HARRISHEALTH

BOARD OF TRUSTEES

Quality Committee

Tuesday, March 11, 2025
12:15 P.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Notice: Some Board Members may participate by videoconference.

Mission

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

AGENDA

I.	**Call to Order and Record of Attendance**	**Ms. Sima Ladjevardian**	**1 min**
II.	**Approval of the Minutes of Previous Meeting** • Quality Committee Meeting – February 11, 2025	**Ms. Sima Ladjevardian**	**2 min**
III.	**Harris Health Safety Message: Minute for Medicine Videos** ***– Dr. Steven Brass and Mr. Mark Fanning*** • Shared Decision Making • Call Don't Fall		**5 min**
IV.	**Consideration of Recommendation for Approval of Revisions to the Harris Health Quality Manual – *Dr. Joseph Kunisch***		**5 min**
V.	**Executive Session**	**Ms. Sima Ladjevardian**	**75 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 Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils ***– Dr. Steven Brass and Dr. Yashwant Chathampally***		*(60 min)*
B.	Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session ***– Mr. Anthony Williams and Ms. Vivian Ho-Nguyen***		*(15 min)*

VI.	**Reconvene**	**Ms. Sima Ladjevardian**	**1 min**
VII.	**Adjournment**	**Ms. Sima Ladjevardian**	**1 min**

HARRIS HEALTH SYSTEM
MINUTES OF THE BOARD OF TRUSTEES
QUALITY COMMITTEE MEETING
Tuesday, February 11, 2025
12:15 PM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Dr. Andrea Caracostis, Committee Chair, called the meeting to order at 12:16 p.m. It was noted that a quorum was present and the attendance was recorded. The meeting may be viewed online through the Harris Health website: http://harrishealthtx.swagit.com/live.	
II. Approval of the Minutes of Previous Meeting	• Quality Committee Meeting – January 7, 2025	**Moved by Ms. Sima Ladjevardian, seconded by Dr. Cody Pyke, and unanimously approved the minutes of the January 7, 2025 meeting.**
III. Harris Health Safety Message: Minute for Medicine Video • Ventilator Associated Pneumonia (VAP)	Dr. Steven Brass, Executive Vice President & Chief Medical Executive, presented a Minute for Medicine video series related to Ventilator Associated Pneumonia (VAP). A copy of the video series is available in the permanent record.	**As Presented.**
IV. Executive Session	At 12:21 p.m., Dr. Caracostis stated that the Quality Committee of the Board of Trustees would go into Executive Session for items IV. 'A through C' as permitted by law under to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §§151.002, 160.007.	
A. Report Regarding Harris Health Correctional Health 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		**No Action Taken.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
B. 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 Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils		**No Action Taken.**
C. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session		**No Action Taken.**
V. Reconvene	At 1:02 p.m., Dr. Andrea Caracostis reconvened the meeting in open session; she noted that a quorum was present and that no action was taken in Executive Session.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
VI. Adjournment	There being no further business, the meeting adjourned at 1:02 p.m.	

I certify that the foregoing are the Minutes of the Meeting of the Quality Committee of the Board of Trustees of the Harris Health System held on February 11, 2025.

Respectfully submitted,

Andrea Caracostis, MD, MPH, Committee Chair

Recorded by Cherry Joseph, MBA

HARRISHEALTH

Tuesday, February 11, 2025
Harris Health Board of Trustees Quality Committee Attendance

COMMITTEE MEMBERS PRESENT	COMMITTEE MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Andrea Caracostis *(Committee Chair)*	Afsheen Davis	
Dr. Cody Pyke		
Sima Ladjevardian		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Alexander Barrie	Louis Smith
Amineh Kostov	Maria Cowles
Dr. Amy Smith	Dr. Matasha Russell
Dr. Asim Shah	Matthew Schlueter
Berrlyn Nelson	Michael Nnadi
Carolynn Jones	Nicholas Bell
Cherry Pierson	Dr. O. Reggie Egins
Derek Curtis	Olga Rodriguez
Ebon Swofford *(Harris County Attorney's Office)*	Patrick Casey
Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*	Randy Manarang
Dr. Esmaeil Porsa *(Harris Health System President & CEO)*	Dr. Sandeep Markan
Dr. Glorimar Medina	Sara Thomas *(Harris County Attorney's Office)*
Dr. Jackie Brock	Shawn DeCosta
Dr. Jennifer Small	Stephanie Garrett
Jennifer Zarate	Dr. Steven Brass
Jocelyn Thomas	Tekhesia Phillips
John Matcek	Dr. Tien Ko
Dr. Joseph Kunisch	Tiffani Dusang
Kiki Teal	Vivian Ho-Nguyen
Dr. Kunal Sharma	Dr. Yashwant Chathampally

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.*

Tuesday, March 11, 2025

Harris Health Safety Message: Minute for Medicine Videos

High-reliability Organization (HRO) Safety Message Videos:

