BOARD OF TRUSTEES

Public Meeting Agenda

HARRISHEALTH

Wednesday, June 10, 2026
9:00 AM
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 public, integrated health system dedicated to improving the health of our communities by delivering high-quality, person-centered care in collaboration with community and academic partners.

AGENDA

I. Call to Order and Record of Attendance	**Dr. Andrea Caracostis**	**2 min**
II. Approval of the Minutes of Previous Meeting	**Dr. Andrea Caracostis**	**2 min**
• Board Meeting – May 13, 2026		
III. Announcements / Special Presentations	**Dr. Andrea Caracostis**	**15 min**
A. CEO Report Including Special Announcements **– *Dr. Esmaeil Porsa***		*(10 min)*
• Harris Health's Trauma Survivors Event • June 13th Settegast Health Fair • Values Campaign		
B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements		*(5 min)*
IV. Public Comment	**Dr. Andrea Caracostis**	**3 min**
V. Executive Session	**Dr. Andrea Caracostis**	**50 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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session ***– Dr. Andrea Caracostis and Dr. Thomas Cummins***		*(10 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 the 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, with Credentialing Discussion and Operational Updates, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007, Tex. Health & Safety Code Ann. §161.032 and Tex. Govt Code Ann . §551.071 to Receive Peer Review and/or Medical Committee Report, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session – ***Dr. O. Reggie Egins*** *(10 min)*

D. Consultation with Attorney Regarding Harris Health's Medical School Affiliation and Support Agreements, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action Upon Return to Open Session – ***Mr. Louis Smith and Ms. Sara Thomas*** *(10 min)*

E. Consultation with Attorney Regarding Prevailing Wages, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session – ***Ms. Sara Thomas*** *(10 min)*

VI. Reconvene to Open Meeting — **Dr. Andrea Caracostis** — **3 min**

VII. General Action Item(s) — **Dr. Andrea Caracostis** — **18 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 (NP) / Physician Assistant (PA) General Clinical Privileges – ***Dr. Kunal Sharma*** *(2 min)*
3. Consideration of Approval of Changes to the Obstetrics/Gynecology (OB/GYN) Clinical Privileges – ***Dr. Kunal Sharma*** *(2 min)*
4. Review and Discussion Regarding the Harris Health Staffing Advisory Committees Semi -Annual Evaluation of the Nurse Staffing Plan and Aggregate Staffing Variance – ***Dr. Jackie Brock*** *(10 min)*

B. General Action Item(s) Related to Quality: Correctional Health Medical Staff

1. Consideration of Approval of Credentialing Changes for Members of Harris Health Correctional Health Medical Staff – ***Dr. O. Reggie Egins*** *(2 min)*

VIII. New Items for Board Consideration — **Dr. Andrea Caracostis** — **37 min**

A. Discussion Regarding Prevailing Wages – ***Mr. Louis Smith*** *(10 min)*

B. Consideration of Approval of Staffing Plans and Payment for the Contracted Services Specified in the Harris Health Operating and Support Agreement with Baylor College of Medicine (BCM) for the Contract Year Ended June 30, 2027 – ***Ms. Victoria Nikitin and Mr. Louis Smith*** *(5 min)*

C. Consideration of Approval of Staffing Plans and Payment for the Contracted Services Specified in the Harris Health Affiliation and Support Agreement with the University of Texas Health Science Center at Houston (UT Health) for the Contract Year Ended June 30, 2027 ***Ms. Victoria Nikitin and Mr. Louis Smith*** *(5 min)*

D. Consideration of Approval of a Resolution Setting the Rate of Mandatory Payment for the Harris County Hospital District Local Provider Participation Fund ***Ms. Victoria Nikitin*** *(10 min)*

E. Presentation of the Harris County Hospital District 401(k) and Pension Plan Independent Auditors Reports and Overview for the Fiscal Year Ended December 31, 2025 ***Mr. Ryan Singleton, Forvis Mazars*** *(5 min)*

