGEND

SS	STORM SEWER
S	SANITARY SEWER
W	WATER LINE
P	OVERHEAD POWER
BP	POWER LINE (BURIED)
T	TELEPHONE LINE (BURIED)
G	GAS LINE
DG	DOWN GUY
	INLET
	MANHOLE
	POWER POLE
	FIRE HYDRANT
	GATE VALVE
	STREET SIGN
	STREET LIGHT
	TELEPHONE ENCLOSURE

NOTES:

1. THE SURVEYOR HAS NOT HAD THE BENEFIT OF A TITLE REPORT BUT HAS RELIED ON CHARTER TITLE COMPANY TO PROVIDE DEED COPIES FOR SUBJECT PROPERTY AND ADJOINERS. EASEMENTS, RESTRICTIONS OR ENCUMBRANCES AFFECTING THE SUBJECT PROPERTY MAY NOT BE SHOWN HEREON.
2. COORDINATES SHOWN HEREON ARE TEXAS SOUTH CENTRAL ZONE NO. 4204 STATE PLANE GRID COORDINATES (NAD 83) AND MAY BE BROUGHT TO SURFACE BY APPLYING THE FOLLOWING COMBINED SCALE FACTOR 0.9999841. COORDINATES SHOWN ARE GRID.
3. THE BUILDINGS OR IMPROVEMENTS SHOWN HEREON REPRESENT THE OUTLINE AT GROUND SURFACE LEVEL, UNLESS OTHERWISE NOTED.
4. FUTURE DEVELOPMENT OF THIS SITE IS SUBJECT TO CITY OF HOUSTON ORDINANCE No. 1999-262, ADOPTED BY THE CITY OF HOUSTON RELATING TO RULES, REGULATIONS, PROCEDURES AND DESIGN STANDARDS FOR DEVELOPMENT AND PLATTING AND PROVIDING FOR THE ESTABLISHING OF BUILDING SET-BACK LINES.
5. ALL CAPPED 5/8" IRON RODS STAMPED "C.L. DAVIS RPLS 4464" UNLESS OTHERWISE NOTED.
6. THIS SURVEY PLAT IS ACCOMPANIED BY A SEPARATE METES AND BOUNDS DESCRIPTION PER TEXAS BOARD OF PROFESSIONAL LAND SURVEYOR'S "GENERAL RULES OF PROCEDURES AND PRACTICES" SECTION 663.19(9).
7. THE CITY OF HOUSTON PLANNING COMMISSION GRANTED A VARIANCE TO ALLOW A 0' DUAL BUILDING LINE ALONG HARRINGTON STREET, AND NO RIGHT-OF-WAY WIDENING TO HARRINGTON STREET, SUBJECT TO SPECIFIC CONDITIONS ON 09/01/2022. THE VARIANCE APPROVAL WAS CONTINGENT ON THE SITE PLAN AND SUPPORTING DRAWINGS SUBMITTED WITH THE PLAT APPLICATION. ANY MODIFICATIONS TO THE SITE PLAN WOULD MAKE THE VARIANCE APPROVAL INVALID AND THE PLAT MUST MEET ALL APPLICABLE BUILDING LINES PER THE ORDINANCE (SEC 42-81)
8. CITY OF HOUSTON AGREEMENT FOR PERMIT FOR USE AND OCCUPANCY OF PUBLIC STREET RIGHT-OF-WAY LICENSE NO. 51512474 SIGNED BY THE CITY ON 09-11-2023. PERMITTING TO CONSTRUCT, USE, OCCUPY, OPERATE, MAINTAIN AND REPAIR A CERTAIN ENCROACHMENT WITHIN, UNDER, OVER, ACROSS AND/OR ALONG THE STREET, BEING A PUBLIC STREET RIGHT-OF-WAY OF THE CITY.
9. HARRINGTON STREET RIGHT-OF-WAY BASED ON THE FOLLOWING CITY OF HOUSTON RIGHT-OF-WAY DEPARTMENT DRAWINGS:

SHT 01

REVISED: 12-07-2024

C.L. DAVIS & CO. LAND SURVEYING
1500 WINDING WAY
FRIENDSWOOD, TEXAS 77546
281-482-9490
FIRM NO. 10082000

ABANDONMENT SURVEY

PARCEL SY24-063
0.2713 ACRE BEING A PORTION OF
HARRINGTON STREET
BETWEEN KEENE STREET AND
NORTH MAIN STREET
JOHN AUSTIN SURVEY, ABSTRACT 1
HOUSTON, HARRIS COUNTY, TEXAS

DATE: 10-10-2024 | SCALE: 1" = 20' | JOB NO.: 11-1105
DWG FILE: 11-1105-ABANDONMENT AND DEDICATION-2024

HOUSTON PUBLIC WORKS

APPROVAL
SURVEY SECTION
12/16/24
DATE
RIGHT OF WAY SECTION

KEY MAP No. 493-G&H | GIMS MAP No. 5458C
PARCEL NO. SY24-063
HPW NO.
WBS NO.
ILMS NO.

ACCEPTED AND FILED
HOUSTON PUBLIC WORKS
78979
CITY DRAWING NUMBER
HOUSTON, TEXAS

N:\11-Wide 11-1101-THRU-11-1150\11-1105-CASA DE AMIGOS\11-1105-ABANDONMENT AND DEDICATION-2024.dwg

PARCEL VY25-001
UTILITY EASEMENT
0.2654 ACRE BEING A PORTION OF
LOT 7, BLOCK 23
MRS. A.C. ALLEN'S ADDITION
AND A PORTION OF HARRINGTON STREET
BETWEEN KEENE STREET AND NORTH MAIN STREET
JOHN AUSTIN SURVEY, ABSTRACT 1
HOUSTON, HARRIS COUNTY, TEXAS

All that certain 0.2654 acre (11,562 square feet) being a portion of Lot 7, Block 23, Mrs. A.C. Allen's Addition according to the plat thereof as filed in Volume Z, Page 518 Harris County Deed Records and being a portion of Harrington Street (width varies) between Keene Street and North Main Street as dedicated by Marlan Addition No. 1 according to the plat thereof as filed in Volume 01, Page 48 Harris County Map Records, John Austin Survey, Abstract 1, Houston, Harris County, Texas and being more particularly described by metes and bounds as follows (Coordinates and Bearings shown are based on the Texas Coordinate System of 1983, South Central Zone 4204. Distances shown are surface and can be converted to grid by multiplying by a combined scale factor of 0.9998941);

Commencing at Harris County Floodplain Reference Marker No. 050005 having published grid coordinates of N: 13,846,999.60, E: 3,121,067.23 and from which Harris County Floodplain Reference Mark No. 050010 bears N 51° 30' 23" W – 2,544.91' for reference; Thence S 89° 26' 14" E – 1,693.32' to a point (unable to set due to construction) marking the most northerly corner of Restricted Reserve "A", Block 1, Harris Health System Casa de Amigos according to the plat thereof as filed in Film Code Number 706085 Harris County Map Records and being located on the southeasterly right-of-way line of said Harrington Street and marking the POINT OF BEGINNING of herein described tract, having grid coordinates of N: 13,846,983.18, E: 3,122,760.34;

1. Thence S 42° 57' 08" W – 241.14' with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to a set 5/8" iron rod with cap (stamped C.L. DAVIS RPLS 4464) for corner, from which a found 3/4" iron rod marking the most westerly corner of said Restricted Reserve "A", Block 1 bears S 42° 57' 08" W – 17.89' for reference;

2. Thence N 49° 07' 11" W – 40.03' to a found 2" iron pipe for corner;

3. Thence N 42° 57' 08" E – 288.17' with the common northwesterly right-of-way line of said Harrington Street and the southeast line of Lots 1-4 of said Marlan Addition No. 1 to a set 5/8" iron rod with cap (stamped C.L. DAVIS RPLS 4464) for corner, marking a point on the westerly right-of-way line of North Main Street (80' wide) as dedicated by said plat of Mrs. A.C. Allen's Addition;

PARCEL NO.	VY25-001
PROJECT NO.	
DWG NO	78979

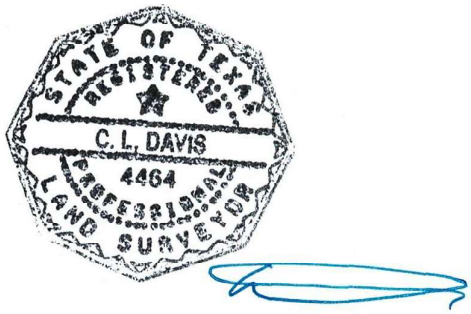
4. Thence S 24° 26' 52" E – 64.68' to a point (unable to set due to construction) for corner;

5. Thence S 65° 37' 08" W – 21.86' with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to a point for corner (unable to set due to construction);

6. Thence N 49° 50' 52" W – 11.30' continuing with the common southeasterly right-of-way line of said Harrington Street and the northwesterly line of said Restricted Reserve "A", Block 1 to the POINT OF BEGINNING and containing 0.2654 acre (11,562 square feet) of land more or less.

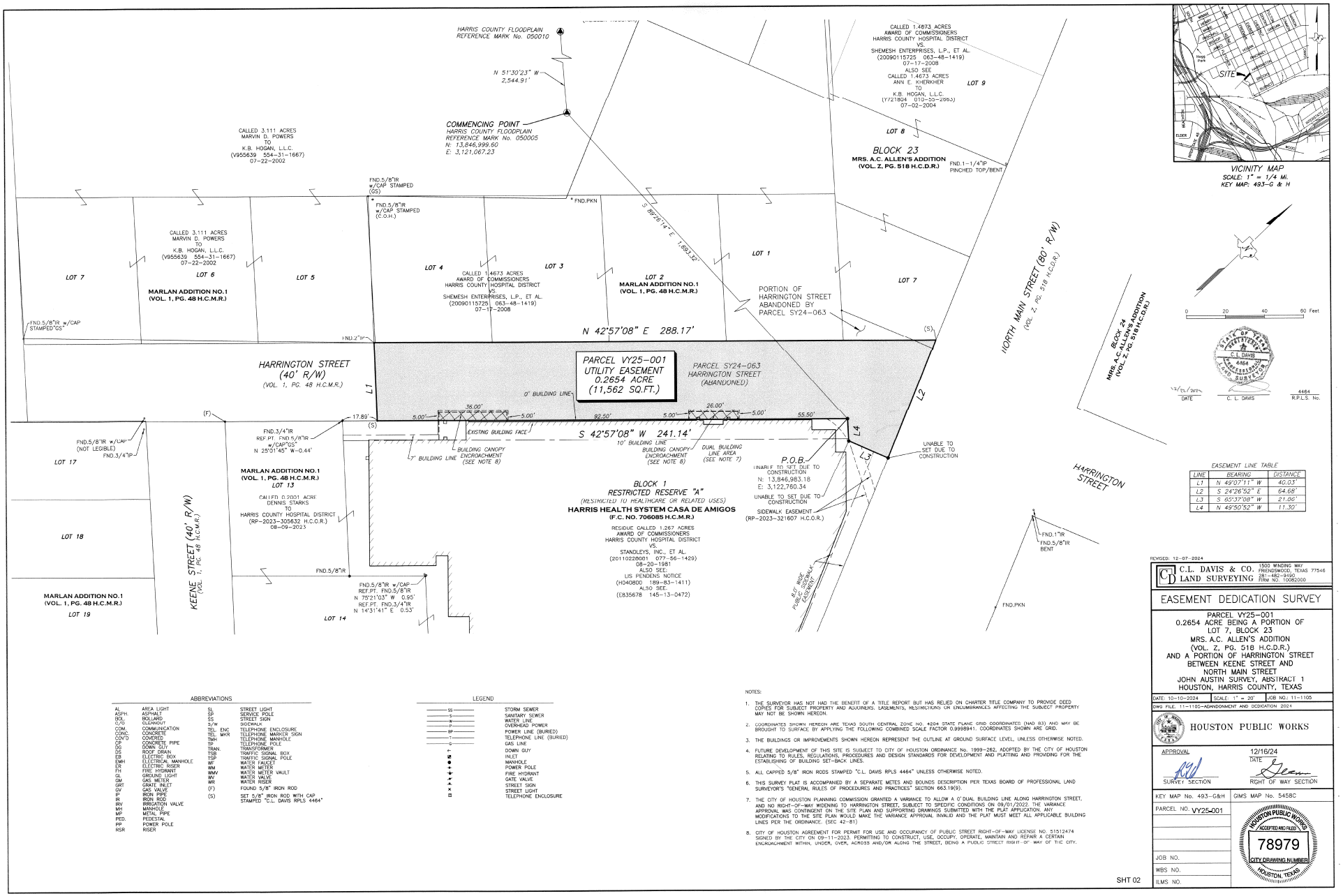
This metes and bounds description is accompanied by a separate plat, drawing or exhibit per Texas Board of Professional Land Surveyor's "General Rules of Procedures and Practices" Section 663.19(9).

Compiled by: C.L. Davis & Company
Firm No. 10082000
Job Number: 11-1105-VY25-001 REV.doc
10-10-2024
Revised 12-11-2024



PARCEL NO. VY25-001
PROJECT NO.
DWG NO 78979

CHECKED
DATE 12/16/24
APPROVED



EASEMENT LINE TABLE

LINE	BEARING	DISTANCE
L1	N 49°07'17" W	40.03'
L2	S 24°26'52" E	64.68'
L3	S 60°37'08" W	21.06'
L4	N 49°50'52" W	11.30'

ABBREVIATIONS

AL	AREA LIGHT	SL	STREET LIGHT
ASPH.	ASPHALT	SP	SERVICE POLE
BOL.	BOLLARD	SS	STREET SIGN
C/O	CLEANOUT	S/W	SIDEWALK
COM.	COMMUNICATION	TEL. ENC	TELEPHONE ENCLOSURE
CONC.	CONCRETE	TEL. MKR	TELEPHONE MARKER SIGN
COV'D	COVERED	TMH	TELEPHONE MANHOLE
CP	CONCRETE PIPE	TP	TELEPHONE POLE
DG	DOWN GUY	TRAN.	TRANSFORMER
DS	ROOF DRAIN	TSB	TRAFFIC SIGNAL BOX
EB	ELECTRICAL BOX	TSP	TRAFFIC SIGNAL POLE
EMH	ELECTRICAL MANHOLE	WF	WATER FAUCET
ER	ELECTRIC RISER	WM	WATER METER
FH	FIRE HYDRANT	WMV	WATER METER VAULT
GL	GROUND LIGHT	WV	WATER VALVE
GM	GAS METER	WR	WATER RISER
GMT	GRATE INLET	(F)	FOUND 5/8" IRON ROD
GV	GAS VALVE	(S)	SET 5/8" IRON ROD WITH CAP STAMPED "C.L. DAVIS RPLS 4464"
IP	IRON PIPE		
IR	IRON ROD		
IRV	IRRIGATION VALVE		
MH	MANHOLE		
MP	METAL PIPE		
PED.	PEDESTAL		
PP	POWER POLE		
RSR	RISER		

LEGEND

SS	STORM SEWER
S	SANITARY SEWER
W	WATER LINE
OHP	OVERHEAD POWER
BP	POWER LINE (BURIED)
T	TELEPHONE LINE (BURIED)
G	GAS LINE
	DOWN GUY
	INLET
	MANHOLE
	POWER POLE
	FIRE HYDRANT
	GATE VALVE
	STREET SIGN
	STREET LIGHT
	TELEPHONE ENCLOSURE

NOTES:

1. THE SURVEYOR HAS NOT HAD THE BENEFIT OF A TITLE REPORT BUT HAS RELIED ON CHARTER TITLE COMPANY TO PROVIDE DEED COPIES FOR SUBJECT PROPERTY AND ADJOINERS. EASEMENTS, RESTRICTIONS OR ENCUMBRANCES AFFECTING THE SUBJECT PROPERTY MAY NOT BE SHOWN HEREON.
2. COORDINATES SHOWN HEREON ARE TEXAS SOUTH CENTRAL ZONE NO. 4204 STATE PLANE GRID COORDINATES (NAD 83) AND MAY BE BROUGHT TO SURFACE BY APPLYING THE FOLLOWING COMBINED SCALE FACTOR 0.9998941. COORDINATES SHOWN ARE GRID.
3. THE BUILDINGS OR IMPROVEMENTS SHOWN HEREON REPRESENT THE OUTLINE AT GROUND SURFACE LEVEL, UNLESS OTHERWISE NOTED.
4. FUTURE DEVELOPMENT OF THIS SITE IS SUBJECT TO CITY OF HOUSTON ORDINANCE No. 1999-282, ADOPTED BY THE CITY OF HOUSTON RELATING TO RULES, REGULATIONS, PROCEDURES AND DESIGN STANDARDS FOR DEVELOPMENT AND PLATTING AND PROVIDING FOR THE ESTABLISHING OF BUILDING SET-BACK LINES.
5. ALL CAPPED 5/8" IRON RODS STAMPED "C.L. DAVIS RPLS 4464" UNLESS OTHERWISE NOTED.
6. THIS SURVEY PLAT IS ACCOMPANIED BY A SEPARATE METES AND BOUNDS DESCRIPTION PER TEXAS BOARD OF PROFESSIONAL LAND SURVEYOR'S "GENERAL RULES OF PROCEDURES AND PRACTICES" SECTION 663.19(9).
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SHT 02

REVISED: 12-07-2024

C.L. DAVIS & CO. LAND SURVEYING
1500 WINDING WAY
FRIENDSWOOD, TEXAS 77546
281-482-9490
FIRM NO. 10082000

EASEMENT DEDICATION SURVEY

PARCEL VY25-001
0.2654 ACRE BEING A PORTION OF
LOT 7, BLOCK 23
MRS. A.C. ALLEN'S ADDITION
(VOL. Z, PG. 518 H.C.D.R.)
AND A PORTION OF HARRINGTON STREET
BETWEEN KEENE STREET AND
NORTH MAIN STREET
JOHN AUSTIN SURVEY, ABSTRACT 1
HOUSTON, HARRIS COUNTY, TEXAS

DATE: 10-10-2024 | SCALE: 1" = 20' | JOB NO.: 11-1105
DWG FILE: 11-1105-ABANDONMENT AND DEDICATION 2024

HOUSTON PUBLIC WORKS

APPROVAL — 12/16/24 DATE

SURVEY SECTION — RIGHT OF WAY SECTION

KEY MAP No. 493-G&H | GIMS MAP No. 5458C

PARCEL NO. VY25-001

JOB NO.

WBS NO.

ILMS NO.

HOUSTON PUBLIC WORKS
ACCEPTED AND FILED
78979
CITY DRAWING NUMBER
HOUSTON, TEXAS

docusign

Certificate Of Completion

Envelope Id: 4F40F7BD-92FE-46F9-92F2-787693D7F477
Status: Completed
Subject: Complete with Docusign: Offer Letter - Harrington Street SY24-063.pdf
Source Envelope:
Document Pages: 11
Signatures: 1
Certificate Pages: 2
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-06:00) Central Time (US & Canada)

Envelope Originator:
Debra Watson
611 Walker St.
HITS
Houston, TX 77002
Debra.Watson@houstontx.gov
IP Address: 50.58.210.12

Record Tracking

Status: Original
4/23/2025 9:00:15 AM
Security Appliance Status: Connected
Storage Appliance Status: Connected

Holder: Debra Watson
Debra.Watson@houstontx.gov
Pool: FedRamp
Pool: City of Houston IT Services

Location: DocuSign
Location: Docusign

Signer Events	Signature	Timestamp
AL Jackson addie.jackson@houstontx.gov Asst. Director, Real Estate City of Houston Security Level: Email, Account Authentication (None)	DocuSigned by: Al Jackson 5E1D621925F944C... Signature Adoption: Pre-selected Style Using IP Address: 50.58.210.12	Sent: 4/23/2025 9:01:53 AM Viewed: 4/23/2025 9:27:33 AM Signed: 4/23/2025 9:34:32 AM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Tiffany Cano Tiffany.Cano@houstontx.gov City of Houston IT Services Security Level: Email, Account Authentication (None)	COPIED	Sent: 4/23/2025 9:34:33 AM Viewed: 4/23/2025 9:35:22 AM

Electronic Record and Signature Disclosure:
Not Offered via Docusign

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	4/23/2025 9:01:53 AM
Certified Delivered	Security Checked	4/23/2025 9:27:33 AM
Signing Complete	Security Checked	4/23/2025 9:34:32 AM

Thursday, May 22, 2025

Consideration of Approval to Convey a Perpetual Blanket Easement and Right of Way to CenterPoint Energy Houston Electric, LLC on Harrington Street (the "Easement Area") adjacent to the Casa de Amigos Health Center

---

Administration recommends Board of Trustees approval to authorize the conveyance of a perpetual blanket easement to CenterPoint Energy Houston Electric, LLC. for electric distribution and related communication facilities located within a 11,582 square foot easement on Harrington Street between North Main Street Southwest ±284 feet towards Keene Street. The easement is further referred to as, "Facilities lying on, over, under, and across the following described lands" owned by Harris Health System:

> Being a portion of Harrington Street (closed) and containing 0.2654 acres, the location of which is shown on Exhibit "A", attached hereto and made a part hereof, situated between that called 1.4673 acre tract of land situated in the John Austin Survey, Abstract 1, as recorded in an Award of Commissioners to Harris County Hospital District under County Clerk's file 20090115725 in Harris County, Texas, AND, Restricted Reserve "A" in Block 1 of Harris Health System Casa De Amigos, a subdivision according to the map or plat thereof, recorded Film Code No 706085 of the Map Records of Harris County, Texas (the "Easement Area").