- Shared Decision Making
- Call Don't Fall

Yashwant Chathampally, MD, MSc
Associate CMO & SVP, Quality & Patient Safety

High Reliability Organization (HRO)
Safety Message

Shared Decision Making

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

Board of Trustees Quality Committee
March 11, 2025

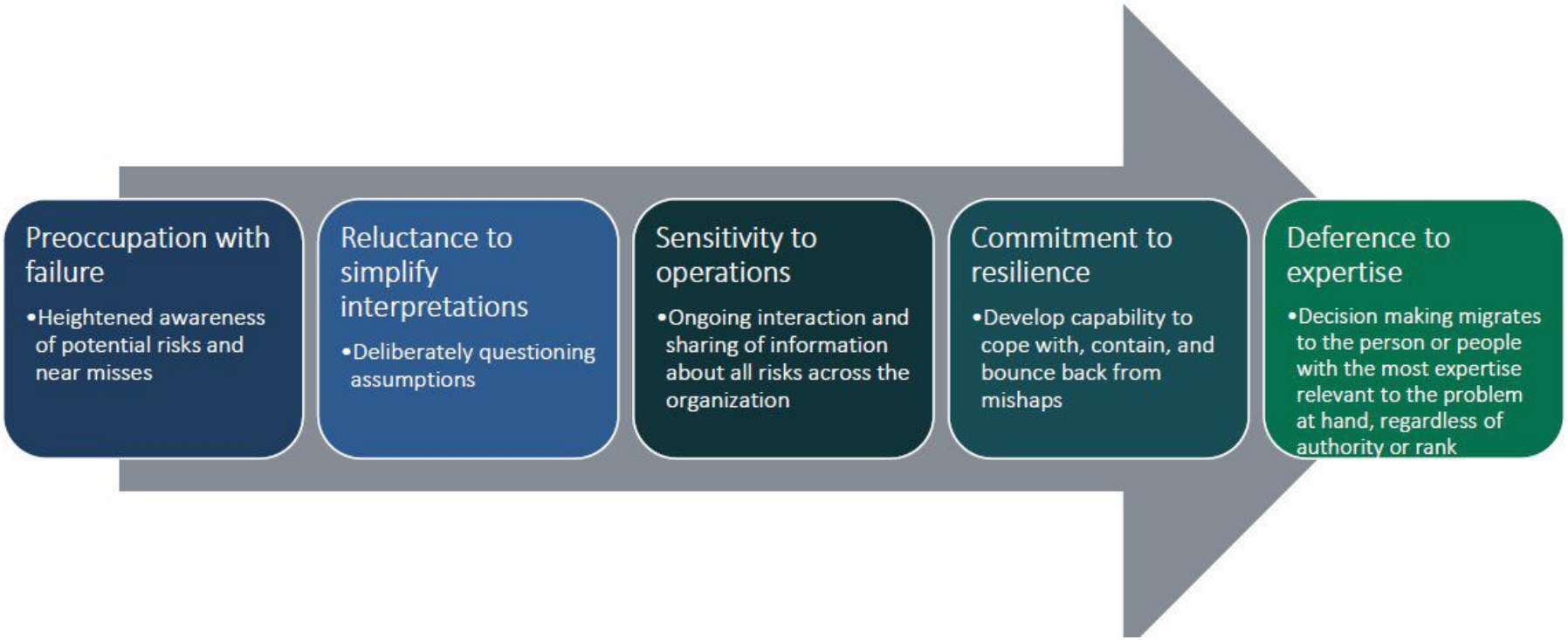
HARRISHEALTH

SAFETY MESSAGE

HARRIS HEALTH SYSTEM | ZERO HARM

Safety 1st. Always.

Five Principles of a High Reliability Organization



HRO Mindset:

Harris Health System Minute For Medicine

Video: Shared Decision Making

- https://youtu.be/FYh3sTG95pQ

High Reliability Organization (HRO) Safety Video

Call Don't Fall

Mark Fanning, MSN, BA, RN
Monica Herrera, RN
Sidney Brown, RN
Ben Taub Hospital

Board of Trustees Quality Committee
March 11, 2025

HARRISHEALTH

HRO Mindset:

- Video: Call Don’t Fall

https://u.pcloud.link/publink/show?code=XZdDdX5ZNXuWHtEJIMX8y3xyOVKYLBn8cQFy

BOARD OF TRUSTEES

Quality Committee

HARRISHEALTH

Tuesday, March 11, 2025

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

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Yashwant Chathampally, MD, MSc
Associate CMO & SVP, Quality & Patient Safety

CY2025 Harris Health Quality Manual Updates
(Voting Required)

Joseph Kunisch, PhD, RN-BC, CPHQ
VP, Quality Programs

Board of Trustees Quality Committee
March 11, 2025

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CY2025 Harris Health Quality Manual
Summary of Updates

- Changed all references to “Harris Health System” to “Harris Health”
- Strengthened reference to the Patient Safety Collaborative (PSC) as part of the Quality Management System with the goal of achieving zero harm
- Removed reference to the Policy and Procedure Committee from the Quality Governance Structure to support the current P&P approval to the full Board of Trustees
- Removed reference to Medical Peer Review as that committee reports out at the full Board of Trustees
- Revised Appendix A “Quality and Patient Safety Organizational Structure” Diagram to reflect the PSC reports directly to the Quality Board of Trustees (QBoT)

Quality Manual - Provided as a separate document

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Quality Manual

20254

Approved by:
Harris Health ~~System~~ Quality Governance Council
Approved: March 19, 2024

Board of Trustees ~~Harris Health System~~Harris Health
Approved: April 25, 2024

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Commented [SE1]: Note to remove all "System" from Manual and only reference as Harris Health

Commented [HAL2]: Will need to update the dates once approved.

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Table of Contents

I. INTRODUCTION

Harris Health ~~System~~ is a community-owned, healthcare system dedicated to providing high-quality, ~~cost-effective~~cost-effective, compassionate, ~~health care~~healthcare to residents of Harris County regardless of their ability to pay. ~~Harris Health System~~Harris Health is a teaching system for Baylor College of Medicine and The University of Texas Health Science Center at Houston (UT Health). Harris Health trains the next generation of healthcare providers, nurses and allied health professionals. A nine (9)-member Board of Trustees appointed by the Harris County Commissioners Court governs ~~Harris Health System~~Harris Health and approves this Manual. The Board of Trustees appoints the ~~Harris Health System~~Harris Health President~~-~~/Chief Executive Officer to oversee operations of the system.

II. PURPOSE

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

III. GUIDING PRINCIPLES

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

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

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

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

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

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

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

IV. JUST AND ACCOUNTABLE CULTURE

It is inevitable that people will make mistakes. Thus, a Just and Accountable Culture creates an open, fair, and learning culture by recognizing that individuals demonstrate certain behaviors, which organizational leaders should identify and manage appropriately. Behavioral choices include Human Error, At-Risk Behavior, and Reckless Behavior.

A Just and Accountable Culture promotes learning so employees are engaged and encouraged to speak up and share near misses, etc. to learn from events and prevent future occurrences.

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

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

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

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

Our Mission:

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

Our Vision:

Harris Health will become the premier public academic healthcare system in the nation.
We Value:

QUALITY

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

VI. STRATEGIC GOALS AND QUALITY OBJECTIVES

~~Harris Health System~~Harris Health leadership, in collaboration with the Board of Trustees and affiliated Medical Staff, has cooperatively developed strategic pillars related to Quality and Patient Safety, People, ~~Harris Health System~~Harris Health, Population Health Management Infrastructure Optimization and Diversity and Inclusion.

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

Strategic Plan Overview:

- Quality and patient safety: Harris Health will become a high-reliability organization (HRO) with quality and patient safety as a core value where zero patient harm is not only a possibility but an expectation.

- People: Harris Health will enhance the patient, employee and medical staff experience and develop a culture of respect, recognition and trust by actively listening to feedback and developing strategies to address high-impact areas of opportunity.

- One ~~Harris Health System~~Harris Health: Harris Health will act as one system in its approach to the management and delivery of healthcare.

- Population health management: Harris Health will measurably improve patient health outcomes by optimizing a cross-continuum approach to health that is anchored in high-impact preventive, virtual and community-based services, deployed in coordination with clinical and social services partners, and underwritten by actionable population health analytics and technology.

- Infrastructure optimization: Harris Health will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety and meet the current and future needs of ~~Harris Health System~~Harris Health patients.

- Diversity, Equity, and Inclusion: Harris Health will ensure equitable access to high-quality care for patients, foster a diverse and inclusive workplace, cultivate and sustain strategic relationships with supplies and community partners, and broaden its reach and understanding of the communities it serves.

The Pathway - A Transformative Model of Patient Care Delivery

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

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VII. SCOPE

The Quality Manual encompasses all Harris Health services that impact patient care, safety, and health outcomes, unless those services are governed by a separate quality manual~~The Quality Manual encompasses all Harris Health System~~Harris Health ~~departments and services (including those furnished under contract or arrangement) that impact patient care, safety, and health outcomes.~~

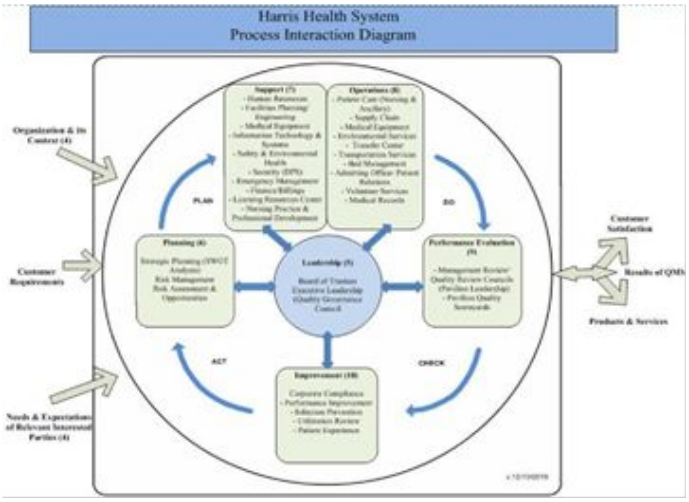
A. Overview:

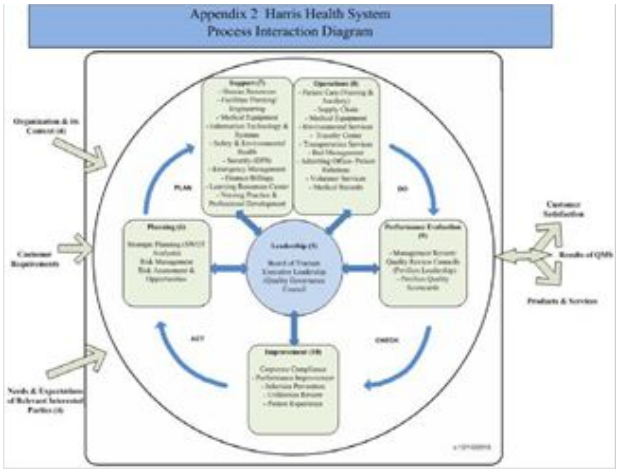
~~Harris Health System~~Harris Health is a community-owned, comprehensive, integrated, healthcare system dedicated to providing high quality, cost effective, compassionate health care to all residents of Harris County regardless of their ability to pay. To fulfill its service mission, ~~Harris Health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

1. Two (2) acute care hospitals
2. Fifteen (15) Community Health Centers;
3. Two (2) Pediatric and Adolescent Health Centers;
4. Seven (7) Homeless Shelter Sites;
5. Mobile Health Fleet;
6. Three (3) Specialty Clinic Sites;
7. Three (3) Same-Day Clinics;
8. Dental Center;
9. Dialysis Center;
10. HIV Clinic;
11. Contracted Outside Medical Services;
12. “Ask My Nurse” 24/7 Telephone Nurse Triage line;
13. Emergency Medical Services Fleet;
14. Ambulatory Surgery Center

B. Process Interaction:

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





C. Key Processes and Support Processes

Patient experience as a process approach can be grouped into 4 key processes:

1. Patient identification and assessment – includes patient intake, triage, registration, and health assessment leading to admission or discharge.