Patrick Casey
SVP, Facilities Construction & Systems Engineering

Louis G. Smith, Jr.
Sr. EVP/Chief Operating Officer

SHORT FORM BLANKET EASEMENT

NOTICE OF CONFIDENTIALITY RIGHTS: IF YOU ARE A NATURAL PERSON, YOU MAY REMOVE OR STRIKE ANY OR ALL OF THE FOLLOWING INFORMATION FROM ANY INSTRUMENT THAT TRANSFERS AN INTEREST IN REAL PROPERTY BEFORE IT IS FILED FOR RECORD IN THE PUBLIC RECORDS: YOUR SOCIAL SECURITY NUMBER OR YOUR DRIVER'S LICENSE NUMBER.

STATE OF TEXAS }
KNOW ALL PERSONS BY THESE PRESENTS:
COUNTY OF HARRIS }

THAT, HARRIS COUNTY HOSPITAL DISTRICT, its successors and assigns, hereinafter referred to as Grantor, whether one or more, for and in consideration of the sum of ONE DOLLAR ($1.00) CASH to Grantor paid by CenterPoint Energy Houston Electric, LLC, its successors and assigns, hereinafter referred to as "Grantee", has **GRANTED, SOLD AND CONVEYED** and by these presents, does **GRANT, SELL AND CONVEY** unto said Grantee, all or in part, a perpetual **blanket** easement, hereinafter referred to as the "Easement", for electric distribution facilities and related communication facilities consisting of a variable number of wires and cables and all necessary and desirable equipment and appurtenances, including, but not limited to, towers or poles made of wood, metal or other materials, props and guys, hereinafter referred to as "Facilities", located on, over, under and across the following described lands owned by Grantor, ("Grantor's Property"), to wit:

> Being a portion of Harrington Street (closed) and containing 0.2654 acres, the location of which is shown on Exhibit "A", attached hereto and made a part hereof, situated between that called 1.4673 acre tract of land situated in the John Austin Survey, Abstract 1, as recorded in an Award of Commissioners to Harris County Hospital District under County Clerk's File 20090115725 in Harris County, Texas, **AND**, Restricted Reserve "A" in Block 1 of Harris Health System Casa De Amigos, a subdivision according to the map or plat thereof, recorded Film Code No 706085 of the Map Records of Harris County, Texas (the "Easement Area");

The Easement Area herein granted is a blanket easement and shall apply only insofar as the boundaries of Grantor's Property will permit. Grantee further reserves the right to extend services and drops within Grantor's Property and to adjacent land owners from said Facilities.

Grantor or its successors or assigns shall observe and exercise all notification laws as per the Underground Facility Damage Prevention and Safety Act, also known as "ONE CALL" & "CALL BEFORE YOU DIG" when working in or near the Easement Area.

To the extent that such laws and codes apply to Grantor, its successors and assigns, Grantor, its successors and assigns shall observe all safety codes and laws which apply to working along, within and or near the Easement Area and Facilities during construction activities and safe clearance from such Facilities, including the Occupational Safety and Health Administration ("O.S.H.A."), Chapter 752 of the Texas Health and Safety Code, the National Electric Code, and the National Electrical Safety Code.

If Grantor, its successors or assigns should, at any future date, request that the Easement herein granted be further defined, Grantee agrees, at Grantor's expense, to prepare a new, defined easement described by a sealed survey sketch. Defined easements shall be unobstructed and may be further described by, but not limited to, the following descriptions:

1.) A ten (10) foot wide easement (for above and below ground facilities);
2.) A ten (10) foot wide easement together with ten (10) foot aerial easement adjoining both sides of said ten (10) foot wide easement (for above ground and overhead facilities that are not located adjacent to property lines);

3.) A ten (10) foot wide easement together with an adjoining eleven (11) foot, six (6) inch wide aerial easement (for above ground and overhead perimeter facilities);
4.) A fourteen (14) foot wide easement together with an adjoining seven (7) foot, six (6) inch wide aerial easement (for above ground and overhead perimeter facilities);
5.) An easement sixteen (16) feet wide and twenty-four (24) feet long (for Grantee's pad-mounted transformer station purposes).

In the event that Grantor, its successors and assigns, desires that Grantee's Facilities be relocated, then Grantee agrees to relocate said Facilities provided that Grantor furnishes a suitable and feasible site or location for such relocation and, provided that Grantor, its successors and assigns, shall, if requested by Grantee, furnish to Grantee a suitable and acceptable easement covering the new location. Any and all costs associated with relocating said Facilities will be at Grantor's sole expense.

Grantee shall also have reasonable rights of ingress and egress to and from said Easement Area, together with reasonable working space, for the purposes of erecting, installing, operating, maintaining, replacing, inspecting, and removing said Facilities, together with the additional right to remove from said Easement Area, all bushes, trees and parts thereof, or other structures which, in the opinion of Grantee, endanger or may interfere with the efficient, safe and proper operation, and maintenance of said Facilities.

TO HAVE AND TO HOLD the above described Easement, together with all and singular the rights and appurtenances thereto in anywise belonging, unto Grantee forever, and Grantor does hereby bind itself and its successors, heirs, assigns, and legal representatives, to fully warrant and forever defend all and singular the above described Easement Area and rights unto said Grantee, against every person

whomsoever lawfully claiming or to claim the same or any part thereof, by, through or under Grantor, but not otherwise. In the event of a deficiency in title or actions taken by others which results in the relocation of Grantee's Facilities, the Grantor herein, its successors and assigns, will be responsible for all costs associated with the relocation and/or removal of Grantee's Facilities.

The terms, conditions and provisions contained herein constitute the complete and final agreement between Grantor and Grantee, (collectively the "Parties") with respect to the subject matter hereof and supersedes all prior agreements, representations and understandings of the Parties and, by Grantor's signature affixed hereto and Grantee's use of the Easement, the Parties evidence their agreement thereof. No oral or written agreements made or discussed prior to, or subsequent to, the execution of this Easement shall supersede those contained herein. Any and all revisions, amendments and/or exceptions to the terms, conditions and provisions contained in this Easement shall be in written, recordable form and executed by both parties, or their respective successors or assigns in order to be deemed valid.

EXECUTED this _____ day of _____, 2025.

HARRIS COUNTY HOSPITAL DISTRICT

BY: _____
Signature

_____
Name typed or printed

_____
Title

STATE OF TEXAS }

COUNTY OF HARRIS }

BEFORE ME, the undersigned authority, a Notary Public in and for the State of Texas, on this day personally appeared _____, _____ of _____, known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that (__)he executed the same for the purposes and consideration therein expressed, in the capacity therein stated, and as the act and deed of said corporation.

Given under my hand and seal of office this _____ day of _____, 2025

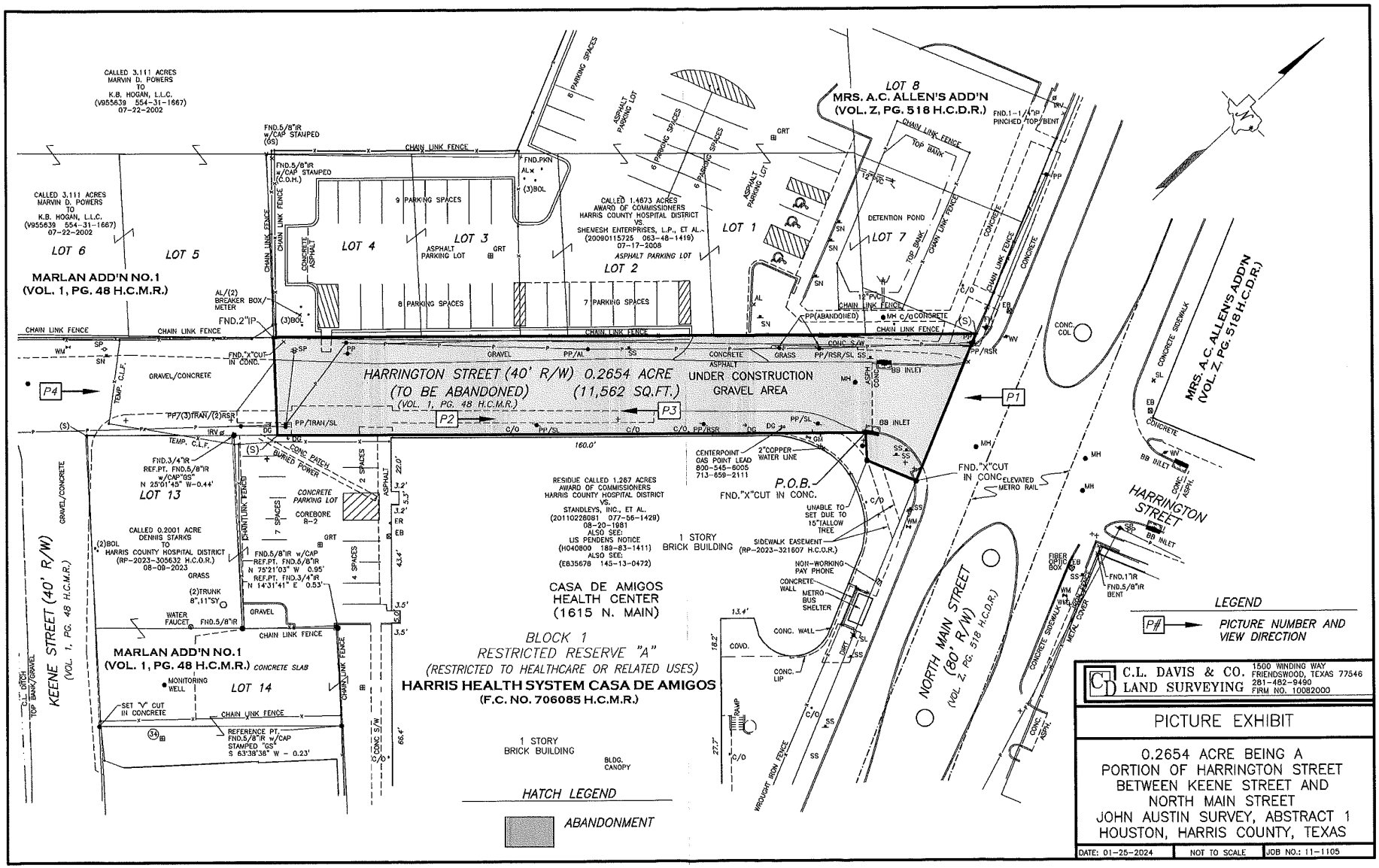
_____
Notary's Signature

_____
Name typed or printed

_____
Commission Expires

AFTER RECORDING RETURN TO:
SURVEYING & RIGHT OF WAY
CENTERPOINT ENERGY HOUSTON ELECTRIC, LLC
P. O. BOX 1700
HOUSTON, TX 77251-1700

Exhibit "A"



N:\11-Misc-11-1101-THRU-11-1150\11-1105-CASA DE AMIGOS\11-1105-BASE-2024.dwg

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Thursday, May 22, 2025

Consideration of Acceptance of the Harris Health April 2025 Financial Report Subject to Audit

---

Attached for your review and consideration is the April 2025 Financial Report.

Administration recommends that the Board accept the financial report for the period ended April 30, 2025, subject to final audit.

Victoria Nikitin
EVP – Chief Financial Officer

HARRISHEALTH

Financial Statements

As of April 30, 2025
Subject to Audit

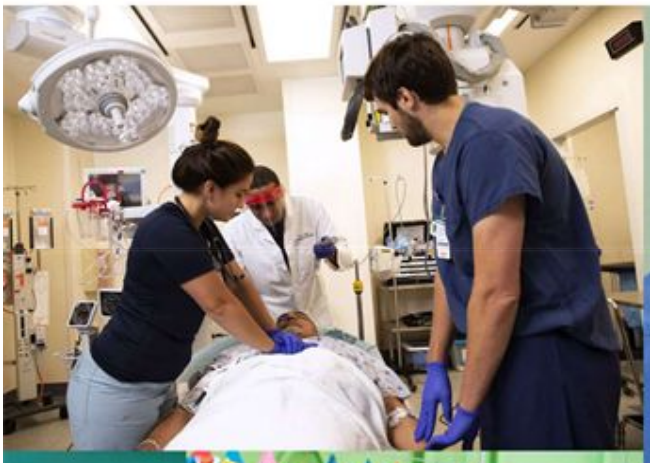


Table of Contents

HARRISHEALTH

Operating income for the month ended April 30, 2025 was $35.4 million compared to budgeted income of $25.2 million.

Total net revenue for the month ended April 30, 2025 of $245.2 million was $8.3 million or 3.5% more than budget. Net patient revenue was $10.9 million less than budget while ad valorem taxes were $0.8 more than budget. Medicaid Supplemental programs were $14.7 million more than expected primarily due to the late release of the overdue CHIRP funds by the State.

As of April 30, 2025, total expenses of $209.8 million were $1.9 million or 0.9% less than budget driven mostly by lower purchased services.

For the month ended April 30, 2025, total patient days and average daily census increased 2.9% compared to budget. Inpatient case mix index, a measure of patient acuity, and length of stay were 6.6% and 13.0% higher, respectively, than budget. Emergency room visits were 4.4% more than budget. Total clinic visits, including telehealth, were 8.2% higher compared to budget. Births were down 15.8%.

Total cash receipts for the month were $144.4 million. The System has $1,717.0 million in unrestricted cash, cash equivalents and investments, representing 260.1 days cash on hand. Harris Health has $138.6 million in net accounts receivable, representing 65.4 days of outstanding patient accounts receivable at April 30, 2025. The April balance sheet reflects a combined net receivable position of $144.0 million under the various Medicaid Supplemental programs. The current portion of ad valorem taxes receivable is $21.1 million, which is offset by ad valorem tax collections as received. Accounts payable and accrued liabilities include $439.9 million in deferred ad valorem tax revenues that are released as ad valorem tax revenue is recognized. As of April 30, 2025, $1,017.9 million in ad valorem tax collections were received and $86.8 million in current ad valorem tax revenue was recognized.

Income Statement

HARRISHEALTH

As of April 30, 2025 and 2024 (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	$ 52.3	$ 63.0	-16.9%	$ 449.6	$ 437.2	2.9%	$ 432.1	4.1%
Medicaid Supplemental Programs	68.9	53.9	27.7%	403.7	377.5	6.9%	380.3	6.1%
Other Operating Revenue	12.2	12.3	-1.6%	87.0	84.6	2.8%	76.3	14.0%
Total Operating Revenue	**$ 133.3**	**$ 129.3**	**3.2%**	**$ 940.3**	**$ 899.3**	**4.6%**	**$ 888.7**	**5.8%**
Net Ad Valorem Taxes	85.8	85.1	0.9%	598.3	595.5	0.5%	528.8	13.1%
Net Tobacco Settlement Revenue	19.0	15.2	24.7%	19.0	15.2	24.7%	15.2	24.8%
Capital Gifts & Grants	-	0.8	0.0%	2.0	5.8	-65.7%	-	0.0%
Interest Income & Other	7.0	6.5	8.2%	36.9	45.3	-18.4%	43.6	-15.2%
Total Nonoperating Revenue	**$ 111.8**	**$ 107.6**	**3.9%**	**$ 656.2**	**$ 661.8**	**-0.8%**	**$ 587.6**	**11.7%**
Total Net Revenue	**$ 245.2**	**$ 236.9**	**3.5%**	**$ 1,596.5**	**$ 1,561.1**	**2.3%**	**$ 1,476.3**	**8.1%**
EXPENSE								
Salaries and Wages	$ 80.4	$ 82.6	2.7%	$ 569.3	$ 584.9	2.7%	$ 550.5	-3.4%
Employee Benefits	29.0	27.7	-4.9%	186.5	193.6	3.7%	185.2	-0.7%
Total Labor Cost	**$ 109.4**	**$ 110.3**	**0.8%**	**$ 755.9**	**$ 778.5**	**2.9%**	**$ 735.7**	**-2.7%**
Supply Expenses	27.8	28.9	3.7%	186.8	204.0	8.4%	171.2	-9.2%
Physician Services	38.4	38.7	0.8%	268.5	271.2	1.0%	253.8	-5.8%
Purchased Services	25.4	26.7	4.6%	176.2	195.4	9.8%	155.3	-13.4%
Depreciation & Interest	8.7	7.1	-22.3%	61.3	51.3	-19.5%	58.6	-4.6%
Total Operating Expense	**$ 209.8**	**$ 211.6**	**0.9%**	**$ 1,448.8**	**$ 1,500.4**	**3.4%**	**$ 1,374.6**	**-5.4%**
Operating Income (Loss)	**$ 35.4**	**$ 25.2**		**$ 147.8**	**$ 60.7**		**$ 101.7**	
Total Margin %	**14.4%**	**10.6%**		**9.3%**	**3.9%**		**6.9%**	

Balance Sheet

HARRISHEALTH

April 2025 and 2024 (in $ Millions)

	CURRENT YEAR	PRIOR YEAR
CURRENT ASSETS		
Cash, Cash Equivalents and Short Term Investments	$ 1,717.1	$ 1,692.8
Net Patient Accounts Receivable	138.6	177.2
Net Ad Valorem Taxes, Current Portion	21.1	25.6
Other Current Assets	243.1	221.0
Total Current Assets	**$ 2,119.9**	**$ 2,116.6**
CAPITAL ASSETS		
Plant, Property, & Equipment, Net of Accumulated Depreciation	$ 574.8	$ 552.9
Construction in Progress	370.1	150.8
Right of Use Assets	35.6	39.5
Total Capital Assets	**$ 980.5**	**$ 743.2**
ASSETS LIMITED AS TO USE & RESTRICTED ASSETS		
Debt Service & Capital Asset Funds	$ 37.7	$ 38.7
LPPF Restricted Cash	53.3	51.3
Capital Gift Proceeds	55.1	55.1
Other - Restricted	1.1	1.0
Total Assets Limited As to Use & Restricted Assets	**$ 147.2**	**$ 146.1**
Other Assets	42.6	45.5
Deferred Outflows of Resources	182.3	223.3
Total Assets & Deferred Outflows of Resources	**$ 3,472.6**	**$ 3,274.6**
CURRENT LIABILITIES		
Accounts Payable and Accrued Liabilities	$ 251.0	$ 212.2
Employee Compensation & Related Liabilities	151.4	134.7
Deferred Revenue - Ad Valorem	439.9	378.8
Estimated Third-Party Payor Settlements	31.3	30.5
Current Portion Long-Term Debt and Capital Leases	36.8	37.2
Total Current Liabilities	**$ 910.3**	**$ 793.4**
Long-Term Debt	264.1	282.1
Net Pension & Post Employment Benefits Liability	679.2	762.1
Other Long-Term Liabilities	7.9	6.8
Deferred Inflows of Resources	110.4	115.1
Total Liabilities	**$ 1,971.9**	**$ 1,959.5**
Total Net Assets	**$ 1,500.7**	**$ 1,315.1**
Total Liabilities & Net Assets	**$ 3,472.6**	**$ 3,274.6**

Cash Flow Summary

HARRISHEALTH

As of April 30, 2025 and 2024 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE	
	CURRENT YEAR	PRIOR YEAR	CURRENT YEAR	PRIOR YEAR
CASH RECEIPTS				
Collections on Patient Accounts	$ 66.6	$ 73.4	$ 490.6	$ 469.3
Medicaid Supplemental Programs	10.4	30.2	261.6	633.6
Net Ad Valorem Taxes	10.0	6.8	1,017.9	873.0
Tobacco Settlement	-	15.2	-	15.2
Other Revenue	57.4	41.6	107.8	168.6
Total Cash Receipts	**$ 144.4**	**$ 167.2**	**$ 1,877.9**	**$ 2,159.7**
CASH DISBURSEMENTS				
Salaries, Wages and Benefits	$ 116.4	$ 118.3	$ 776.5	$ 788.4
Supplies	27.4	25.0	206.5	182.8
Physician Services	37.9	36.1	254.1	244.2
Purchased Services	17.2	23.2	172.7	158.3
Capital Expenditures	11.9	8.2	217.6	88.8
Debt and Interest Payments	0.3	0.3	19.7	6.2
Other Uses	(19.8)	2.6	(22.8)	10.8
Total Cash Disbursements	**$ 191.2**	**$ 213.7**	**$ 1,624.3**	**$ 1,479.5**
Net Change	**$ (46.8)**	**$ (46.5)**	**$ 253.7**	**$ 680.2**