2. Development of treatment plan – includes care and treatment planning, provided

either for inpatient or outpatient.

3. Delivery of care – includes delivery and coordination of care (treatment and ancillary services such as diagnostic, therapeutic, and custodial.

4. Transition of care – includes assessment of treatment plan effectiveness, analysis of patient outcomes, patient status determination to either continue treatment, change treatment or discharge, and patient feedback.

VIII. GOVERNANCE, STRUCTURE, AND LEADERSHIP RESPONSIBILITIES

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

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

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

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

Commented [RL3]: Patient Safety Collaborative needs to be added equivalent to QGC

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

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

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

4. Patient Safety Collaborative (PSC)
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. All functions of the Patient Safety Collaborative Committee are confidential, privileged and protected from disclosure pursuant to Federal and State laws, including but not limited to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code. The Patient Safety Collaborative 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.

~~4.~~5. Pavilion Quality Review Council (QRC)
The QRC provides oversight for the Quality Management System/QAPI Plan at the Pavilion level. Each Pavilion has its own QRC. The QRC has the responsibility and authority to determine t h a t the Quality Management System has been effectively implemented and maintained at the Pavilion level. The QRC acts at the direction of the QGC and reports to the QGC. The QRC is responsible for measurement, monitoring, and analysis of the National Integrated Accreditation for Healthcare Organizations (NIAHO) QM.7 Standard Requirements (SR 4).~~14~~a-SR.~~19~~ 4s quality of care metrics and other regulatory survey findings. The QRCs develop performance goals that are in alignment with the ~~Harris Health System~~Harris Health strategic objectives. In addition, all accredited and certified programs are required to routinely report (minimum of once per year) outcomes and performance metrics to QRC. The different service area Committees are to report up to the QRCs. The QRCs may also initiate performance improvement teams for issues that are unique to the

departments within the pavilion. Refer to Ben Taub Hospital QRC Bylaws, Lyndon B. Johnson Hospital QRC Bylaws, and Ambulatory Care Services QRC Bylaws for their respective membership composition and oversight responsibility.

~~5.~~6. Medical Executive Board and Pavilion Medical Executive Committees
The Medical Executive Board (MEB) is a delegated BOT authority to oversee the operations of the Medical Staff. The Medical Executive Board and Pavilion Medical Executive Committees receive quality information and share Medical Staff quality information at the appropriate ~~Harris Health System~~Harris Health quality forum(s). See Medical Staff Bylaws for the committees' membership composition and oversight responsibility.

~~6.~~7. System Level Committees
~~Harris Health System~~Harris Health has multiple forums with specific functions that support the Quality Management System. When supporting the Quality Management System, these committees act at the direction of the QRC/QGC. These committees include but are not limited to the following:

7. Service Area Committees
The Service Area Committees are responsible for ensuring that quality and safe care is delivered to its patients. Each area committee shall ensure that the service and quality management system is established that includes a leadership structure, key processes, key support processes, outcome metrics, performance improvement processes, and reporting processes from the service delivery up to the board. Each service area committee is responsible for implementing and reviewing the effectiveness of its charter.

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

~~Policy and Procedure Committee~~

9. Structure and Organizational Standards (SOS) Committee
The SOS serves as executive-level decision point of authority for all non-clinical and clinical practice and operations Policies, Procedures, Standards, and Standard Operating Procedures.

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

11. Executive Corporate Compliance Survey Readiness Subcommittee (ECCSR)
This is a subcommittee of the ~~Harris Health System~~Harris Health Executive Corporate Compliance. The subcommittee serves as an oversight body to ensure a state of survey readiness and to maintain compliance with federal, state, local,

accreditation and other certification standards that govern the quality and safe care to Harris Health patients. This committee meets six (6) times annually. The provision of maintaining regulatory compliance is an interdisciplinary, collaborative effort and therefore, a system-wide management approach is implemented across the health system.

12. The Survey Readiness Subcommittee is designed to fulfill the following objectives:
    - Continuously evaluating for compliance to federal, state or local laws and regulations to maintain licensure/accreditation/certification status and fiduciary responsibilities;
    - Taking a proactive stance to developing & implementing policy or procedure to meet the intent of regulatory requirements;
    - Standardizing the process for management of survey activity including staff involvement, awareness, and delineating roles & responsibilities;
    - Identifying opportunities, improve processes and provide resources, as appropriate, to deliver quality and safe care and maintain regulatory compliance; and
    - Developing an approach for achieving an integrated health system

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

      Refer to ECCSR Plan and Charter for additional information.

14. Department/Service Committees/Councils

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

15. Clinical Care Committees (CCC)

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

    A. Identifies and implements specific initiatives and projects that:
       I. Are consistent with the overall goals and purposes of the entire ~~Harris Health System~~Harris Health in advancing the delivery of care to the patient population;
       II. Articulate, clearly, the requisite resources required and the associated work plan;

III. Have a clear, demonstrable end point that results in readily measurable improvements in patient outcomes and/or readily measurable reductions in patient mortality and length of stay; and
IV. Articulate, clearly, the requisite resources required and the associated work plan including an explicitly stated time frame for their completion and implementation.

B. Identifies patient care best practices as supported by scientific evidence and facilitate their usage throughout the system.
C. Works to eliminate unnecessary variations in patient care processes to achieve the highest outcomes in efficiency and safety.
D. Develops and reviews clinical outcomes performance reports and shares them with the providers and pavilions to improve patient care.
~~E.~~ Provides meaningful communication of its initiatives to Harris Health Executives by leveraging the Quality Reporting Council/Committee framework.

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

G. The CCC is composed of the 4 types of members;

a. Chairs- this consists of 2 designated leaders that will guide the committee in the direction of improving overall patient care at Harris Health
b. Voting Members- this consists of designated physicians designated by the Chief Medical Executive and Registered Nurse leaders designated by each Pavilion Chief Nursing Officer (CNO). These members will be the official votes counted for any motions introduced by either of the 2 Chairs. Every voting member may temporarily designate a representative to vote for them when they cannot attend.
c. Non-Voting Members- This consists representatives from various clinical and non-clinical areas that provide input on any topic of discussion. Each assigned non-voting member can pull other staff members from their respective areas to participate to lend their expertise when certain topics are discussed.
d. Non-Voting Ad-hoc Member- This consists of staff members that serve as either ~~back ups~~back-up to the other permanent non-voting members or are added to specific meetings to lend their expertise.
e. Recommendations and Reports
The CCC recommendations and performance improvement reports will be submitted monthly in writing to the Quality Reporting Committees which may consists of Pavilion level QRCs, QGC and Quality Board Subcommittee when appropriate. Within this Quality Assurance and Performance Improvement (QAPI) framework, any additional resources will be requested and assistance with any barriers to performance improvement will be presented.

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

~~17.~~B. Structure
The Appendix B describes and illustrates the structure and flow of quality information within ~~Harris Health System~~Harris Health.

~~18.~~C. Leadership Responsibilities
The ~~Harris Health System~~Harris Health Quality Programs (QP) Department has an integral role in facilitating quality, patient safety, and performance improvement activities and forums. The QP Department collaborates with Medical Staff, ~~Harris Health System~~Harris Health leadership, and staff to facilitate measurement and improvement in an effective and timely manner. The QP Department also assists in the implementation of an interdisciplinary approach and provides quality resources through an integrated delivery network and information management. The QP Department serves as an improvement subject matter expert and support resource. Accountability of metrics and improvements are owned by the leadership of the reporting service and/or department.

Commented [RL6]: I would move these out as they are not committees.

IX. MEASUREMENT, ANALYSIS AND IMPROVEMENT

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

A. Quality Measures
Key performance indicators are identified and monitored at the system, pavilion, and department levels of the organization.

Harris Health follows the guidance referenced in the National Integrated Accreditation for Healthcare Organizations (NIAHO) standard, Quality Management System section 7, 1-~~19~~ 5 (QM.7 SR.1-~~19~~5) to monitor for the effectiveness of the Quality Management System. It also correlates with the ISO (International Standard) 9001:2015 Clause 9 Performance Evaluation.

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

C. Reporting Communication

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

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

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

1. Quality information request, design and approval

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

E. Data Management

1. Data Acquisition/Collection

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

2. Data Sampling

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

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

3. Validation

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

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

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

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

X. QUALITY GOALS

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

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

XI. CONTINUAL IMPROVEMENT (PERFORMANCE IMPROVEMENT)

A. Overview

~~Harris Health System~~Harris Health utilizes improvement cycles to include but not limited to Define- Measure-Analyze-Improve-Control (DMAIC) supported by LEAN Six Sigma methodologies for performance improvement. ~~Harris Health System~~Harris Health shall continually improve its quality management system through the use of the quality policy, quality objectives, audit results, analysis of data, corrective and preventative actions and

management review. System level improvement projects will be initiated and chartered via an effective planning and approval process at QGC. Pavilion level improvement projects will be initiated and chartered via an effective planning and approval process at the pavilion QRC and reported to QGC. A database of ongoing and completed performance improvement and quality improvement initiatives is available in the System PI Project Database (Repository).

B. Models for Improvement

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

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

3. Project Management

The project management approach will be utilized in conducting performance and quality improvement initiatives. The process starts with identification of the gap or need from key performance indicators and other metrics, selection and prioritization of projects are determined by multidisciplinary teams to determine the impact of care and resources available. Identification of the project team includes the executive sponsor, process owner as team lead and project facilitator. The project facilitator shall ensure the project management process is carried out from planning, implementing, monitoring and reporting, closure and project handoff.

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

C. Education/Training

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

D. Coordination and Support

In order to coordinate and support Performance Improvement activities for ~~Harris Health System~~Harris Health shall:

1. Establish a process for selecting and completing PI projects at the service area and system levels.
2. Establish a process for prioritizing PI initiatives based on importance and alignment with the ~~Harris Health System~~Harris Health strategic goals, as well as on the complexity of project management and implementation.
3. Monitor and report the status of PI projects to the QRCs, QGC, and other forum, as appropriate.
4. Establish a process for conducting identified PI projects from initiation, planning, implementing, monitoring, status reporting, to hand-off of project to process owners.
5. Ensure the availability, integrity, accurate analysis and validation of data used to document and evaluate outcomes.
6. Collaborate with PI teams and project sponsors to support the PI initiative through completion and hand-off.
7. Establish and maintain a framework for educating the leaders and staff others on ~~Harris Health System~~Harris Health's PI methodologies for continual quality improvement.
8. Provide consult regarding PI activities at all levels to encourage and support continual improvement.
9. Provide project management and facilitation for PI teams, as needed.