Unrestricted cash, cash equivalents and investments - Beginning of year	$ 1,463.4
Net Change	$ 253.7
Untrestricted cash, cash equivalents and investments - End of period	**$ 1,717.1**

Performance Ratios

HARRISHEALTH

As of April 30, 2025 and 2024 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE		
	CURRENT YEAR	CURRENT BUDGET	CURRENT YEAR	CURRENT BUDGET	PRIOR YEAR
OPERATING HEALTH INDICATORS					
Operating Margin %	14.4%	10.6%	9.3%	3.9%	6.9%
Run Rate per Day (In$ Millions)	$ 6.7	$ 6.8	$ 6.6	$ 6.9	$ 6.2
Salary, Wages & Benefit per APD	$ 2,429	$ 2,539	$ 2,419	$ 2,539	$ 2,410
Supply Cost per APD	$ 617	$ 665	$ 598	$ 665	$ 561
Physician Services per APD	$ 853	$ 892	$ 859	$ 884	$ 831
Total Expense per APD	**$ 4,656**	**$ 4,874**	**$ 4,636**	**$ 4,893**	**$ 4,502**
Overtime as a % of Total Salaries	3.0%	3.0%	3.5%	3.0%	3.3%
Contract as a % of Total Salaries	2.6%	2.8%	3.2%	2.8%	4.4%
Full-time Equivalent Employees	10,361	10,291	10,448	10,590	10,337
FINANCIAL HEALTH INDICATORS					
Quick Ratio			2.3		2.6
Unrestricted Cash (In $ Millions)			$ 1,717.1	$ 1,715.1	$ 1,692.8
Days Cash on Hand			260.1	250.2	271.4
Days Revenue in Accounts Receivable			65.4	74.9	87.3
Days in Accounts Payable			45.7		45.6
Capital Expenditures/Depreciation & Amortization			391.2%		178.5%
Average Age of Plant(years)			9.9		10.5

Harris Health Key Indicators

Statistical Highlights

HARRISHEALTH

As of April 30, 2025 and 2024

	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	45,046	43,298	4.0%	312,473	307,213	1.7%	305,308	2.3%
Outpatient % of Adjusted Volume	64.9%	63.4%	2.5%	63.3%	62.3%	1.5%	62.6%	1.1%
Primary Care Clinic Visits	48,872	45,427	7.6%	319,591	315,678	1.2%	311,411	2.6%
Specialty Clinic Visits	22,438	21,111	6.3%	146,011	142,362	2.6%	142,869	2.2%
Telehealth Clinic Visits	11,237	9,753	15.2%	71,898	69,090	4.1%	67,902	5.9%
Total Clinic Visits	**82,547**	**76,291**	**8.2%**	**537,500**	**527,130**	**2.0%**	**522,182**	**2.9%**
Emergency Room Visits - Outpatient	12,077	11,363	6.3%	82,209	80,730	1.8%	81,320	1.1%
Emergency Room Visits - Admitted	1,668	1,804	-7.5%	12,085	12,924	-6.5%	12,677	-4.7%
Total Emergency Room Visits	**13,745**	**13,167**	**4.4%**	**94,294**	**93,654**	**0.7%**	**93,997**	**0.3%**
Surgery Cases - Outpatient	1,208	908	33.0%	7,149	6,680	7.0%	6,676	7.1%
Surgery Cases - Inpatient	896	775	15.6%	6,200	5,857	5.9%	5,669	9.4%
Total Surgery Cases	**2,104**	**1,683**	**25.0%**	**13,349**	**12,537**	**6.5%**	**12,345**	**8.1%**
Total Outpatient Visits	**137,525**	**124,847**	**10.2%**	**903,198**	**868,745**	**4.0%**	**855,692**	**5.6%**
Inpatient Cases (Discharges)	2,341	2,657	-11.9%	17,364	18,862	-7.9%	17,919	-3.1%
Outpatient Observation Cases	1,156	984	17.5%	7,264	6,417	13.2%	6,758	7.5%
Total Cases Occupying Patient Beds	**3,497**	**3,641**	**-4.0%**	**24,628**	**25,279**	**-2.6%**	**24,677**	**-0.2%**
Births	362	430	-15.8%	3,133	3,174	-1.3%	2,960	5.8%
Inpatient Days	15,803	15,866	-0.4%	114,827	115,762	-0.8%	114,223	0.5%
Outpatient Observation Days	3,603	2,996	20.3%	25,461	20,710	22.9%	23,030	10.6%
Total Patient Days	**19,406**	**18,862**	**2.9%**	**140,288**	**136,472**	**2.8%**	**137,253**	**2.2%**
Average Daily Census	646.9	628.7	2.9%	661.7	643.7	2.8%	644.4	2.7%
Average Operating Beds	702	700	0.3%	702	700	0.3%	699	0.4%
Bed Occupancy %	92.1%	89.8%	2.5%	94.3%	92.0%	2.5%	92.2%	2.3%
Inpatient Average Length of Stay	6.75	5.97	13.0%	6.61	6.14	7.7%	6.37	3.7%
Inpatient Case Mix Index (CMI)	1.826	1.712	6.6%	1.731	1.712	1.1%	1.705	1.5%
Payor Mix (% of Charges)								
Charity & Self Pay	43.5%	43.4%	0.3%	41.8%	43.4%	-3.6%	43.9%	-4.7%
Medicaid & Medicaid Managed	20.1%	19.4%	3.7%	19.7%	19.4%	1.5%	19.4%	1.4%
Medicare & Medicare Managed	11.8%	11.4%	3.0%	11.4%	11.4%	-0.7%	11.8%	-3.3%
Commercial & Other	24.6%	25.8%	-4.5%	27.1%	25.8%	5.2%	25.0%	8.7%
Total Unduplicated Patients - Rolling 12				**245,260**			**248,228**	**-1.2%**
Total New Patient - Rolling 12				**88,417**			**89,635**	**-1.4%**

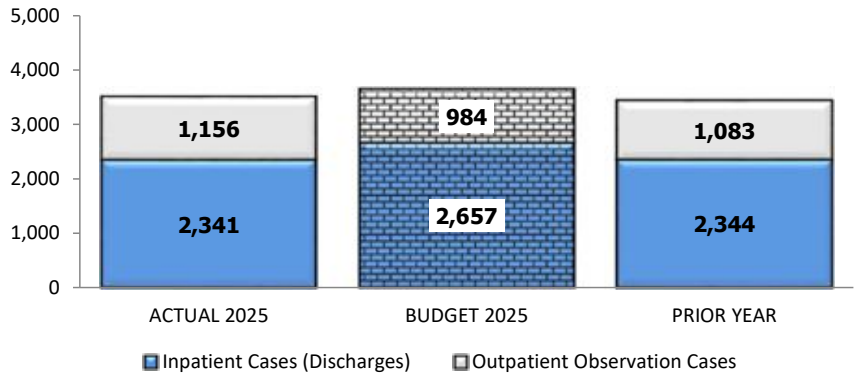
Harris Health

Statistical Highlights

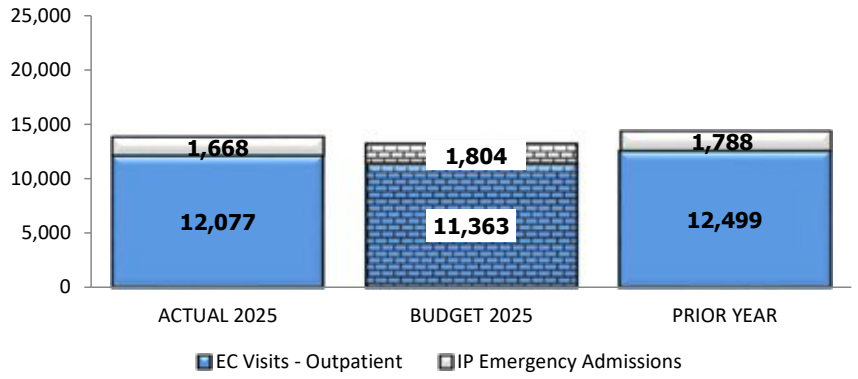
April FY 2025

Cases Occupying Beds - CM			Cases Occupying Beds - YTD			Emergency Visits - CM			Emergency Visits - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
3,497	3,641	3,427	24,628	25,279	24,677	13,745	13,167	14,287	94,294	93,654	93,997

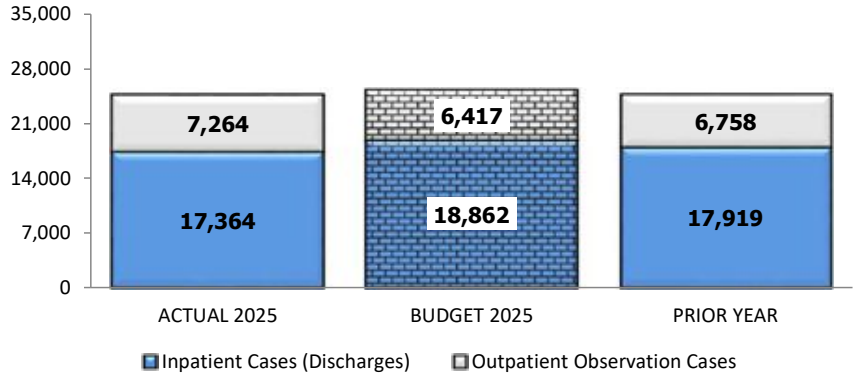
Cases Occupying Beds - Current Month



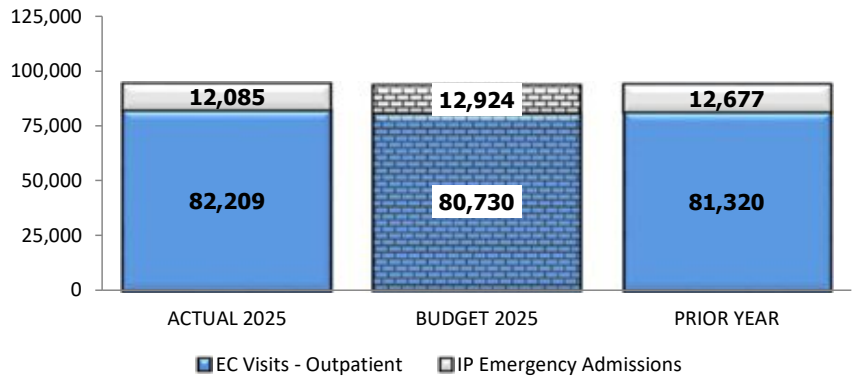
Emergency Visits - Current Month



Cases Occupying Beds - YTD



Emergency Visits - YTD



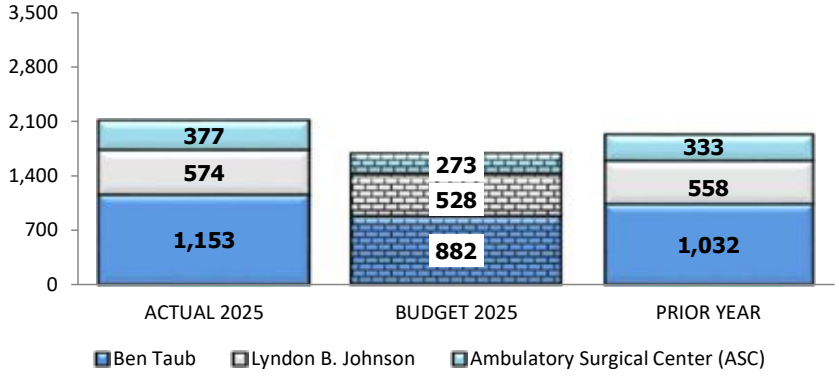
Harris Health

Statistical Highlights

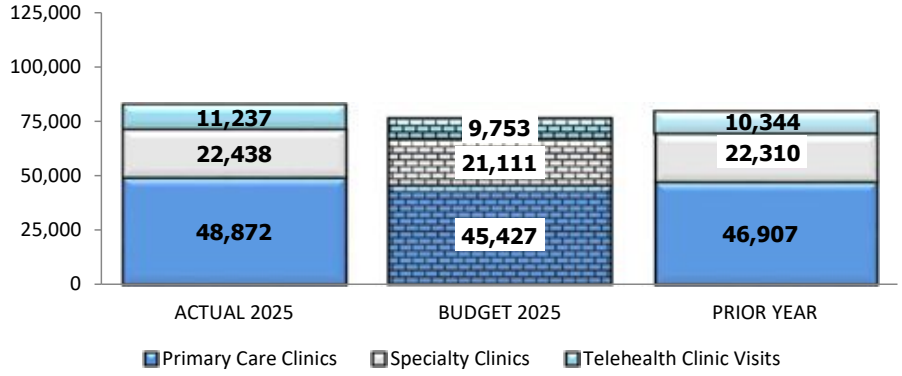
April FY 2025

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
2,104	1,683	1,923	13,349	12,537	12,345	82,547	76,291	79,561	537,500	527,130	522,182

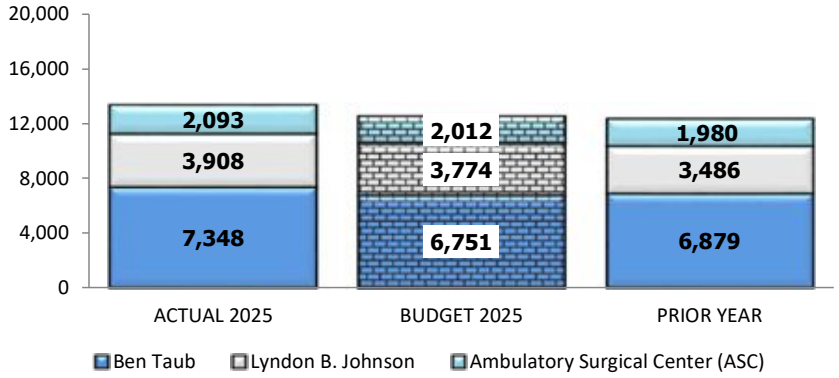
Surgery Cases - Current Month



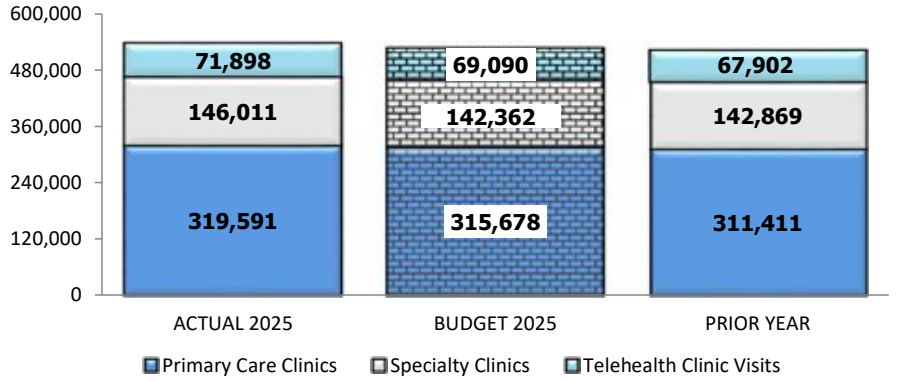
Clinic Visits - Current Month



Surgery Cases - YTD



Clinic Visits - YTD



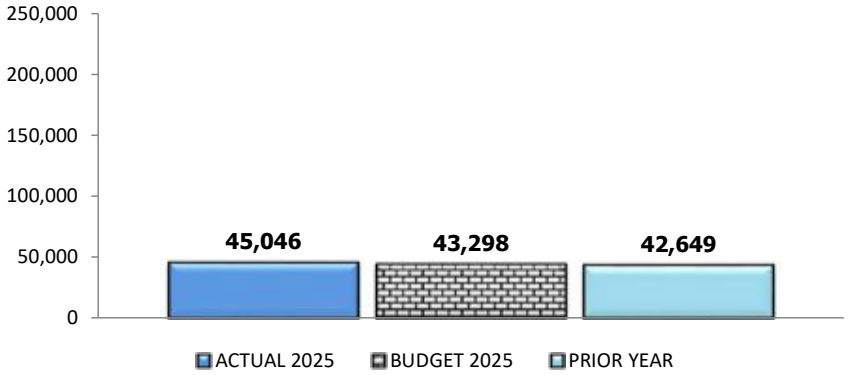
Harris Health

Statistical Highlights

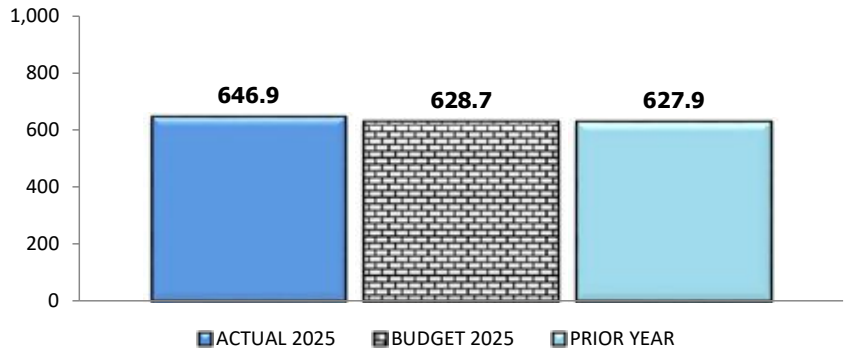
April FY 2025

Adjusted Patient Days - CM	Adjusted Patient Days - YTD	Average Daily Census - CM	Average Daily Census - YTD
45,046	312,473	646.9	661.7

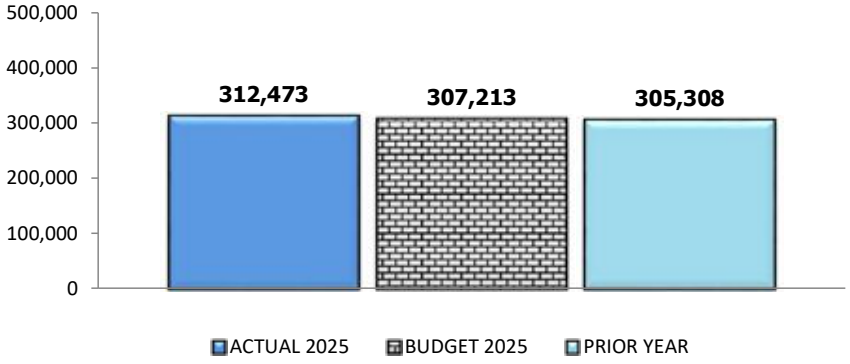
Adjusted Patient Days - Current Month



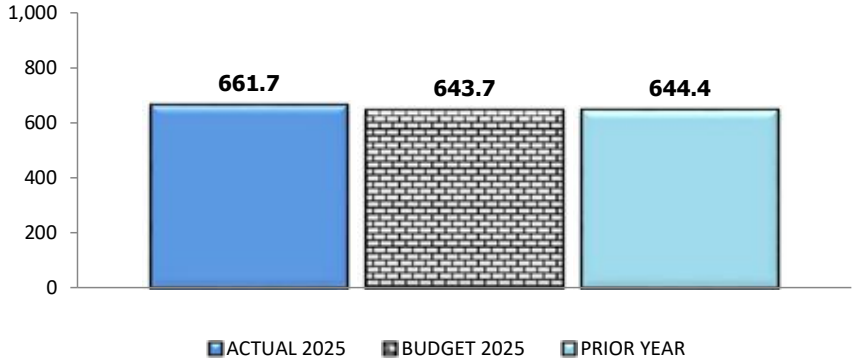
Average Daily Census - Current Month



Adjusted Patient Days - YTD



Average Daily Census - YTD



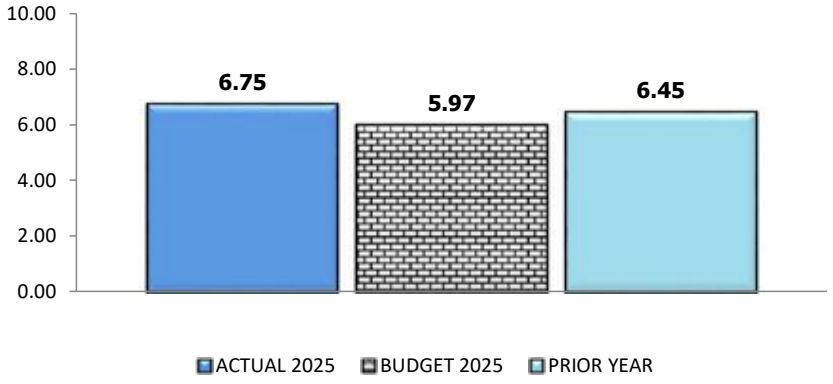
Harris Health

Statistical Highlights

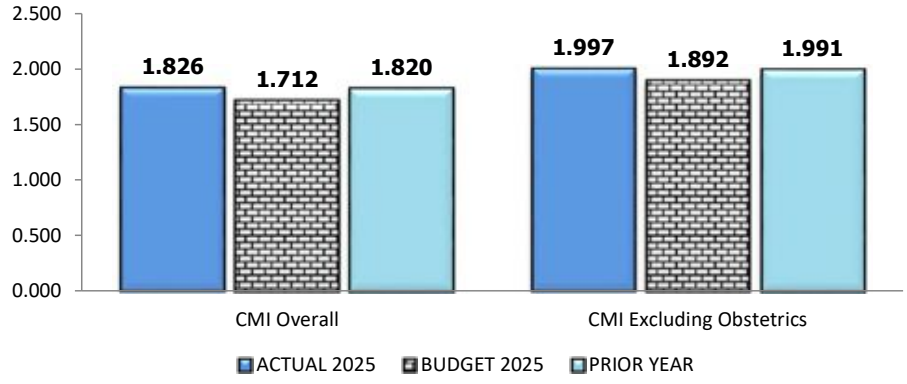
April FY 2025

Inpatient ALOS - CM	Inpatient ALOS - YTD	Case Mix Index (CMI) - CM		Case Mix Index (CMI) - YTD	
		Overall	Excl. Obstetrics	Overall	Excl. Obstetrics
6.75	6.61	1.826	1.997	1.731	1.921