E. Point of Service Performance Improvement

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

XII. PATIENT SAFETY/RISK MANAGEMENT

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

XIII. CONFIDENTIALITY & PRIVILEGE

BOT Quality Committee

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

Commented [KJ7]: Deleted reference to medical peer review per our discussion. Medical Peer Review occurs in the full Board meeting. Not sure if we have to add any other verbiage under this heading

Commented [KJ8]: Deleted per our discussion that the medical peer review process takes place in the full Board Meeting, not in QBoT

Privilege/Confidentiality of Quality Manual Activities

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

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

The records and proceedings of Harris Health departments *that support* the quality and peer review functions of Quality Committees/Councils, such as the Patient Safety/Risk Management and Quality Programs & Accreditation departments are also confidential, legally privileged, and protected from disclosure if prepared by or at the direction of the Quality Committees/Councils, and not kept in the ordinary course of business. All work performed pursuant to this Quality Manual must also comply with state and federal (HIPAA) privacy laws, as well as Harris Health policies and procedures.

XIV. ANNUAL EVALUATION

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

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

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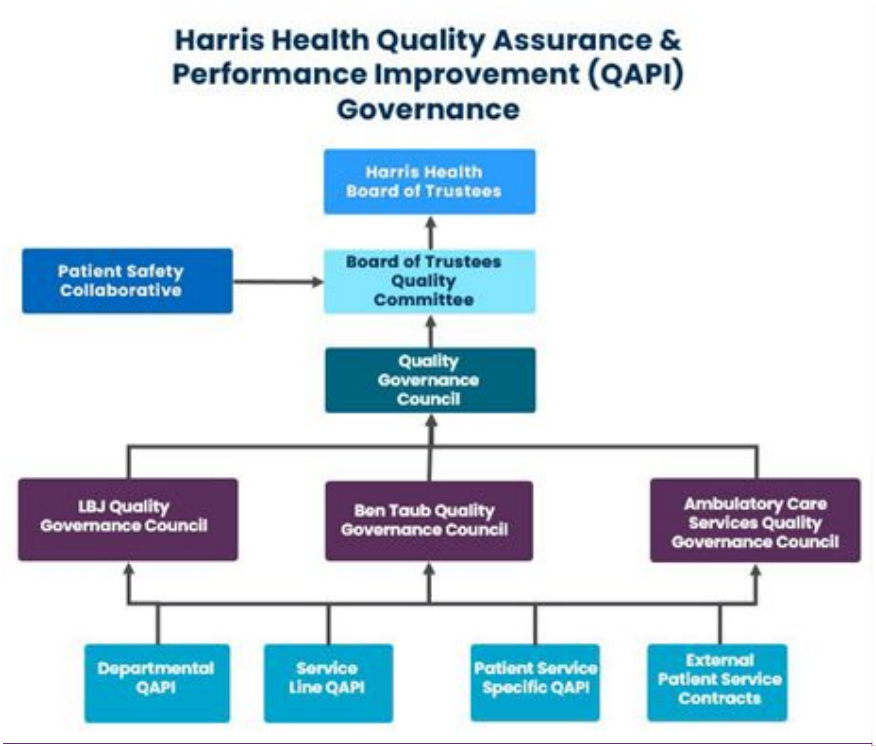
Appendix A

Quality and Patient Safety Organizational Structure



23

Commented [RL9]: Revise so that Patient Safety Collaborative reports to Quality Board of Trustees

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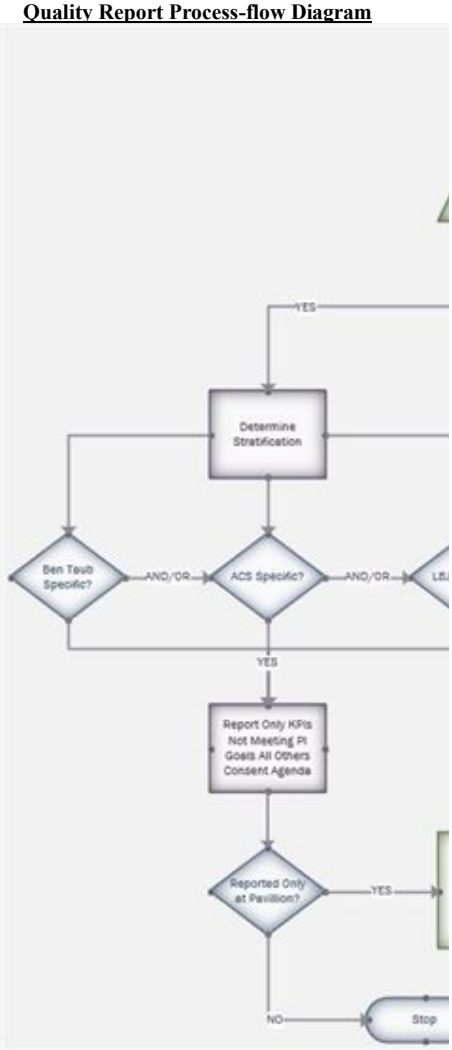
Appendix B