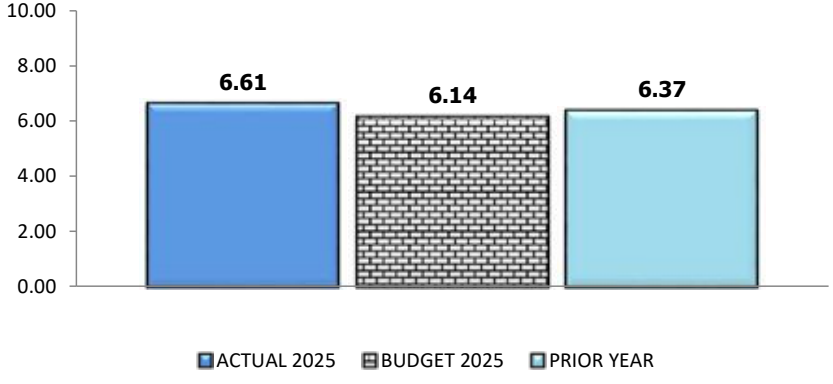
Inpatient ALOS - Current Month



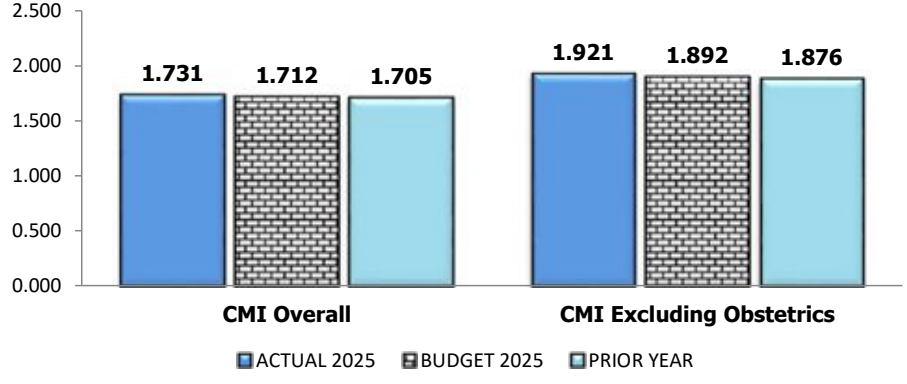
Case Mix Index - Current Month



Inpatient ALOS - YTD



Case Mix Index - YTD



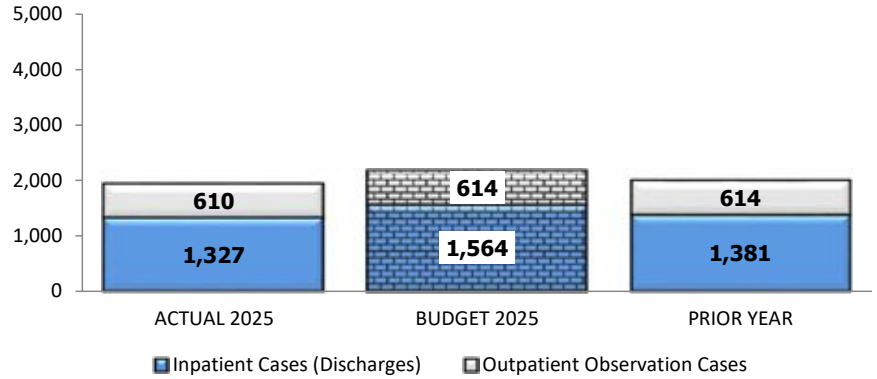
Harris Health

Statistical Highlights - Cases Occupying Beds

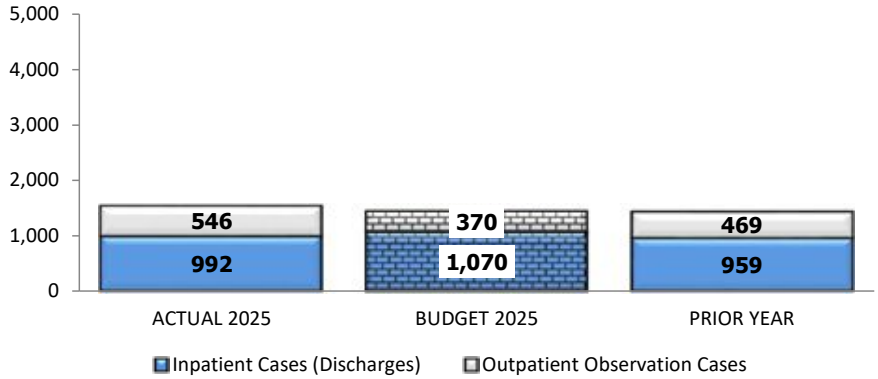
April FY 2025

BT Cases Occupying Beds - CM			BT Cases Occupying Beds - YTD			LBJ Cases Occupying Beds - CM			LBJ Cases Occupying Beds - YTD		
Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year	Actual	Budget	Prior Year
1,937	2,178	1,995	14,233	15,164	14,622	1,538	1,440	1,428	10,284	9,998	10,047

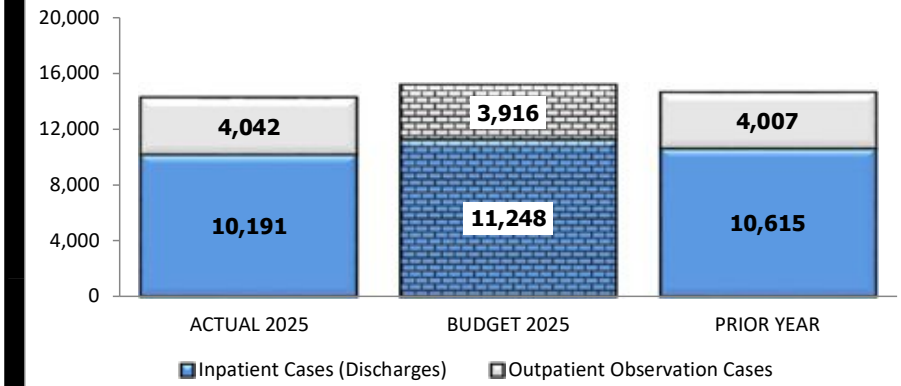
Ben Taub Cases - Current Month



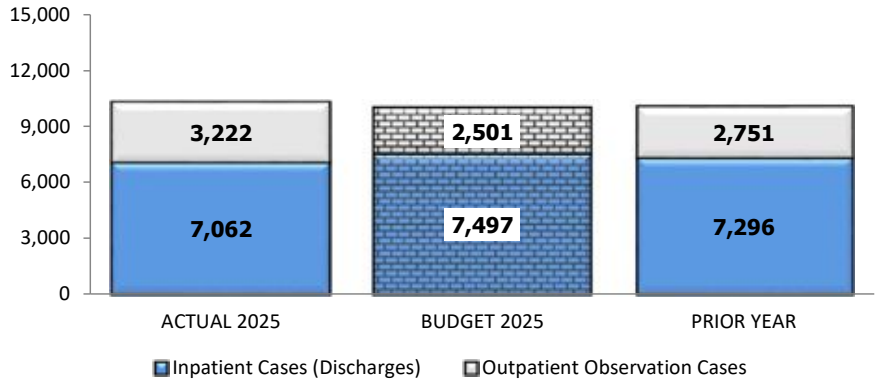
Lyndon B. Johnson Cases - Current Month



Ben Taub Cases - YTD



Lyndon B. Johnson Cases - YTD

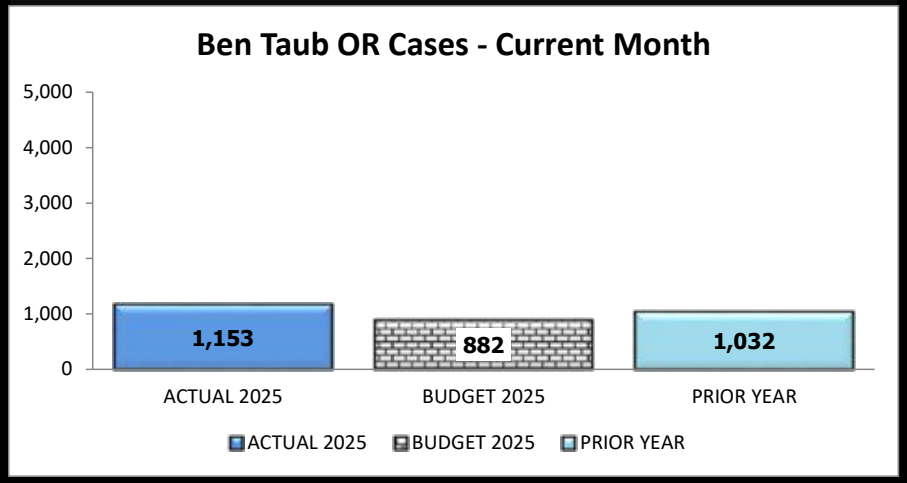


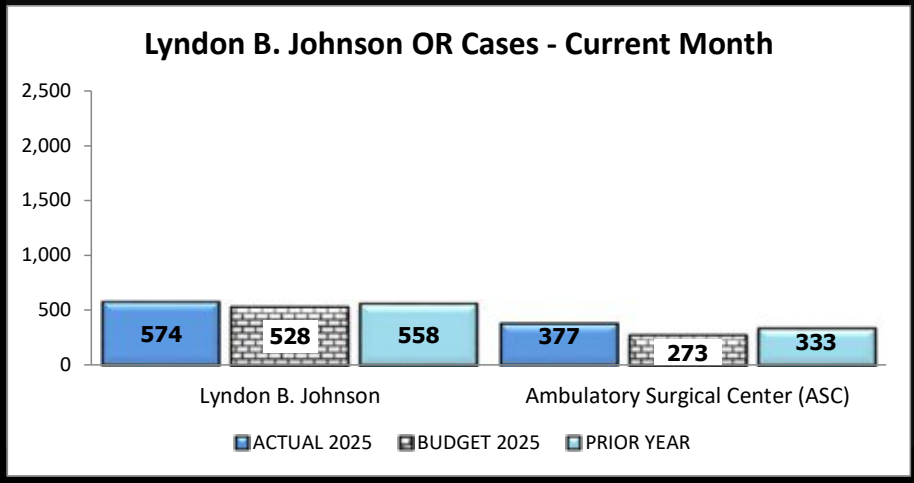
Harris Health

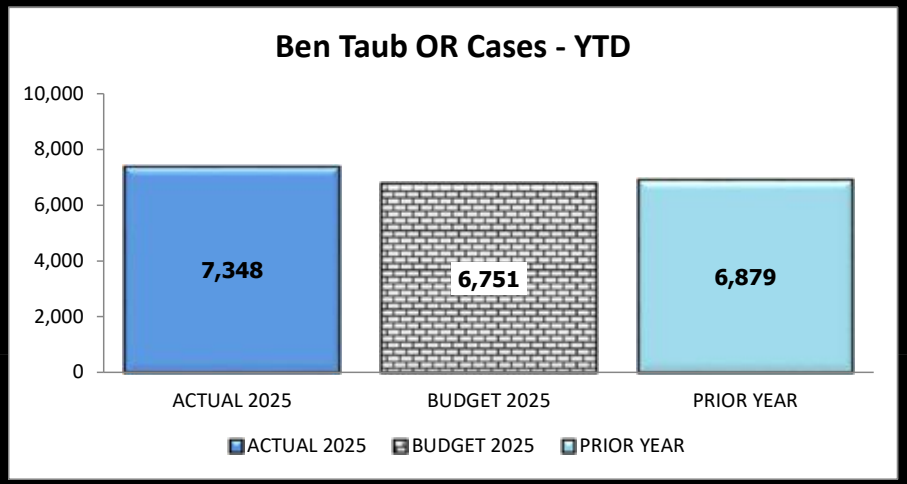
Statistical Highlights - Surgery Cases

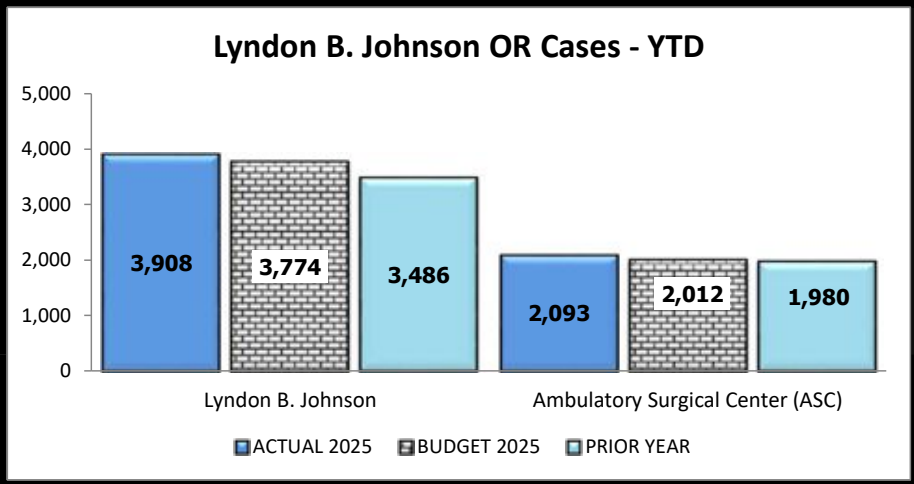
April FY 2025

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
1,153	882	1,032	7,348	6,751	6,879	951	801	891	6,001	5,786	5,466







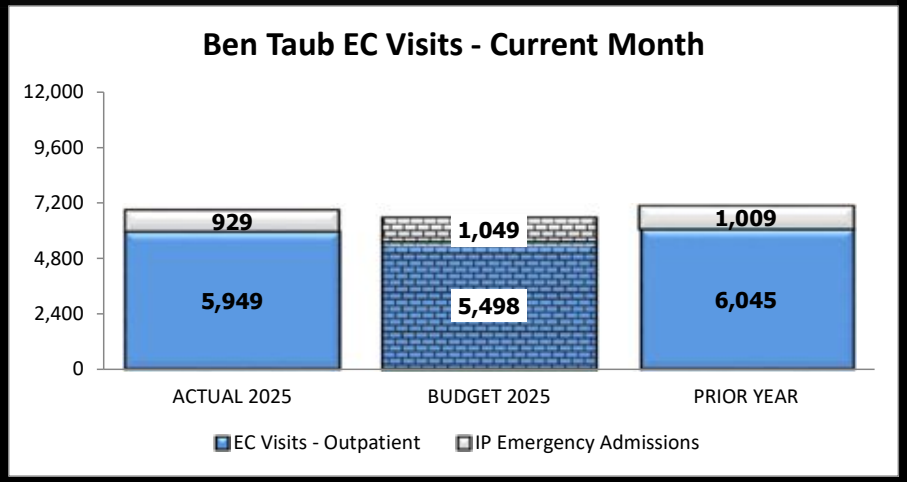


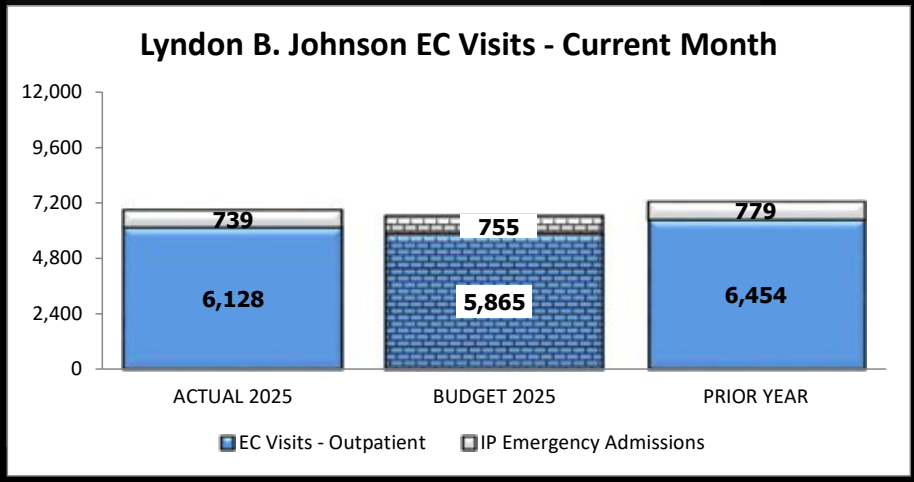
Harris Health

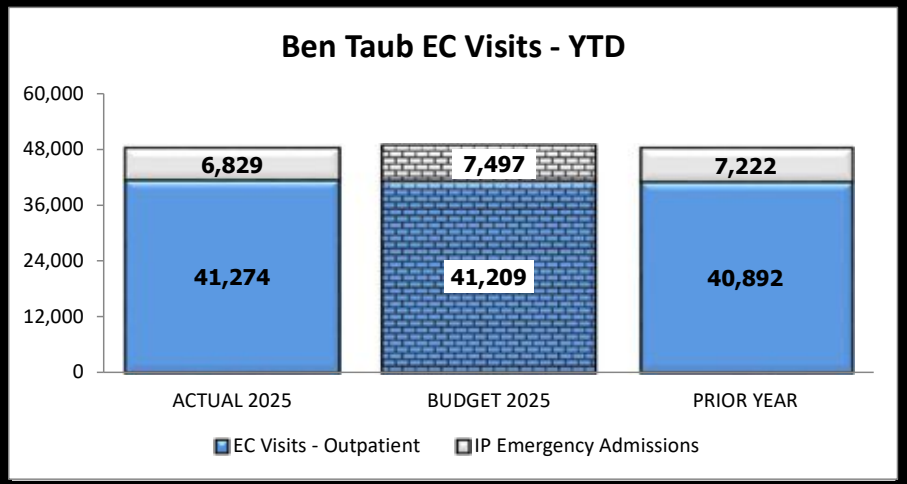
Statistical Highlights - Emergency Room Visits

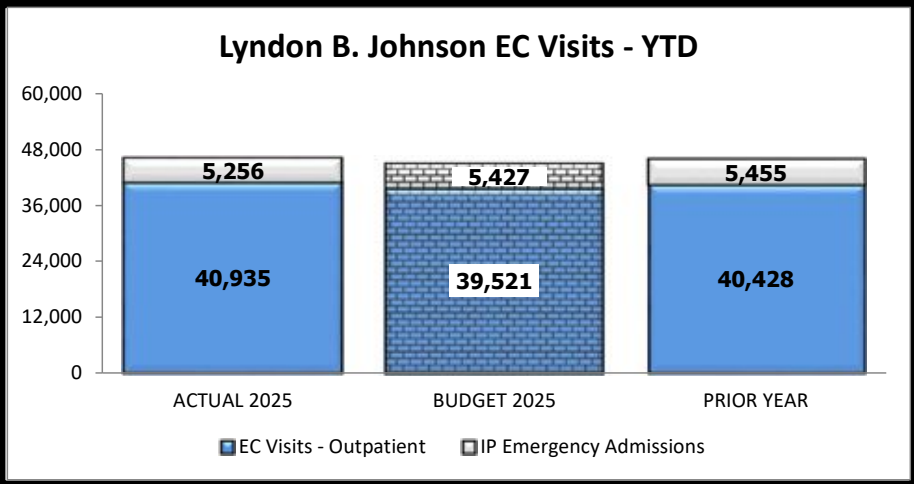
April FY 2025

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
6,878	6,547	7,054	48,103	48,706	48,114	6,867	6,620	7,233	46,191	44,948	45,883







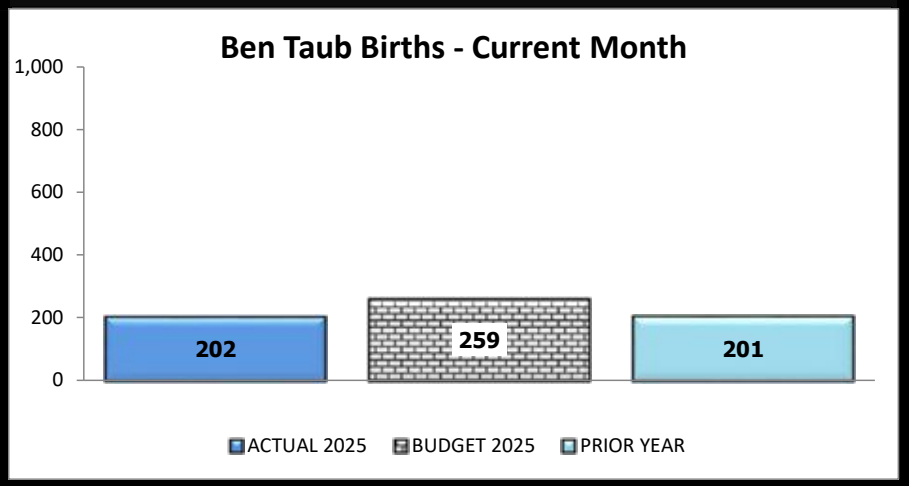


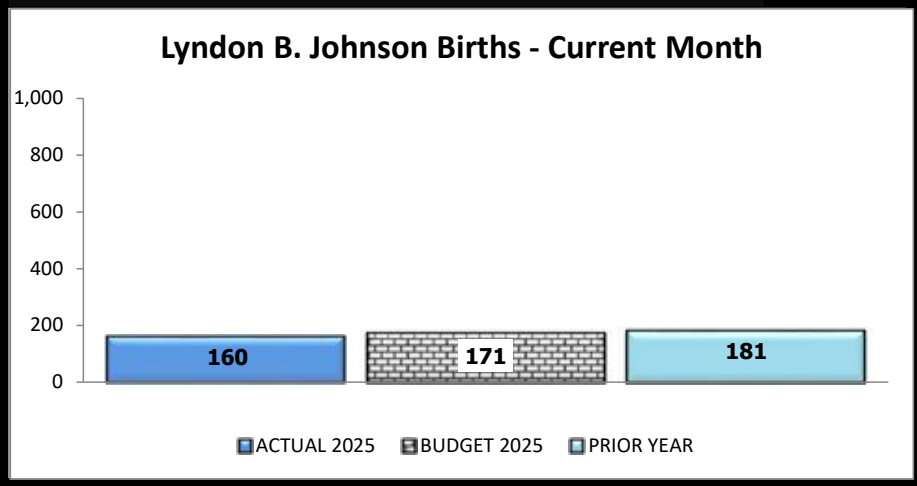
Harris Health

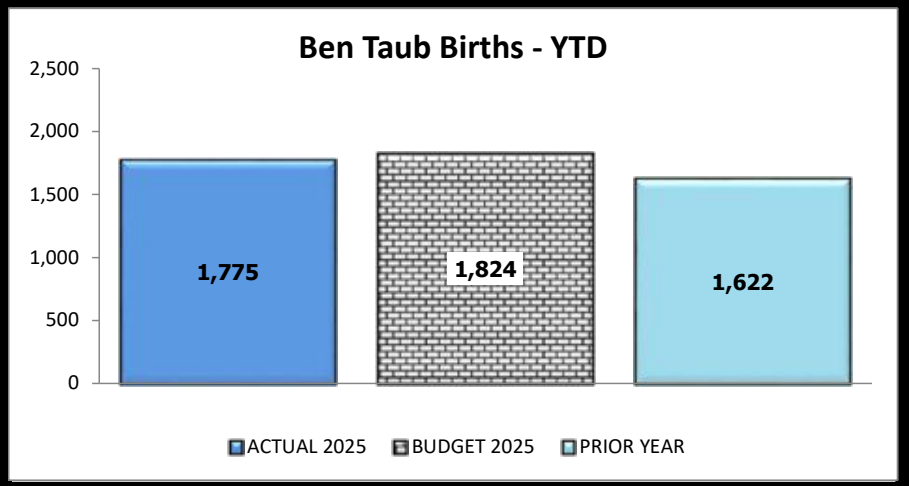
Statistical Highlights - Births

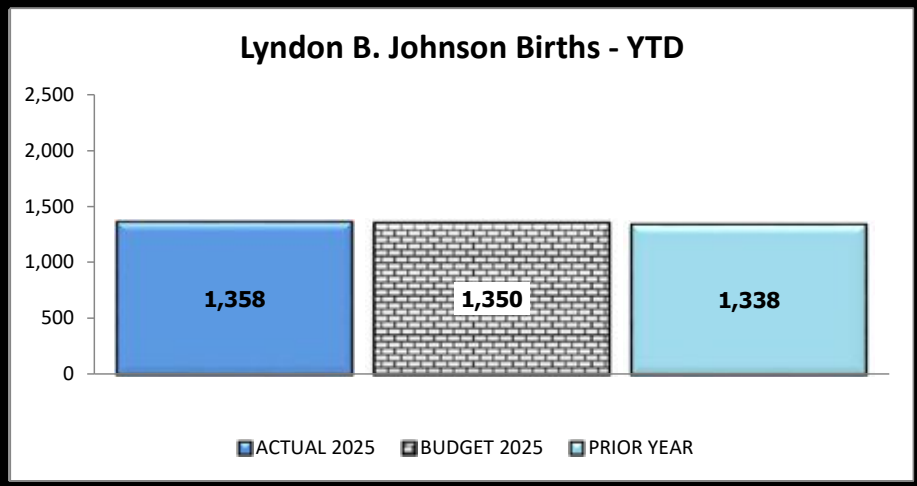
April FY 2025

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
202	259	201	1,775	1,824	1,622	160	171	181	1,358	1,350	1,338







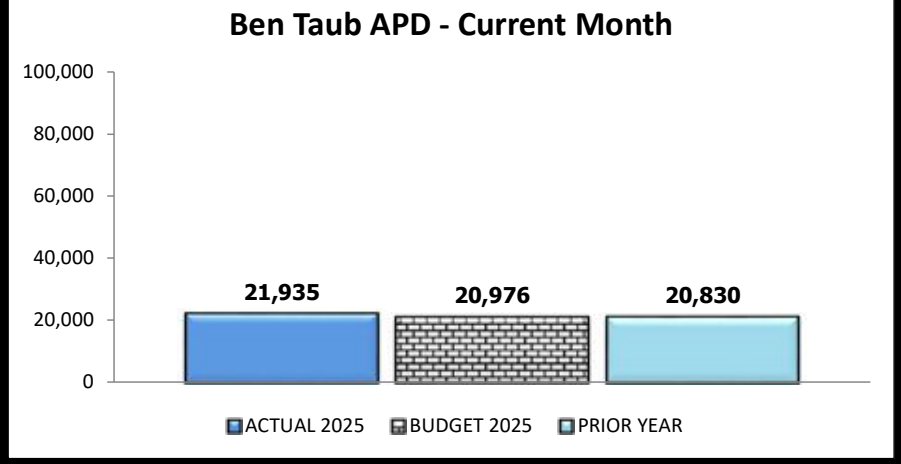


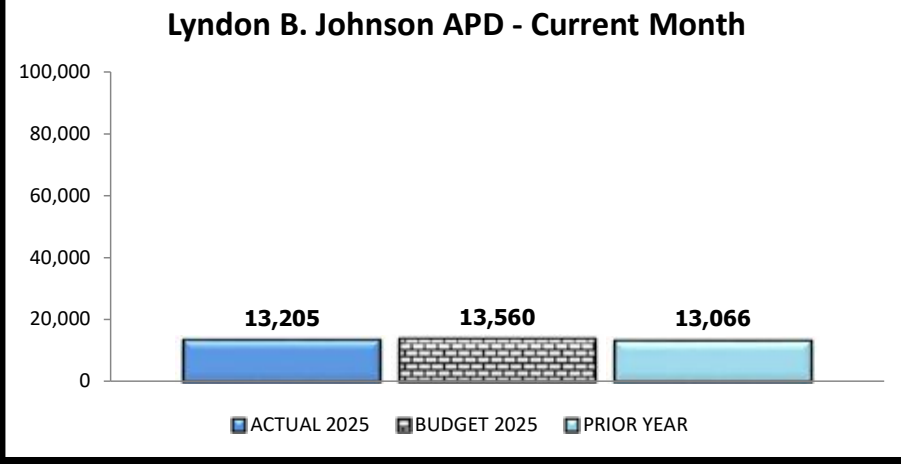
Harris Health

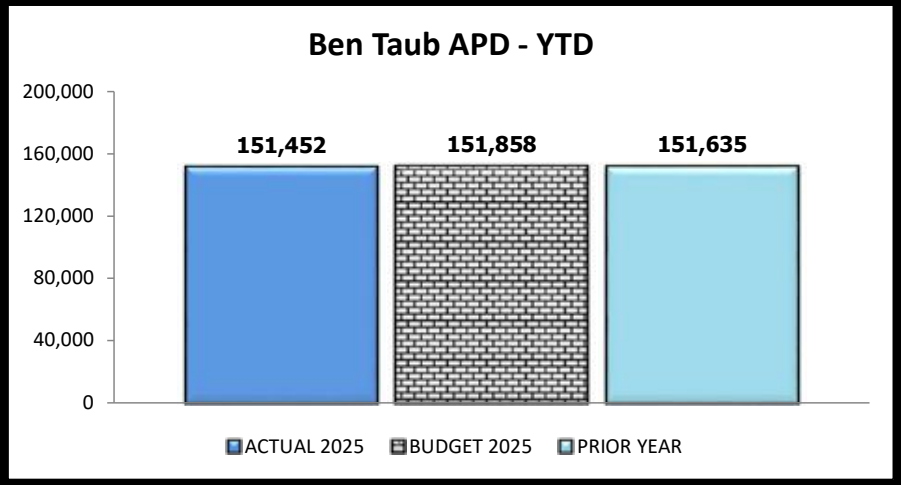
Statistical Highlights - Adjusted Patient Days

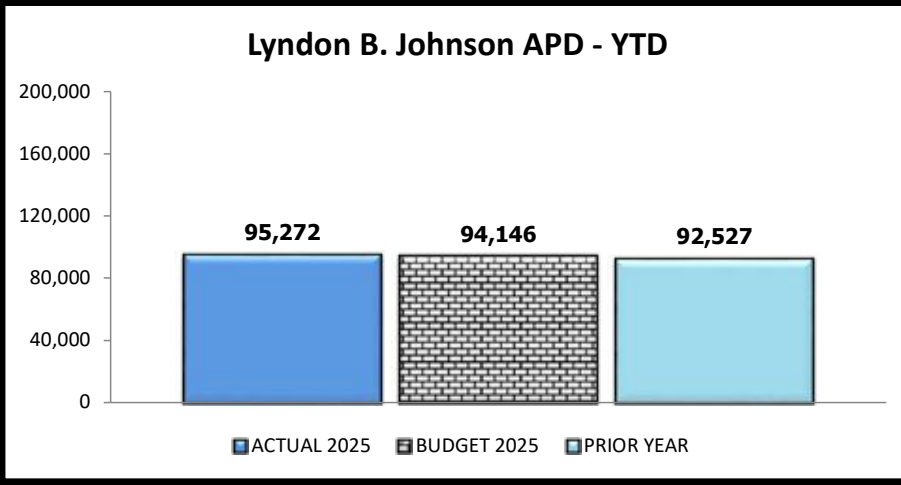
April FY 2025

BT Adjusted Patient Days - CM	BT Adjusted Patient Days - YTD	LBJ Adjusted Patient Days - CM	LBJ Adjusted Patient Days - YTD
21,935	151,452	13,205	95,272









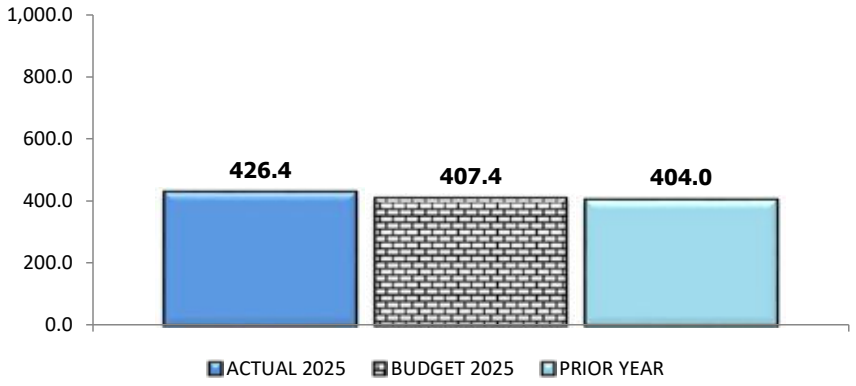
Harris Health

Statistical Highlights - Average Daily Census (ADC)

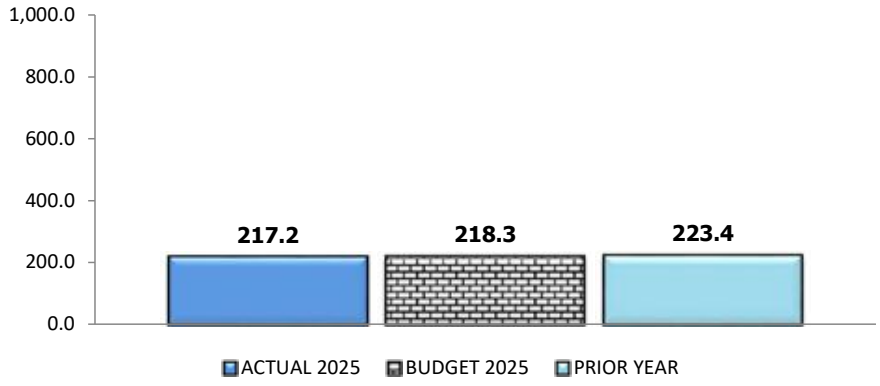
April FY 2025

BT Average Daily Census - CM	BT Average Daily Census - YTD	LBJ Average Daily Census - CM	LBJ Average Daily Census - YTD
426.4	430.2	217.2	229.7

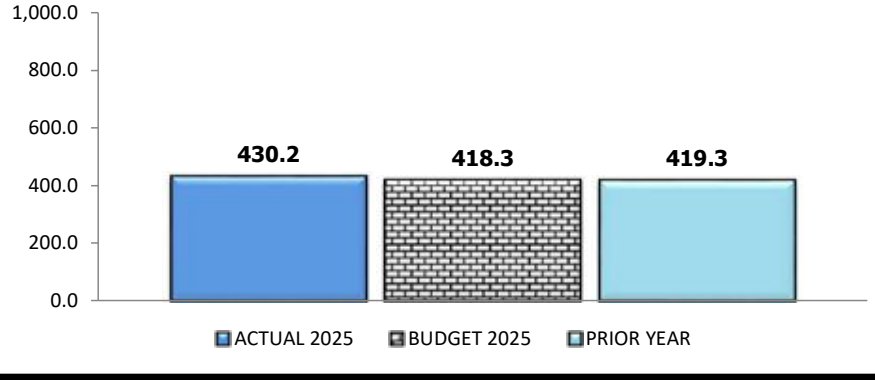
Ben Taub ADC - Current Month



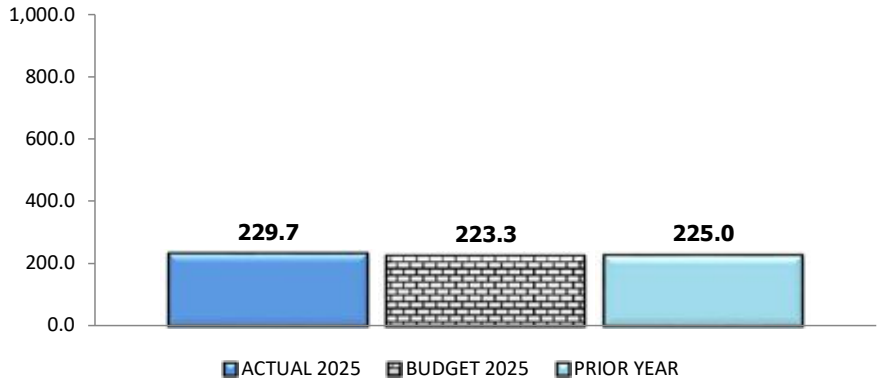
Lyndon B. Johnson ADC - Current Month



Ben Taub ADC - YTD



Lyndon B. Johnson ADC - YTD



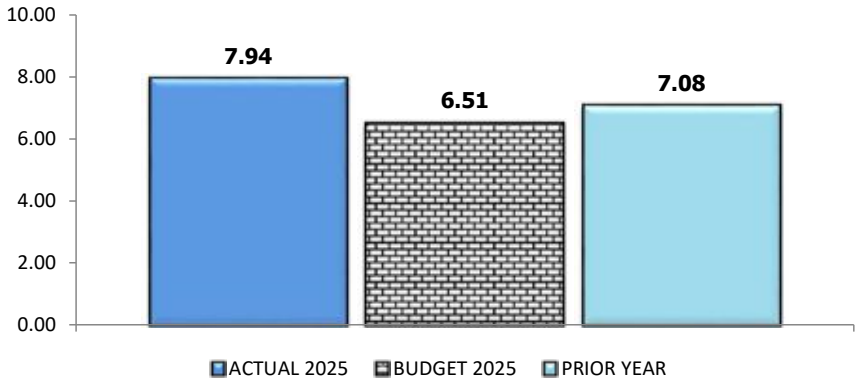
Harris Health

Statistical Highlights - Inpatient Average Length of Stay (ALOS)

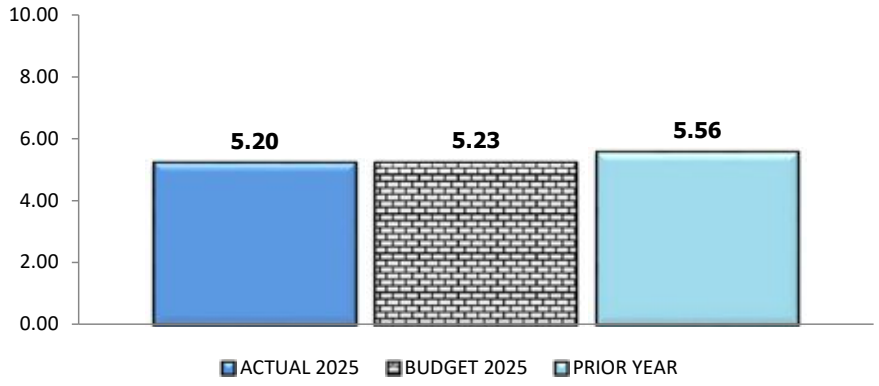
April FY 2025

BT Inpatient ALOS - CM	BT Inpatient ALOS - YTD	LBJ Inpatient ALOS - CM	LBJ Inpatient ALOS - YTD
7.94	7.36	5.20	5.58

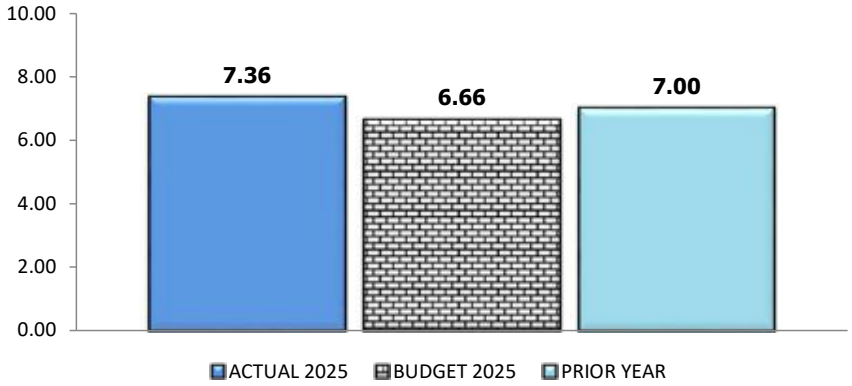
Ben Taub ALOS - Current Month



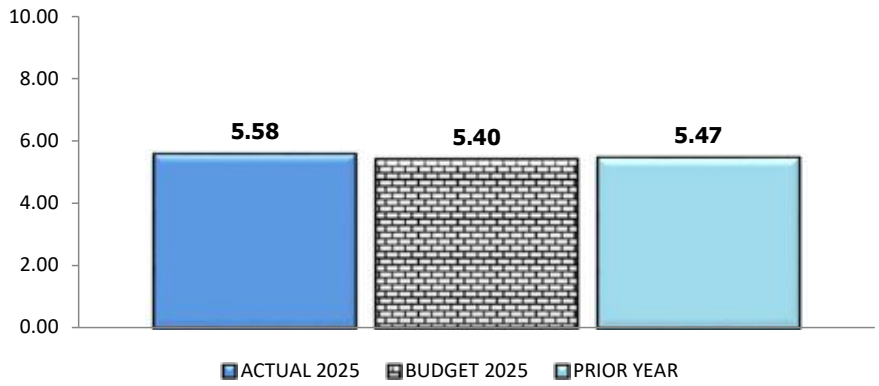
Lyndon B. Johnson ALOS - Current Month



Ben Taub ALOS - YTD



Lyndon B. Johnson ALOS - YTD



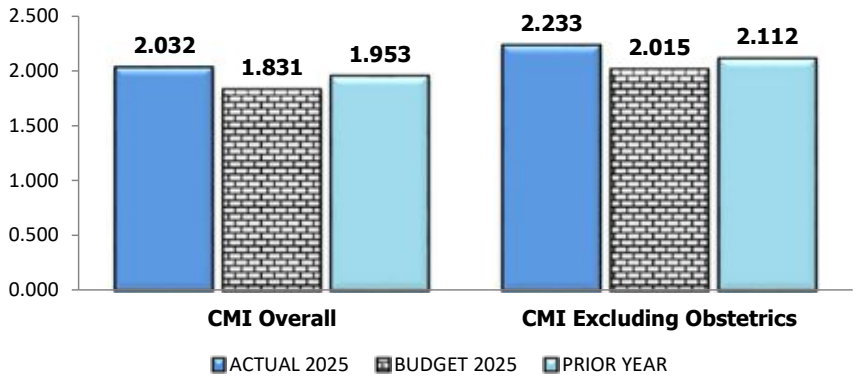
Harris Health

Statistical Highlights - Case Mix Index (CMI)