Quality Reporting Procedure

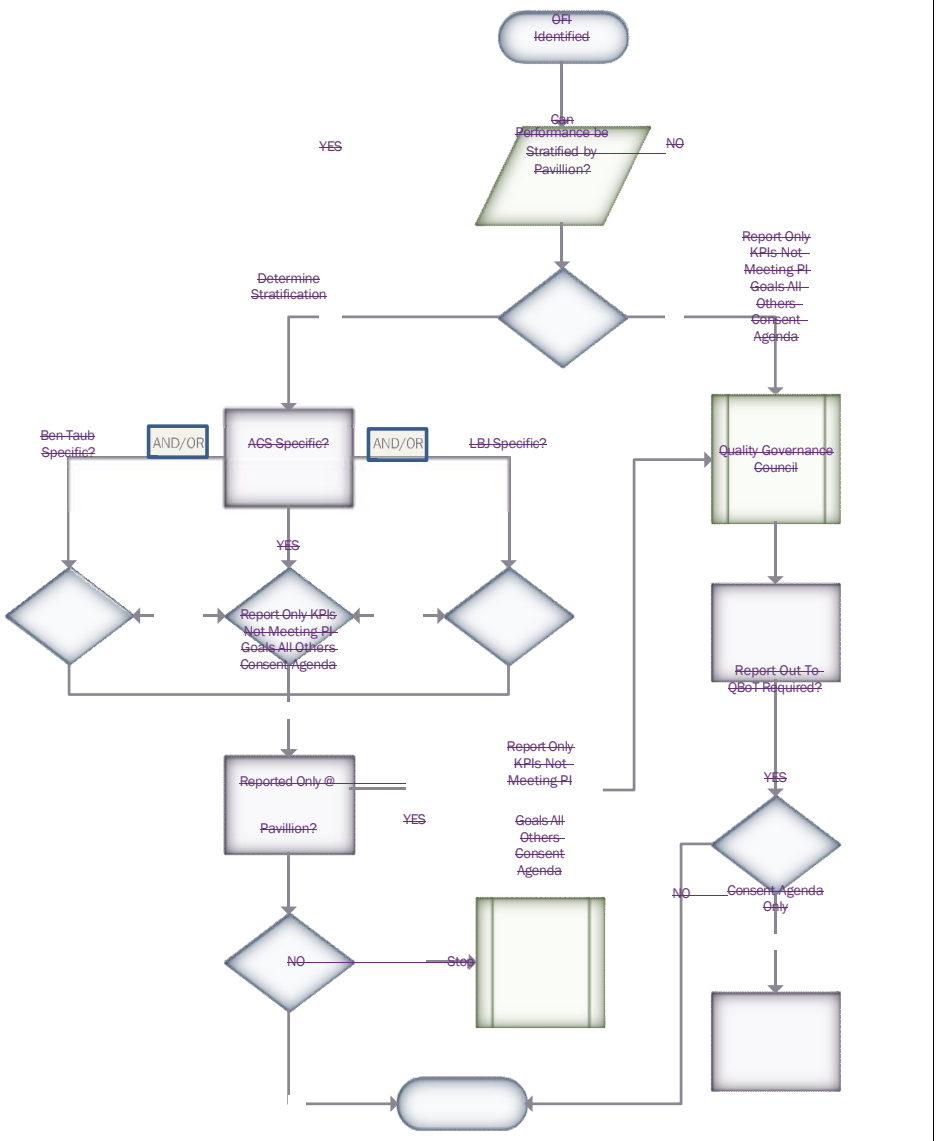
1) Process owners will be responsible for monitoring Key Performance Indicators (KPI) for their area including areas identified for Opportunities For Improvement (OFI)
2) KPIs will focus on patient impacting quality metrics. Operational metrics will only be included when required by accrediting organization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

Quality Report Process-flow Diagram



~~Process Owner Monitors KPIs~~

~~Performance Report Generated~~


OFI Identified
Can Performance be Stratified by Pavillion?
YES
NO
Determine Stratification
Report Only KPIs Not Meeting PI Goals All Others Consent Agenda
Ben Taub Specific?
AND/OR
ACS Specific?
AND/OR
LBJ Specific?
Quality Governance Council
YES
Report Only KPIs Not Meeting PI Goals All Others Consent Agenda
Report Out To QBoT Required?
Report Only KPIs Not Meeting PI
Reported Only @ Pavillion?
YES
Goals All Others Consent Agenda
YES
NO
Consent Agenda Only
NO
Step

26

Consent Agenda Guidance:

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

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

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

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

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

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

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

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

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

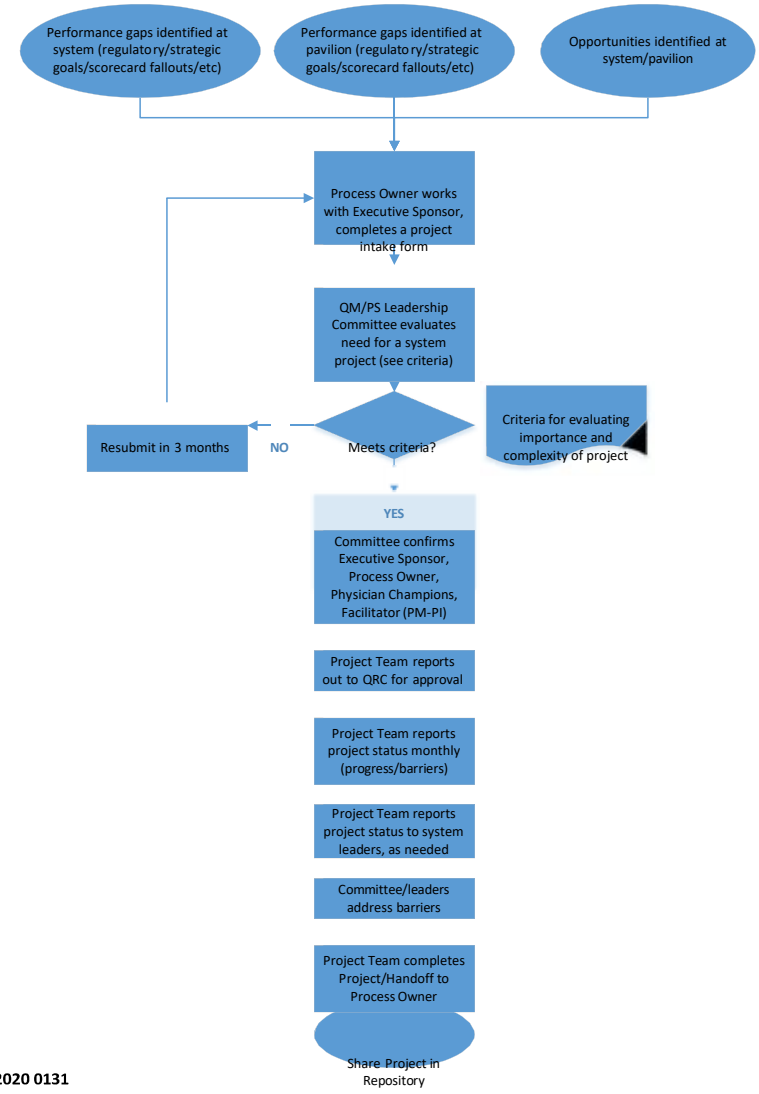
- Approval of the consent agenda by the committee constitutes approval of each of the items listed under the consent agenda portion of the meeting. No separate vote to approve each consent agenda item is required.

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

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

Appendix C

System Performance Improvement Process



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Appendix D

Service Area Committee Charter

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

I. Purpose:

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

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

II. Duties and Responsibilities:

The Committee's responsibilities include:

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

Selecting and conducting performance improvement (PI) initiatives/projects utilizing the PI Project Selection and Completion Process.

- Reviewing and evaluating quality and PI initiatives/projects, innovations, quality improvement plans, and risk reduction activities initiated in response to data fallouts, safety events and/or other negative trends to determine the effectiveness of those activities to address the identified issues/goals.
- Performing, at least annually, a review and evaluation of the Service Area Dashboard for any necessary revisions to established measures/metrics and benchmarks.
- Maintaining oversight of survey readiness for the Service Area, including staying abreast of significant developments relating to regulatory requirements and standards and expectations of accrediting bodies in coordination with the Accreditation/Regulatory Affairs Department.
- Assessing periodically, and no less than annually, the Service Area's oversight of its quality and safety plan as evidenced by its operation in conformance with all Charter requirements and reporting such to the QGC.
- Maintain departmental quality and safety documents as a portion of their respective operational manual as required for survey readiness.

III. Membership

The Committee will be composed of:

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

IV. Meetings, Minutes and Committee Action

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

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

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

V. Amendments

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

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers and Stakeholders, etc.)
06/14/2016	Original 1.0	Reviewed 06/14/16	Approved by ~~Harris Health System~~Harris Health Quality Governance Council
07/14/2016		Reviewed 07/04/16	Approved by ~~Harris Health System~~Harris Health Board of Managers
11/08/2016	2.0	Revised 11/08/16	Approved by ~~Harris Health System~~Harris Health Quality Governance Council
01/25/2017		Reviewed 01/25/2017	Approved by ~~Harris Health System~~Harris Health Board of Managers
02/22/2018		Reviewed 02/22/2018	Approved by ~~Harris Health System~~Harris Health Board of Trustees
3/13/2019		Reviewed 3/13/2019	Approved by ~~Harris Health System~~Harris Health Quality Governance Council
3/13/2019		Reviewed 04/11/2019	Approved by ~~Harris Health System~~Harris Health Board of Trustees
3/10/2020		Reviewed 3/12/2020	Approved by ~~Harris Health System~~Harris Health Quality Governance Council
3/10/2020		Reviewed 3/14/2020	Approved by ~~Harris Health System~~Harris Health Board of Trustees
5/17/2022		Reviewed 5/17/2022	Approved by ~~Harris Health System~~Harris Health Board of Trustees
4/28/2023	3.0	Updated with minor changes in scope and added ECCSR structure	
6/20/2023		Reviewed 6/20/2023	Approved by ~~Harris Health System~~Harris Health Quality Governance Council

9/28/2023		Reviewed 9/28/2023	Approved by ~~Harris Health System~~Harris Health Board of Trustees
3/19/2024		Reviewed 3/19/2024	Approved by ~~Harris Health System~~Harris Health Quality Governance Council
4/9/2024		Reviewed 4/25/2024	Approved by ~~Harris Health System~~Harris Health Board of Trustees

BOARD OF TRUSTEES
Quality Committee

HARRISHEALTH

Tuesday, March 11, 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 Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils.

Yashwant Chathampally, MD, MSc
Associate CMO & SVP, Quality & Patient Safety

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BOARD OF TRUSTEES
Quality Committee

HARRISHEALTH

Tuesday, March 11, 2025

Executive Session

Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session.

Carolynn Jones, JD, CHC
Executive Vice President, Chief Compliance and Risk Officer

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