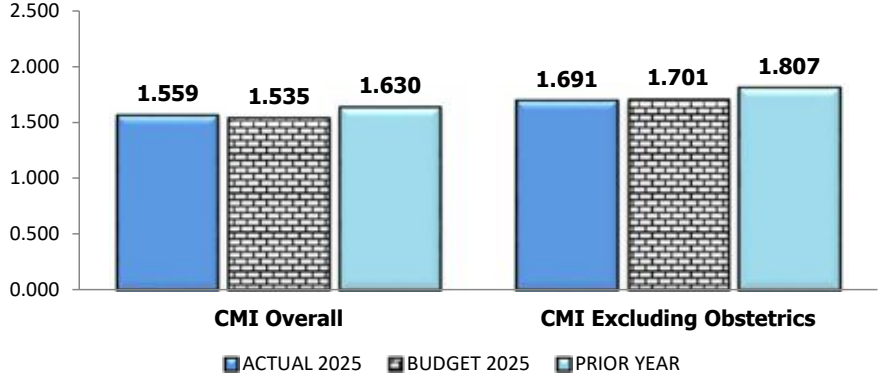
April FY 2025

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
2.032	2.233	1.871	2.079	1.559	1.691	1.538	1.703

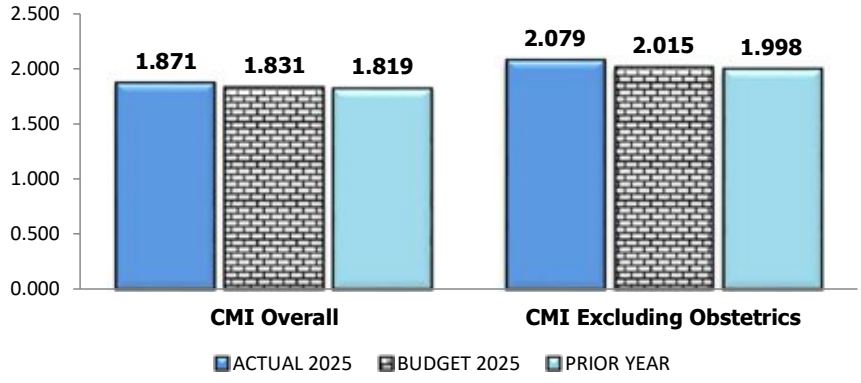
Ben Taub CMI - Current Month



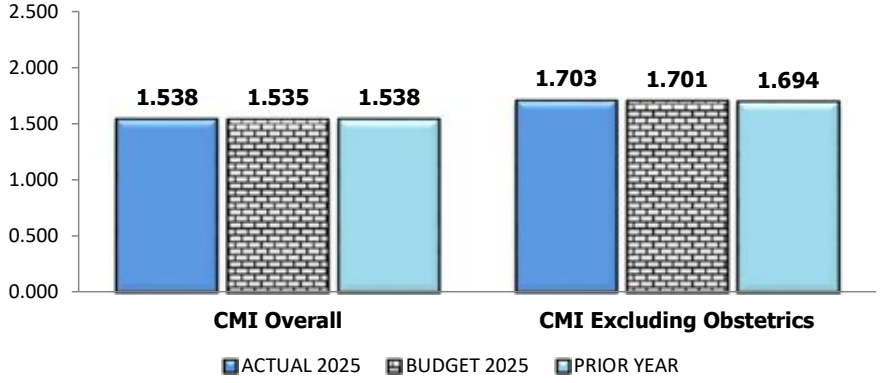
Lyndon B. Johnson CMI - Current Month



Ben Taub CMI - YTD



Lyndon B. Johnson CMI - YTD



BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Thursday, May 22, 2025

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

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R. King Hillier
SVP, Public Policy & Government Relations

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May 2025
Board of Trustees Monthly Legislative Report

Federal Update

Budget Reconciliation Update: The Energy & Commerce Committee and Ways and Means Committee marked up their respective budget reconciliation legislation earlier this month. Highlights of the mark-ups are below:

Medicaid:

- Moratorium on new or increased provider taxes
- Moratorium on new State Directed Payments that exceed the Medicare rate
- Close the MCO tax "broad-based" loophole (used by California, Illinois, Massachusetts, Michigan, New York, Ohio, and West Virginia)
- Repeal the Biden-era eligibility and nursing home regulations
- Eligibility verification for the expansion population every six months
- Presumptive eligibility to be retroactive to 30 days instead of 90 days (with some exceptions)
- Hard ceiling of $1 million in home equity for people applying for Medicaid-covered long-term services and supports
- Implement work requirements, with extensive exceptions
- Require states to implement cost sharing for the Medicaid Expansion population over 100% of the federal poverty level. Cost sharing capped at $35 per service
- Ban spread pricing by pharmacy benefit managers
- Prohibit funding for gender transition procedures for minors
- Prohibits federal payments to certain entities that provide abortions (i.e. Planned Parenthood)
- Reduce federal match for the expansion population to 80% for states that cover undocumented immigrants with state funds not to exceed 5% of income
- Check immigration status sooner than 90 days
- Delays any disproportionate share hospitals payment cuts until 2029
- Require states to implement screenings of enrollee addresses, provider databases, and the Social Security Administration's Death Master File

ACA Marketplaces—Energy and Commerce:

- Individuals ineligible for Medicaid due to failure to meet Medicaid work requirements will also be ineligible to receive Advanced Premium Tax Credits (APTCs)
- ACA Program Integrity Rule– This would codify the March 2025 proposed rule, which:
- Prohibits issuers of coverage subject to EHB requirements from providing coverage for sex-trait modification as an EHB
- Excludes Deferred Action for Childhood Arrivals recipients from the definition of "lawfully present"

- Permits issuers to require past-due premium payments before effectuating new coverage
- Changes rules related to failure to file and reconcile
- Requires income eligibility verifications for premium tax credits and cost-sharing reductions
- Requires APTCs be reduced so that consumers who are automatically re-enrolled are charged $5 per month until such time as they complete a new, annual eligibility determination
- Prohibits Bronze to Silver in the reenrollment hierarchy
- Prohibits state and federal exchanges from offering a SEP for consumers under 150% FPL
- The annual open enrollment period and special enrollment periods and changes open enrollment period rules
- Lowers de minimis thresholds for the actuarial value for plans subject to essential health benefits (EHB) requirements and for income-based cost-sharing reduction plan variations
- Adjusts premium adjustment percentage methodology

ACA Marketplaces—Ways and Means:

- Ends passive enrollment. All individuals must provide documentation to the Exchanges for pre-enrollment verification on income, family size, changes in marital or family status or income, and citizenship or lawful presence status starting in August of the year prior to coverage in order to receive advance PTCs (rather than PTCs at tax time). Note: the Exchange must use applicable enrollment information that is provided or verified by the applicant and is not permitted to rely on information provided entirely by other sources
- Disallows PTCs for any consumer enrolling via an income-based special enrollment period, such as the SEP for consumers under 150 percent FPL
- Ends the limitations on APTC recapture for lower-income consumers. All consumers, regardless of income, would be required to repay the full balance of any excess APTC
- Denies PTC for certain lawfully-present immigrants, including immigrants subject to Medicaid's "five-year bar," who were otherwise eligible for PTC even if their income is below the FPL
- Creates CHOICE arrangements, which would codify ICHRAs. Small employers would receive per-employee monthly tax credits
- Would make catastrophic and bronze Marketplace plans high deductible health plans, eligible for use as with an HAS

Below are links that give a more detailed analysis of the provisions listed above:

- **A summary of Energy and Commerce's Medicaid and CHIP from our colleagues at McDermott+**
- **The Energy and Commerce memorandum on the markup language to be considered**
- **Energy and Commerce's updated, full committee print with legislative language**
- **A section by section breakdown of Ways and Means' markup text**
- **A description of the provisions to be considered by Ways and Means from the Joint Committee on Taxation**

The Congressional Budget Office estimates that these provisions would increase the number of people without insurance by at least 13.7 million in 2034. The provisions of the proposals meet and exceeds the budget target of $880 billion by an amount that exceeds $912 billion over 10 years to fund the extension of the 2017 Trump tax cut for upper income taxpayers.

The impact on Texas Medicaid and hospital payments includes a grandfathering of the state's Local Provider Participation Fund (provider tax). No reduction in the 6% cap while stipulating no future increases in provider taxes. The initial proposal would have reduced the provider tax cap from 6% to 5% which could have resulted in a $130 million reduction in payments to Harris Health.

The ACA DSH cuts would be deferred from 2025 to 2029.

Medicaid Directed Provider Payments (DPPs) or State Directed Payments (SDPs) will also be grandfathered at current levels with no future growth. It would allow for additional DPPs that are currently in a preprint status in CMS at the time of enactment. Texas has over $1 billion in a preprint status. Initial proposals were to fully eliminate DDPs/SDPs which could have resulted in a $300 million reduction for Harris Health collections.

Lastly, eligibility would be redetermined every 6 months and presumptive eligibility for new Medicaid recipients would be reduced from the current 90 days to 30 days. This potentially will end the 12 months continuous eligibility for post-partum women in Texas.

There are also some provisions regarding immigration status validation that are very vague in terms of its impact. This measure will have to be further reviewed to understand the impact.

We are currently assessing the impact of the reduction of the ACA Marketplace APTCs from 400% of Federal Poverty to 150% of Federal Poverty.

The House Freedom Caucus is voicing concern that the House package is not going far enough in reductions in Medicaid. There is a level of uncertainty that Speaker Johnson will get the 218 votes it needs to pass the packages in the House.

The Senate has yet to markup its reconciliation package at the time of the writing of this report. Many provisions in the House version are facing growing opposition amongst Republican Senators from both expansion and non-expansion states. There is no Democratic support in either the upper or lower chambers.

The House and Senate leadership hope is to have legislation on the President's desk this summer or very early fall. Time will tell.

State Update

Critical Deadlines & Packed Calendars: As lawmakers sprint toward the final days of session, all legislation faces critical deadlines they must meet to remain viable.

A few major deadlines are as follows:

- May 12 – Last day for House committees to report house bills and house joint resolutions
- May 15 – Last day for the full House to give initial approval to house bills and house joint resolutions
- May 24 – Last day for House committees to report senate bills and senate joint resolutions
- May 27 – Last day for the full House to give initial approval to senate bills and senate joint resolutions
- May 28 – Last day for the full Senate to consider any bill or joint resolution

Any measure failing to meet these deadlines is considered dead as a standalone piece of legislation, though certain measures may still be revived via amendment to other still viable pieces of legislation.

As more and more bills are added to the House calendar for consideration, the House's floor schedule becomes ever more crowed and ever more backed up. Accordingly, even though many bills may technically be set for consideration ahead of critical deadlines, the House will nonetheless lack sufficient time to address each and every bill thus scheduled.

Medicaid Contracting Proposals: Community Health Choice and Harris Health personnel continue to monitor the legislative landscape regarding Medicaid contracting.

We have had face-to-face good faith negotiations with primary stakeholders and have continued to interface with key policymakers in support of the most recent procurement process and the tentative awards resulting from it.

Thus far, efforts to retroactively cancel the procurement both in the lawmaking process and the appropriations process have been unsuccessful, though there is still time for last minute amendments that could accomplish this or something similar.

Critical legislative deadlines loom that will soon preclude any effort at cancelling the procurement, though the last of these will not occur till late May.

Facility Fee Advocacy: Stand-alone pieces of legislation on facility fees and national provider identifier (NPI) numbers have stalled as critical session deadlines loom.

As a reminder, the initial versions of these bills would have resulted in significant financial losses to Harris Health. In contrast the most recent, highly negotiated, House and Senate versions—though differing slightly from one another—are both vast improvements with provisions largely agreeable to Harris Health.

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As of this writing, both House and Senate versions have received committee approval in their respective chambers of origin. Neither, however, has made it to a floor debate, and it remains uncertain if either one will.

There are, however, separate efforts to include a state budget provision directing state agencies to study the NPI issue, though we will not know the result till House and Senate budget conferees issue their conference committee report on this session's General Appropriations Act.

Curbing Concrete Crushing: Both House and Senate measures seeking to provide hospitals with greater protection from concrete crushing facilities have passed committee in their respective chambers of origin, but time is running short as both have yet to receive consideration by the full House or Senate bodies.

Per direction from Senate leadership, the upper chamber's version is bracketed such that it only applies to LBJ Hospital and exempts temporary crushers from its restrictions. The House version remains more expansive and is scheduled for House floor debate, albeit behind many other House bills up for consideration as time runs short.

Authorizing Harris Health to Employ Peace Officers: Both House and Senate bills allowing Harris Health to commission and employ peace officers have made significant procedural progress, with the Senate bill making its way through the House and the House bill scheduled for House floor consideration.

Final passage, however, is not guaranteed as all legislation faces imminent and critical deadlines and as the list of bills set for floor consideration gets longer with each passing day.

State Legislation Protecting 340B: State level legislation supported by Harris Health seeking to protect the 340B program is stalled and unlikely to pass this session, though advocates seek to amend portions of it onto still viable legislation.

In spite of support from a coalition of provider-based stakeholder groups, this measure made it out of committee with insufficient time and too much opposition to—as of this writing—make it through the influential House Calendars committee.

Efforts at 340B protection remain in play on the federal level, however.

Local Debt Legislation: Certain bills seeking to severely curtain the ability of local governments, including hospital districts, to take advantage of low-cost debt have stalled such that they are effectively dead for this session.

One such piece of legislation sought to—among other restrictions—prevent hospital districts from issuing certificates of obligation. But it has failed to meet a critical deadline.

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Other standalone pieces of legislation with less stringent provisions continue to make their way through the legislative process, and we continue to monitor them for adverse floor amendments. One such standalone piece of legislation would prevent issuance of anticipation notes if voters rejected a bond for the same purpose within the previous five years.

The most concerning measures, however, are effectively dead for this session, though we continue to monitor floor amendments seeking resurrect portions of these bills.

HOUSTON CHRONICLE

OPINION // OUTLOOK

Texas Medicaid is already lean. Cutting it will hurt all Texans. | Opinion

By **Esmaeil Porsa**
May 5, 2025

Gift Article

Congress is considering various proposals to cut Medicaid dramatically and change the rules for how states can fund the program. These proposed cuts should concern all Texans, not just those who rely on the program for lifesaving care.

Texas has historically run a very lean Medicaid program, providing barebones benefits to an extremely limited eligible population. In fact, most enrollees are low-income pregnant women and children. The program also reimburses providers well below the cost of care, creating a strained and often inadequate network of health care professionals struggling to meet the needs of the 4.1 million Texans enrolled.

Some laud the fact that Texas has the lowest percentage of Medicaid spending above federal minimum requirements of any state. But what this means from a budgetary standpoint is that we don't have any excess to cut.

Republicans in Congress are barreling through a complicated process to achieve targeted budget cuts by eliminating "waste, fraud and abuse" in federal spending. There is no question that, in some states, Medicaid has grown beyond what was originally intended for the program. In Texas, that is not the case.

Texas has been recognized by a non-partisan Congressional advisory commission for its transparency and strict accountability for spending taxpayer dollars. Financing arrangements have been approved for years by the Centers for Medicare and Medicaid Services, and payments are tied to quality measures.

"Waste, fraud and abuse" should not involve misguided cuts to the program and cost shifting to the states.

Cutting billions of dollars from the program would have widespread and devastating consequences for all Texans.

Beyond the obvious impacts to people enrolled in the program, the collateral damage of program cuts will be felt across the board. Hospitals will do everything they can to weather the storm, but some may not survive. Others will have to increase their reliance on state or local support or reduce services. Access to care will decrease, especially for high-cost service lines like maternal care and behavioral health. Jobs will be lost. The impact on communities – which rely on their hospitals for employment and growth – will be profound.

If deep cuts are realized, Harris Health and other Texas hospitals will have to make tough choices about services and jobs. Local taxes will need to increase to backfill the funding hole created by the federal government. Texas families and businesses concerned about property tax hikes should reject these cuts at the federal level, which is nothing more than transferring costs to the state and local taxpayers.

States need stability and trust in their partnership with Washington to make long-term decisions, invest in innovation and meet community needs. Deep cuts to the Medicaid program create uncertainty, jeopardize health and send hospitals and communities scrambling for essential resources to ensure access to care.

Any reforms to Medicaid should be made with a thoughtful "do no harm" approach that takes into consideration the strict guidelines already imposed in Texas. We call on Harris County's elected representatives in Congress — as well as Texas' entire Congressional delegation — to stand up for the health of the residents of their districts, recognize that Texas already runs a tight ship, and reject dangerous cuts to Medicaid.

In Texas, these cuts won't heal.

Esmaeil Porsa, MD, is the president and CEO of the Harris Health -- the public safety-net health system for Harris County.

The Dallas Morning News

OPINION › COMMENTARY

Parkland CEO: What Medicaid cuts really mean for American health

In Texas, Medicaid covers low-income pregnant women, children, individuals with disabilities, and nursing home residents.

By Fred Cerise

May 12, 2025 | Updated 1:30 a.m. CDT | 3 min. read

Congress is contemplating a proposal to cut hundreds of billions of dollars from the Medicaid program while also committing to not directly cut Medicaid services. In the desire of some policymakers to support two opposing policy positions simultaneously, many of us fear that they will be deceived into accepting a simplistic explanation that such a cut will not impact the millions of beneficiaries who depend on Medicaid.

Some policymakers are suggesting that these dollars can come from identifying fraud, waste and abuse without cutting Medicaid itself. Eliminating fraud and abuse wherever it exists is important. Significantly more common than outright fraud are improper payments, mostly due to documentation issues, and that amount ($31 billion or 5% of overall federal payments) does not come close to the hundreds of billions in Medicaid cuts proposed to address fraud.

Medicaid is a state-federal partnership to provide health insurance with eligibility that varies by state. In Texas, Medicaid covers low-income pregnant women, children, individuals with disabilities, and nursing home residents. Medicaid financing is complex. It is this complexity that will allow policymakers to assert they can cut dramatic sums of funding without cutting the program.

Here is one example. Every state must put up money to receive federal matching funds. Rather than relying solely on state general revenue, 49 states levy taxes on health care entities (e.g., hospitals, nursing homes, insurance companies) to help fund the state share. Often, these entities volunteer to be taxed because the federal money that the state share generates comes back to them in the form of higher Medicaid payments. This financing mechanism commonly used by states to fund their Medicaid programs is legal

and patients in these states depend heavily on the federal funds raised to fund their Medicaid programs.

Some people think these funding mechanisms allow states to draw federal funds without putting up their legitimate share of state funds, and they would like to see that end. That is a reasonable position to take. What is not reasonable is to suggest that by eliminating this funding mechanism, the result will be to cut out fraud and not to cut Medicaid. The truth is, that by eliminating this funding mechanism, states will lose billions in federal funding.

States must react by either raising taxes to maintain services or taking actions that will reduce access to care such as cutting Medicaid rolls, reducing services offered, or reducing provider payments.

Proponents anticipate that states will not replace the provider tax revenue with state or local funds. This means there will be billions less in the Medicaid program and people will ultimately have trouble accessing lifesaving care.

Currently, states cannot tax health care entities more than 6% of their total revenue. For each percentage point reduction allowed, the Texas Medicaid program would lose $1.6 billion. One proposal that has been floated that may seem innocuous to the general public: reduce the cap on these taxes from 6% to 3%. What may seem like a modest change would result in the loss of nearly $5 billion to Texas Medicaid.

The provider tax is but one example of a Medicaid cut that will be mischaracterized as addressing fraud. Other proposals include reducing the federal share (thereby increasing the state share) of Medicaid payments, adding work requirements for beneficiaries, and placing caps on the federal portion of the program. While these changes may be worthy of debate, the policies behind them are not fraudulent, and the impact will be the loss of federal funds to support millions of people who depend on Medicaid for their health care.

Fred Cerise is president and CEO of Parkland Health.

Abilene Reporter News

Guest viewpoint: How proposed Medicaid cuts would endanger health care in Texas | Opinion

Brad Holland
Hendrick Health president and CEO

May 2, 2025

Earlier this year, lawmakers in Washington, D.C., introduced a proposed budget focused on reducing our estimated $36 trillion national debt. Voters who gave Republicans control of the White House and Congress expect spending reform. Removing waste, fraud and abuse is laudable and necessary to achieve this monumental task. The health care industry's major concern with current budget discussions involves steep cuts or rule changes to Medicaid.

There is no doubt that nationally Medicaid has, like many programs, grown beyond its original scope. I applaud efforts to restore a level of fiscal responsibility in our government; however, all Texans should know how drastic changes to Medicaid impact all of us.

Established in the 1960s, Medicaid exists as a federal-state partnership. Guidelines are set at the federal level, and states manage the program locally. In 2010, the Affordable Care Act (also known as "Obamacare") brought significant changes to Medicaid, ushering in Medicaid expansion in most states.

The Lone Star State was one of seven that chose not to expand Medicaid. As a result, Texas runs a lean and efficient Medicaid program, serving enrollees' needs without undue taxpayer burden. Recently, a nonpartisan congressional advisory commission recognized Texas for its transparency and strict accountability of taxpayer dollars.

As a populous state, even without expanding Medicaid, Texas has the third largest Medicaid population with 4.1 million enrollees. However, this efficient program has left the state with the highest rate of uninsured residents in the country at 17%.

Most Texans enrolled in Medicaid are children and low-income pregnant women. However, the governmental program reimburses health care

providers well below the actual cost of care, resulting in a strained and often inadequate network of care providers.

With this funding deficit and the already lean Texas Medicaid model, an across-the-board, one-size-fits-all style of proposed cuts across all states would be devastating for Texas. If Congress proceeds with this plan, the Texas Legislature would need to make up for the funding deficit, adding significantly to the state's budgetary burden.

The ripple effects of sweeping Medicaid cuts will be felt close to home in Texas communities. Loss of any Medicaid funding will significantly limit access to health care for millions of Texans and immediately jeopardize the viability of hospitals that serve rural communities every day.

Communities that rely on their hospitals for employment and economic stability will be profoundly impacted. Jobs will be lost; services will be eliminated; and access to care will decrease, especially for high-cost, specialty service lines like maternal care and behavioral health. The already high uninsured rates will increase, leading to higher commercial insurance premiums and shifting health care costs to other hardworking Texans.

Hospitals will do everything possible to weather the storm, but some may not survive. If these deep cuts and rule changes are enacted, Hendrick Health will have to make tough choices that impact services, jobs, investments in equipment and facilities, and advancements in care for our patients.

Hendrick Health is fortunate to have great relationships with our members of Congress, U.S. Rep. Jodey Arrington of the 19th Congressional District and U.S. Rep. August Pfluger of the 17th Congressional District. My team and I have worked with them and their staff to ensure they understand the impact of these proposals.

We trust our representatives in Washington to invest in the future health of our region — one they love and support. However, I do not believe these cuts align with that vision, and I will continue to work, on behalf of Hendrick Health and West Texans, to ensure that efforts to curb excessive and wasteful spending in other parts of the country don't come at the expense of my fellow Texans.

Brad Holland is president and CEO of Hendrick Health in Abilene. He is also a former CEO of the San Angelo Community Medical Center and was raised in San Angelo.

CORNERSTONE
GOVERNMENT AFFAIRS

MEMORANDUM

TO:	Cornerstone Clients
FROM:	Cornerstone Government Affairs
SUBJECT:	House Energy and Commerce Health Reconciliation Provisions
DATE:	May 13, 2025

Overview

On May 13, the House Committee on Energy and Commerce will markup the Committee's legislative recommendations for budget reconciliation. Last month, the House and Senate approved a budget resolution (H.Con.Res 14) that instructed the Committee to report legislation that would produce $880 billion in savings to the federal budget.

The health provisions of the legislative text produced by the Committee would modify several policies that govern the Federal share of the Medicaid program, including eligibility, enrollment, financing, and spending among other areas. The Congressional Budget Office (CBO) issued preliminary cost and coverage estimates for the Committee's health legislative recommendations, indicating they would reduce the federal deficit by $715 billion during the 2025-2034 budget window. The CBO further estimated the Medicaid provisions would generate $625 billion in savings, and result in 10.3 million individuals losing Medicaid coverage and 7.6 million becoming uninsured.

A summary of the Committee's health provisions follows below.

Part 1—Medicaid

Subpart A—Reducing Fraud and Improving Enrollment Processes

Sec.44101: Moratorium on Implementation of Rule Relating Eligibility and Enrollment in Medicare Savings Programs

- Would delay implementation of the Centers for Medicare and Medicaid Services (CMS) final rule – "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment" – published on September 21, 2023, until January 1, 2035.
- Background:
    - The September 2023 final rule issued by the Biden Administration intends to facilitate enrollment in Medicare Savings Programs (MSP), which provide cost-sharing, premium, and other assistance to low-income Medicare beneficiaries.

Sec. 44102: Moratorium on Implementation of Rule Relating to Eligibility and Enrollment for Medicaid, CHIP, and the Basic Health Program

- Would delay implementation of the CMS final rule published – "Medicaid Program; Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination Enrollment, and Renewal Processes" – published on April 2, 2024, until January 1, 2035.

- Background:
    - The Nov. 2024 final rule issued by the Biden Administration eases the eligibility and enrollment processes for Medicaid, CHIP, and the Basic Health Program (BHP) established by the Affordable Care Act (ACA).
    - The final rule aligns CHIP with Medicaid policies that prohibit waiting periods for enrollment, annual or lifetime dollar limits on covered services, and lockout windows for nonpayment of premiums; requires Medicaid and CHIP to confirm and accept eligibility determinations from the other program; and updates renewal, changes in circumstances, and eligibility redetermination processes.

Sec. 44103: Ensuring Appropriate Address Verification Under the Medicaid and CHIP Programs

- Before January 1, 2027, states and the District of Columbia would be required to implement a process to regularly obtain addresses for Medicaid enrollees utilizing "reliable data sources," including the United States Postal Service and Medicaid managed care plans, and other data sources approved by the Secretary of Health and Human Services (HHS).
    - States and the District of Columbia would be required to submit address verification data at least once each month and during the eligibility determination/redetermination period.
- Before October 1, 2029, the HHS Secretary shall establish a system for use by the Department and states to ensure Medicaid beneficiaries are not simultaneously enrolled in multiple state Medicaid plans.
    - HHS would transmit findings to states at least once each month.
    - States would be required to submit beneficiary Social Security numbers to the system to ease identification of individuals enrolled in multiple state plans.
- Beginning January 1, 2027, Medicaid managed care plans operating under state contracts would be required to "promptly transmit to the State" address information for Medicaid beneficiaries.

Sec. 44104: Modifying Certain Requirements for Ensuring Deceased Individuals Do Not Remain Enrolled

- Beginning January 1, 2028, states and the District of Columbia would be required to comply with eligibility verification requirements, including reviewing the Death Master File, to ensure deceased Medicaid enrollees are removed from state Medicaid plans.
- In cases where states erroneously identify an enrollee as deceased and subsequently disenrolled that person, the state is required to "immediately re-enroll" the individual retroactive to the date of disenrollment.

Sec. 44105: Medicaid Provider Screening Requirements

- Beginning January 1, 2028, states would be required to verify provider enrollment status at least once each month by reviewing databases and other systems to confirm and remove providers or suppliers who have been terminated by another state Medicaid program.

Sec. 44106: Additional Medicaid Provider Screening Requirements

- States would be required to check the Death Master File at least once each quarter to determine whether any enrolled providers or suppliers are deceased.

Sec. 44107: Removing Good Faith Waiver for Payment Reduction Related to Certain Erroneous Excess Payments Under Medicaid

- Beginning in Fiscal Year (FY) 2030, HHS would be required to reduce federal financial participation (FFP) to states for excessive erroneous Medicaid payments attributed services provided to ineligible individuals and families and to Medicaid beneficiaries who received ineligible services.

Sec. 44108: Increasing Frequency of Eligibility Redeterminations for Certain Individuals

- Beginning October 1, 2027, Medicaid expansion states would be required to "redetermine the eligibility" of expansion population enrollees once every six months.

Sec. 44109: Revising Home Equity Limit for Determining Eligibility for Long-Term Care Services Under the Medicaid Program

- Reduces the maximum home equity limit to $1,000,000 to qualify for long-term care services in Medicaid, effective Jan. 1, 2028.
- The current limit for 2025 is between $730,000 and $1,097,000, and those amounts are updated annually for inflation.
- Prohibits the use of asset disregards from being used to waive home equity limits.

Sec. 44110: Prohibiting Federal Financial Participation Under Medicaid and CHIP For Individuals Without Verified Citizenship, Nationality, Or Satisfactory Immigration Status

- Would prohibit Medicaid FFP for individuals whose citizenship, nationality, or immigration status cannot be confirmed, including during reasonable opportunity periods.

Sec. 44111: Reducing Expansion FMAP for Certain States Providing Payments for Health Care Furnished to Certain Individuals

- Beginning October 1, 2027, would reduce the FMAP for the Medicaid expansion population by 10 percent if an expansion state provides payment for or coverage of health care services provided to undocumented immigrants.
- Background:
    - The ACA established the FMAP for states that expanded Medicaid eligibility to childless able-bodied adults before March 11, 2021 at 90 percent.

Subpart B—Preventing Wasteful Spending

Sec. 44121: Moratorium on Implementation of Rule Relating to Staffing Standards for Long-Term Care Facilities Under the Medicare and Medicaid Programs

- Would delay implementation of final Nursing Home Staffing Rule until January 1, 2035.

Sec. 44122: Modifying Retroactive Coverage Under the Medicaid and CHIP Programs

- Beginning October 1, 2026 (or FY 2027), would lower retroactive Medicaid and CHIP coverage to 1 month prior to an individual's application date (down from 3 months).

Sec. 44123: Ensuring accurate payments to pharmacies under Medicaid

- Requires certain retail and non-retail pharmacies to participate in the National Average Drug Acquisition Cost survey which measures pharmacy acquisition costs and is used as a tool to establish Medicaid reimbursement to pharmacies.

Sec. 44124: Preventing the Use of Abusive Spread Pricing in Medicaid.

- Bans a practice known as spread pricing, whereby Pharmacy Benefit Managers keep part of the money paid to them for prescription drugs.
- PBM payments for outpatient drugs would equal the ingredient cost (based on actual acquisition cost) plus a professional dispensing fee. However, an exception is provided for 340B drugs, where the payment could exceed the actual acquisition cost.

Sec. 44125: Prohibiting Federal Medicaid and CHIP Funding for Gender Transition Procedures for Minors.

- Prohibits Medicaid and CHIP reimbursement for certain gender transition procedures for minor children.

Sec. 44126: Federal Payments to Prohibited Entities

- Prohibits Medicaid payments to non-profit organizations, who billed Medicaid for more than $1 million in 2024 and are primarily engaged in family planning or reproductive services, including abortions.

Subpart C—Stopping Abusive Financing Practices

Sec. 44131: Sunsetting eligibility for increased FMAP for new expansion states

- Would end the temporary 5% increase to the regular FMAP rate for states that expand Medicaid after March 11, 2021.
- Background:
    - The American Rescue Plan Act (ARPA) increased the regular FMAP rate by 5% for the first two years for states that expanded Medicaid eligibility to childless able-bodied adults after the date of enactment of March 11, 2021.
    - States impacted included Missouri—July 2021; Oklahoma—July 2021; North Carolina—2023; and South Dakota—2023.

Sec. 44132: Moratorium on New or Increased Provider Taxes

- Beginning on the date of enactment, provider taxes would be capped at current rates (as of the date of enactment) and states would be prohibited from establishing new provider taxes and increasing previously established tax rates.

Sec. 44133: Revising The Payment Limit for Certain State Directed Payments

- State directed payments that approved by CMS after the date of enactment would be capped at the Medicare Part A or Part B payment rate.
- Would grandfather and freeze state directed payment dollar amounts, including subsequent renewals, that received "written prior approval" before the date of enactment or preprint applications submitted to the HHS Secretary/CMS "prior to the date of enactment."

Sec. 44134: Requirements Regarding Waiver of Uniform Tax Requirement for Medicaid Provider Tax

- Would establish new requirements for HHS to consider when assessing whether states can impose certain provider taxes, including whether the taxes are "generally redistributive."
- On Monday May 12, 2025, CMS issued a proposed rule that echoes the intent and language of this provision.

Sec. 44135: Requiring Budget Neutrality for Medicaid Demonstration Projects Under Section 1115

- Would establish budget neutrality requirement for demonstration projects approved on section 1115 waivers.
- The HHS Secretary is required to certify that approved 1115 demonstration projects would not result in increased federal Medicaid spending relative to spending without the project.

Subpart D—Increasing Personal Accountability

Sec. 44141: Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals

- Enacts work requirements beginning in 2029 for able-bodied adults, without dependents, between the ages of 19-64. These individuals must complete 80 hours of work, community service, job training, or educational learning. A combination of these activities can be leveraged to meet the 80 hours.
- Establishes exemptions for certain individuals, including parents or caretakers of dependents, pregnant or postpartum women, members of a Tribe, medically frail, and those in compliance with TANF or SNAP work requirements. There are also hardship exemptions for natural disasters, areas of high unemployment.

Sec. 44142: Requires Minimum Cost-Sharing for the Expansion Population

- Requires states to enact cost-sharing for adults in the expansion population with incomes above 100% of the federal poverty level.

- Establishes a $35 maximum co-pay while also giving states flexibility to set co-pays below that amount.

Part 2—Affordable Care Act

Sec. 44201: Addressing Waste, Fraud and Abuse in the Affordable Care Act (ACA) Exchanges

- Rescinds Biden-era provision that provided for special ACA enrollment periods based on a change in income and requires additional screening to determine eligibility for special enrollment periods.
- Requires verification of income and family size when tax data is unavailable.
- Prohibits gender transition procedures from being listed as an essential health benefit (EHB).
- Allows insurers to require enrollees to satisfy debt for past-due premiums as a prerequisite for establishing new health coverage.
- Requires individuals auto-enrolled into a plan with zero premium to pay $5 until eligibility is confirmed.

Part 3—Improving Americans' Access to Care

Sec. 44301: Expanding and Clarifying the Exclusion for Orphan Drugs Under the Drug Price Negotiation Program

- Would expand the exemption for orphan drugs from the Medicare Drug Price Negotiation Program to "one or more rare disease or condition."
- Would establish the "initial price applicability year" period as "beginning on or after January 1, 2028."

Sec. 44302: Streamlined Enrollment Process for Eligible Out of State Providers Under Medicaid and CHIP

- Would include language from the Accelerating Kids' Access to Care Act to simplify the enrollment of eligible out-of-state providers.

Sec. 44303: Delaying DSH Reductions

- Would delay DSH reductions scheduled for each of FYs 2026, 2027, and 2028 until FYs 2029, 2030, and 2031, with the aggregate annual reduction in DSH allotments for all states "equal to" $8 billion.

Sec. 44304: Modifying Update to the Conversion Factor Under the Physician Fee Schedule Under the Medicare Program

- Would replace the dual conversion factor that is scheduled to begin in calendar year (CY) 2026 with a single conversion factor based on a percentage of the Medicare Economic Index (MEI) that measures medical inflation.
- In CY 2026, the conversion factor would be "75%" of the HHS Secretary's "estimate of the percentage increase in MEI."
- Beginning in CY 2027 and for each subsequent year, the conversion factor would be 10% of the Secretary's estimate of the percentage increase in MEI.

Sec. 44305: Modernizing and ensuring PBM accountability

- Requires PBMs in Medicare Part D to share information relating to business practices with Medicare Part D Prescription Drug Plan (PDP) Sponsors, including information relating to formulary decisions and drug coverage that benefits affiliated pharmacies.
- De-links PBM compensation from a drug's list price and instead requires that PBMs be compensated by service fees. Permits rebates that are fully passed through to a PDP sponsor.
- Requires CMS define "reasonable and relevant" contracting terms for the purpose of enforcing Part D's "any willing pharmacy" requirement.

Thursday, May 22, 2025

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

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Attached for review and acceptance:

- **HCHP May 2025 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, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

Health Care for the Homeless Monthly Update Report – May 2025

Jennifer Small AuD, MBA, CCC-A, Chief Executive Officer, Ambulatory Care Services

Tracey Burdine, Director, Health Care for the Homeless Program

HARRISHEALTH

Agenda

- Operational Update
  - Productivity Report
  - Patient Satisfaction
  - Budget Summary Report
  - Carryover Budget

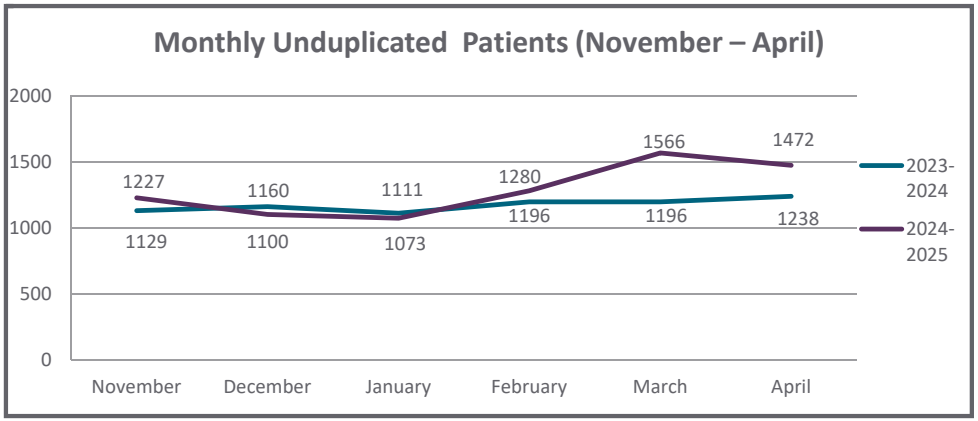
HARRISHEALTH

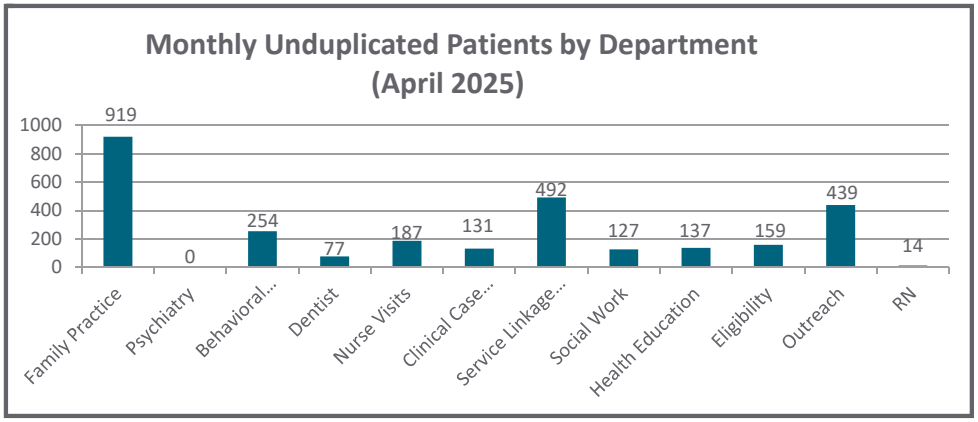
Patients Served

HRSA Unduplicated Patients Target:	HRSA Completed Visit Patients Target:
7,250	**30,496**
YTD Unduplicated Patients: 3,333	YTD Total Completed Visits: 10,536

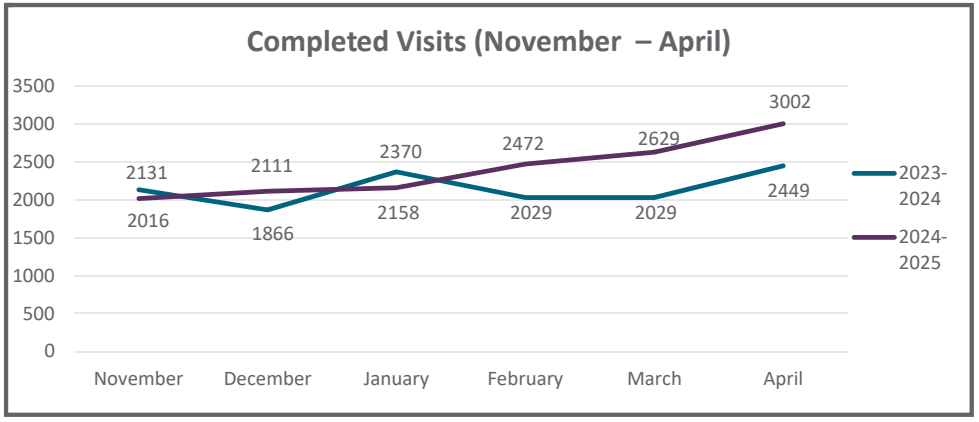
HARRISHEALTH

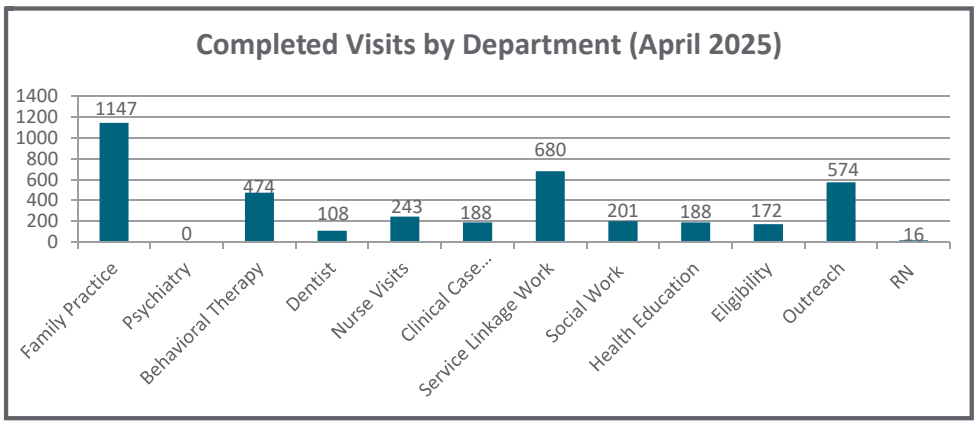
Unduplicated Patients





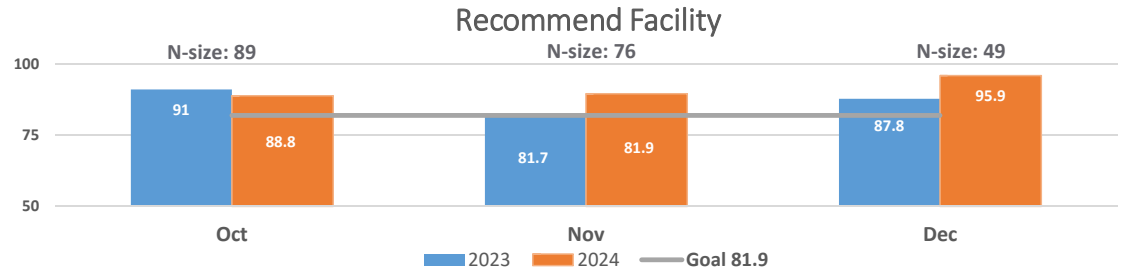
Completed Visits



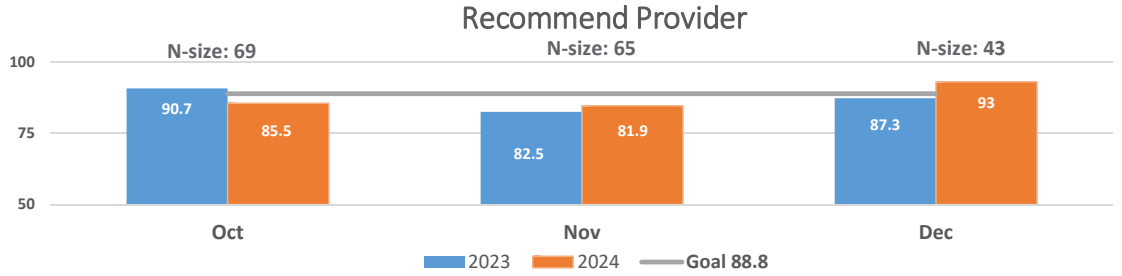


HARRISHEALTH

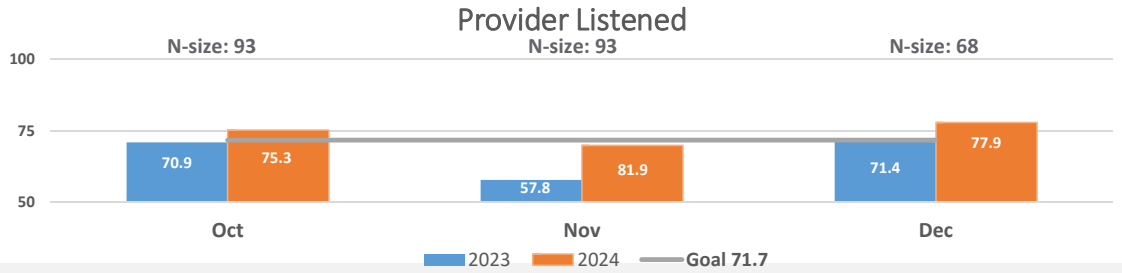
HCHP Patient Satisfaction Trending Data Q4



Q4 Average: 88.8
N-size: 214



Q4 Average: 86.8
N-size:177



Q4 Average: 78.4
N-size: 254

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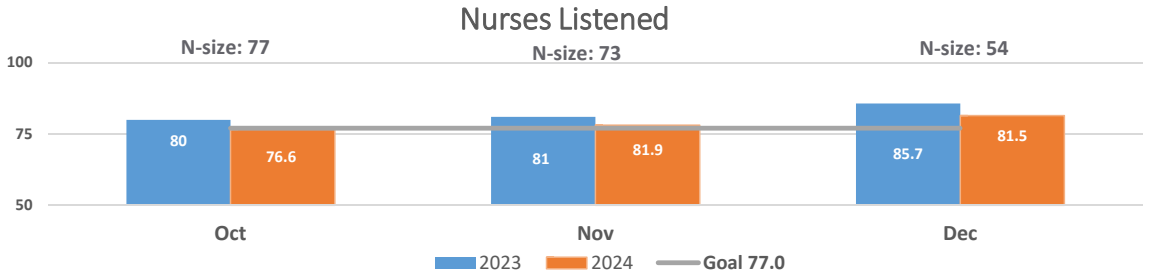
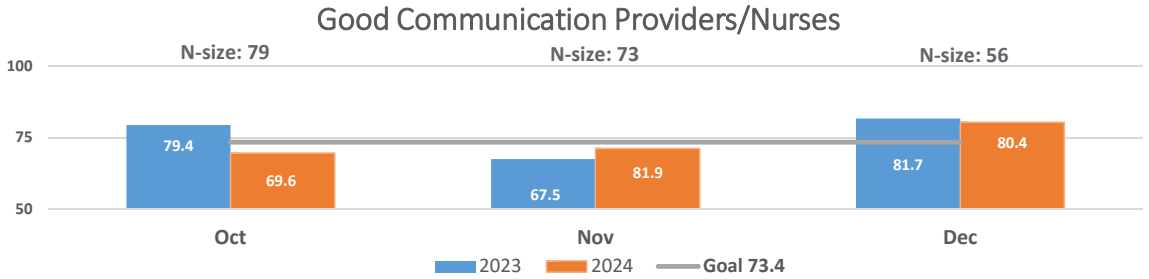
HCHP Patient Satisfaction Trending Data Q4



Q4 Average: 80
N-size: 204



Q4 Average: 77.3
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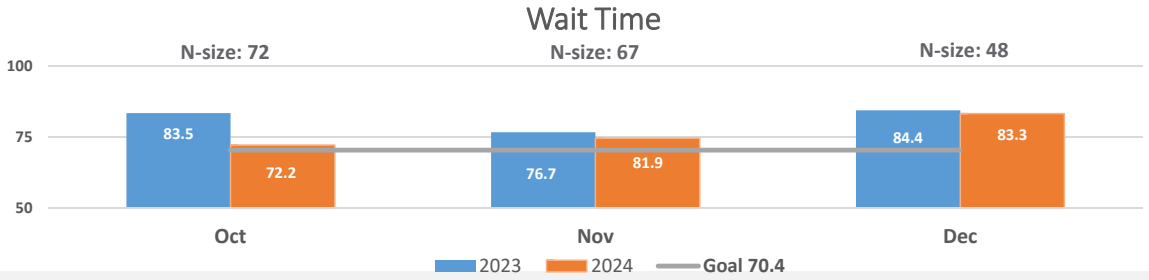

Q4 Average: 79.1
N-size: 187

HARRISHEALTH

Budget Summary Report

Homeless -Primary Grants and Harris Health Funding					
	Period: January 1, 2025 – March 31,2025				
	Reporting Period: January 1, 2025 – December 31, 2025				
	Line Item	Multiple Award Year Budget	YTD Total Expense	Remaining Balance (budget-projected expense)	%Used YTD
Operating	Personnel/Fringe	5,824,006	1,089,881	4,734,125	19%
	Travel	22,009	2,479	19,530	11.3%
	Supplies	669,878	23,505	646,373	3.5%
	Equipment	87,000	0	87,000	0%
	Contractual	830,645	7,500	823,145	0.9%
	Other	110,884	10,783	100,101	9.7%
	Total	**7,544,422**	**1,134,148**	**6,410,274**	**15%**

HARRISHEALTH

2025 Carryover Request

HARRIS HEALTH

HEALTH CARE FOR THE HOMELESS PROGRAM

HARRIS COUNTY HOSPITAL DISTRICT dba Harris Health

6 H80CS00038-24-01

January 1,2025 through December 31, 2025

EXPENSES	FEDERAL
Personnel	$ 495,535
Fringe	$ 118,928
Supplies	$ 14,615
Total Direct Charges Estimate	$ 629,078

HARRISHEALTH

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Thursday, May 22, 2025

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, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

ACS Grants - Homeless

Through March 2025

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2024	Budget/Balance Remaining as of Jan 1, 2025
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant	**1/1/2025**	**12/31/2025**	Salary	3,055,980.00	-	$ 3,055,980.00
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Benefits	732,435.00	-	$ 732,435.00
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Travel	10,114.00	-	$ 10,114.00
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Supplies	154,641.00	-	$ 154,641.00
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Equipment	-	-	$ -
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Contractual	178,140.00	-	$ 178,140.00
Homeless	Homeless-Primary GYE 12/25	3317	HRSA Grant			Other	15,200.00	-	$ 15,200.00
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant	**1/1/2025**	**12/31/2025**	Salary	92,999.90	-	$ 92,999.90
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Benefits	23,320.00	-	$ 23,320.00
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Travel	-	-	$ -
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Supplies	30,000.00	-	$ 30,000.00
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Equipment		-	$ -
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Contractual	176,845.00	-	$ 176,845.00
Homeless	Homeless-Dental GYE 12/25	3318	HRSA Grant			Other	-	-	$ -
Homeless	ARP - Capital	1760	HRSA Grant	**9/15/2021**	**9/14/2025**	Salary	-	-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Benefits		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Travel		-	$ -
Homeless	ARP - Capital	1760	HRSA Grant			Supplies	33,679.00	35,174.00	$ (1,495.00)
Homeless	ARP - Capital	1760	HRSA Grant			Equipment	87,000.00	-	$ 87,000.00
Homeless	ARP - Capital	1760	HRSA Grant			Contractual	471,800.00	-	$ 471,800.00
Homeless	ARP - Capital	1760	HRSA Grant			Other	21,000.00	19,146.09	$ 1,853.91
Homeless Support	Mobile Unit Purch/Spt	793	HCHD Foundation	**8/1/2017**	**7/31/2025**	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	2,124.07	$ 23,645.02
Homeless Support	Shelter Support Dental	3320	Harris Health	**1/1/2025**	**12/31/2025**	Salary	13,580.00	-	$ 13,580.00
Homeless Support	Shelter Support Dental	3320	Harris Health			Benefits	3,260.00	-	$ 3,260.00
Homeless Support	Shelter Support Dental	3320	Harris Health			Travel	-	-	$ -
Homeless Support	Shelter Support Dental	3320	Harris Health			Supplies	70,000.00	-	$ 70,000.00
Homeless Support	Shelter Support Dental	3320	Harris Health			Equipment	-	-	$ -
Homeless Support	Shelter Support Dental	3320	Harris Health			Contractual		-	$ -
Homeless Support	Shelter Support Dental	3320	Harris Health			Other		-	$ -
Homeless Support	Shelter Support Medical	3319	Harris Health	**1/1/2025**	**12/31/2025**	Salary	1,534,218.00	-	$ 1,534,218.00
Homeless Support	Shelter Support Medical	3319	Harris Health			Benefits	368,213.00	-	$ 368,213.00
Homeless Support	Shelter Support Medical	3319	Harris Health			Travel	11,895.00	-	$ 11,895.00
Homeless Support	Shelter Support Medical	3319	Harris Health			Supplies	411,988.00	-	$ 411,988.00
Homeless Support	Shelter Support Medical	3319	Harris Health			Equipment	-	-	$ -
Homeless Support	Shelter Support Medical	3319	Harris Health			Contractual	3,860.00	-	$ 3,860.00
Homeless Support	Shelter Support Medical	3319	Harris Health			Other	70,200.00	-	$ 70,200.00
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	4,993.80	4,979.31	$ 14.49

ACS Grants - Homeless

Through March 2025

Type	Grant	Project ID	Grantor	Grant Start Date	Grant End Date	Expense Category	Award Budget	Expense through Dec 31, 2024	Budget/Balance Remaining as of Jan 1, 2025
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	6.20	20.69	$ (14.49)

Homeless Primary Grant & Non-Federal Funding Period: January 1, 2025 - March 31, 2025 Reporting Period: January 1, 2025 - December 31, 2025							
	Line Item	**Remaining Budget**	**YTD Actual Expense**	**Annualized Expenses (based on Actual)**	**Remaining balance (Budget-YTD Expenses)**	**Actual % YTD**	**Actual % Annualized**
Federal	Salary	$ 3,148,979.90	$ 631,923.59	$ 2,527,694.36	$ 2,517,056.31	20.1%	80.3%
	Benefits	$ 755,755.00	$ 172,984.81	$ 691,939.24	$ 582,770.19	22.9%	91.6%
	Travel	$ 10,114.00	$ -	$ -	$ 10,114.00	0.0%	0.0%
	Supplies	$ 183,146.00	$ 2,833.30	$ 11,333.20	$ 180,312.70	1.5%	6.2%
	Equipment	$ 87,000.00	$ -	$ -	$ 87,000.00	0.0%	0.0%
	Contractual	$ 826,785.00	$ 7,500.00	$ 30,000.00	$ 819,285.00	0.9%	3.6%
	Other	$ 17,053.91	$ 93.69	$ 374.76	$ 16,960.22	0.5%	2.2%
	Total	$ 5,028,833.81	**$ 815,335.39**	**$ 3,261,341.56**	**$ 4,213,498.42**	**16.2%**	**64.9%**
Non-Federal	Salary	$ 1,547,798.00	$ 233,364.34	$ 933,457.36	$ 1,314,433.66	15.1%	60.3%
	Benefits	$ 371,473.00	$ 51,608.22	$ 206,432.88	$ 319,864.78	13.9%	55.6%
	Travel	$ 11,895.00	$ 2,478.83	$ 9,915.32	$ 9,416.17	20.8%	83.4%
	Supplies	$ 486,731.97	$ 20,671.26	$ 82,685.04	$ 466,060.71	4.2%	17.0%
	Equipment	$ -	$ -	$ -	$ -	0.0%	0.0%
	Contractual	$ 3,860.00	$ -	$ -	$ 3,860.00	0.0%	0.0%
	Other	$ 93,830.53	$ 10,689.42	$ 42,757.68	$ 83,141.11	11.4%	45.6%
	Total	**$ 2,515,588.50**	**$ 318,812.07**	**$ 1,275,248.28**	**$ 2,196,776.43**	**12.7%**	**50.7%**
Grand Total	Salary	$ 4,696,777.90	$ 865,287.93	$ 3,461,151.72	$ 3,831,489.97	18.4%	73.7%
	Benefits	$ 1,127,228.00	$ 224,593.03	$ 898,372.12	$ 902,634.97	19.9%	79.7%
	Travel	$ 22,009.00	$ 2,478.83	$ 9,915.32	$ 19,530.17	11.3%	45.1%
	Supplies	$ 669,877.97	$ 23,504.56	$ 94,018.24	$ 646,373.41	3.5%	14.0%
	Equipment	$ 87,000.00	$ -	$ -	$ 87,000.00	0.0%	0.0%
	Contractual	$ 830,645.00	$ 7,500.00	$ 30,000.00	$ 823,145.00	0.9%	3.6%
	Other	$ 110,884.44	$ 10,783.11	$ 43,132.44	$ 100,101.33	9.7%	38.9%
	Total	**$ 7,544,422.31**	**$ 1,134,147.46**	**$ 4,536,589.84**	**$ 6,410,274.85**	**15.0%**	**60.1%**

Project 3317 - Homeless Medical

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary	610,181.44	$ -	$ 610,181.44
Benefits	168,426.81		$ 168,426.81
Travel	$ -	$ -	$ -
Supplies	$ 2,833.30	$ -	$ 2,833.30
Equipment	$ -	$ -	$ -
Contractual	7,500.00		$ 7,500.00
Other	$ 93.69	$ -	$ 93.69
Total	$ 789,035.24	$ -	$ 789,035.24

Project 1760 - ARP Capital

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary	$ -	$ -	$ -
Benefits	$ -	$ -	$ -
Travel	$ -	$ -	$ -
Supplies	$ 35,174.00	$ 35,174.00	$ -
Equipment		$ -	$ -
Contractual	$ -	$ -	$ -
Other	19,146.09	$ 19,146.09	$ -
Total	$ 54,320.09	$ 54,320.09	$ -

Project 3318 - Homeless Dental

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary	21,742.15		$ 21,742.15
Benefits	4,558.00	$ -	$ 4,558.00
Travel	$ -		$ -
Supplies	$ -		$ -
Equipment	$ -		$ -
Contractual		$ -	$ -
Other	$ -		$ -
Total		$ -	$ -

Shelter Support Dental - 3320

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary	$ 3,432.77		$ 3,432.77
Benefits	$ 495.09		$ 495.09
Travel	$ -		$ -
Supplies	4,868.03	$ -	$ 4,868.03
Equipment			$ -
Contractual	$ -	$ -	$ -
Other	78.42	$ -	$ 78.42
Total	$ 8,874.31	$ -	$ 8,874.31

Shelter Support Medical - 3319

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary	229,931.57	$ -	$ 229,931.57
Benefits	51,113.13		$ 51,113.13
Travel	2,478.83		$ 2,478.83
Supplies	15,803.23	$ -	$ 15,803.23
Equipment	$ -	$ -	$ -
Contractual	$ -		$ -
Other	10,611.00	$ -	$ 10,611.00
Total	$ 309,937.76	$ -	$ 309,937.76

Glucometers for the Homeless - 2741

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary			$ -
Benefits			$ -
Travel			$ -
Supplies	4,979.31	4,979.31	$ -
Equipment			$ -
Contractual			$ -
Other	$ 20.69	$ 20.69	$ -
Total	$ 5,000.00	$ 5,000.00	$ -

Mobile Unit Purch/Spt - 793

	Expenses through current year March 2025	Expenses through 12/31/2024	Expenses 01/2025 to 03/2025
Salary			$ -
Benefits			$ -
Travel			$ -
Supplies	5,270.52	5,270.52	$ -
Equipment	$ 164,305.00	$ 164,305.00	$ -
Contractual			$ -
Other	$ 2,124.07	$ 2,124.07	$ -
Total	$ 171,699.59	$ 171,699.59	$ -

Thursday, May 22, 2025

Consideration of Approval of the HCHP 2025 Carryover Budget

Attached for review and approval:

- **HCHP 2025 Carryover Budget**

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, AuD, MBA, CCC-A
Chief Executive Officer – Ambulatory Care Services

HARRIS COUNTY HOSPITAL DISTRICT dba Harris Health
BUDGET NARRATIVE
CARRYOVER REQUEST FROM 2024 FUNDS FOR USE IN JANUARY 1, 2025 TO DECEMBER 31, 2025

REVENUE:

	Carryover Federal
FEDERAL GRANT REQUEST	$629,078
TOTAL REVENUE	**$629,078**

EXPENSES:

PERSONNEL	Carryover Federal
ADMINISTRATION	30,095
MEDICAL STAFF	465,440
TOTAL PERSONNEL	**$495,535**
FRINGE	**Carryover Federal**
FICA @ 7.65%	$37,908
Retirement/401K match @ 5%	$24,777
Insurance @ 11.35%	$56,243
TOTAL FRINGE @ 24%	**$118,928**
SUPPLIES	**Carryover Federal**
Dental Supplies: $1,826.875/month x 8 months = $14,615	$14,615
TOTAL DIRECT CHARGES	**$629,078**