1. Consideration of Acceptance of the Harris County Hospital District 401(k) Plan Independent Auditors Report and Financial Statements for the Years Ended December 31, 2024, and 2025 ***Mr. Ryan Singleton, Forvis Mazars*** *(1 min)*

2. Consideration of Acceptance of the Harris County Hospital District Pension Plan Independent Auditors Report and Financial Statements for the Years Ended December 31, 2024, and 2025 ***Mr. Ryan Singleton, Forvis Mazars*** *(1 min)*

IX. Strategic Discussion — Dr. Andrea Caracostis — 45 min

A. Harris Health Strategic Plan Initiatives

1. Presentation Regarding the Harris Health Leapfrog Spring Update ***Dr. Thomas Cummins*** **[Strategic Pillar 1:** Quality and Patient Safety**]** *(10 min)*

2. Presentation Regarding Harris Healths Technology Roadmap ***Mr. Ron Fuschillo*** **[Strategic Pillar 5:** System Optimization**]** *(10 min)*

3. Presentation Regarding the Harris Health Ambulatory Care Services (ACS) Facilities Strategic Plan ***Dr. Jennifer Small*** **[Strategic Pillar 6:** Access**]** *(15 min)*

B. Committee Reports *(10 min)*

- May 26, 2026 – Quality Committee ***– Dr. Andrea Caracostis***
- May 28, 2026 – Budget & Finance Committee ***– Ms. Ingrid Robinson***
- May 28, 2026 – Compliance & Audit Committee ***– Ms. Carol Paret***

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

A. Consent Purchasing Recommendations

1. Consideration of Approval of Purchasing Recommendations (Items A1 through A13 of the Purchasing Matrix) ***Ms. Kimberly Williams and Mr. Jack Adger, Harris County Purchasing Office*** **[See Attached Purchasing Expenditure Summary: June 10, 2026]**

B. Consent Grant Recommendations

1. Consideration of Approval of Grant Recommendations (Items B1 through B2 of the Grant Matrix) ***Dr. Jennifer Small (B1) and Dr. Jackie Brock (B2)*** **[See Attached Grant Matrix: June 10, 2026]**

C. Consent Contract Recommendations

1. Consideration of Approval of Contract Recommendations (Items C1 through C4 of the Contract Matrix) ***Mr. Ron Fuschillo (C1), Ms. Sara Thomas (C2-C3) and Dr. Amy Smith (C4)***
[See Attached Contract Matrix: June 10, 2026]

D. Consent Governing Body and Committee Recommendations

1. Consideration of Approval of the Amended Governing Body Bylaws for the Ambulatory Surgical Center ***– Mr. Matthew Reeder and Dr. Scott Perry***
[Ambulatory Surgical Center at LBJ Governing Body]

2. Consideration of Acceptance of the Harris Health Second Quarter Fiscal Year 2026 Investment Report ***– Ms. Victoria Nikitin***
[Budget & Finance Committee]

3. Consideration of Acceptance of the Harris Health First Quarter Calendar Year 2026 Pension Plan Report ***– Ms. Victoria Nikitin***
[Budget & Finance Committee]

E. New Consent Items for Board Approval

1. Consideration of Acceptance of the Harris Health April 2026 Financial Report Subject to Audit ***Ms. Victoria Nikitin***

2. Consideration of Approval to Utilize the Construction Manager at Risk (CMAR) Delivery Method for the Construction of the Ben Taub Hospital Expansion ***Mr. Patrick Casey***

3. Consideration of Approval of the Harris Health Policy 3.43 Board of Trustees Member Conflict of Interest and Nepotism ***Ms. Sara Thomas***

4. Consideration of Approval of the Harris Health Policy 3.06 Delegation of Duties of the President and Chief Executive Officer ***Ms. Sara Thomas***

5. Consideration of Approval of the Renewal of Dr. Tien Kos Term of Appointment as Chief of Staff for the LBJ Hospital ***Dr. Glorimar Medina***

6. Consideration of Approval of the Renewal of Dr. Sandeep Markans Term of Appointment as Chief of Staff for the BT Hospital ***Dr. Glorimar Medina***

F. Consent Reports and Updates to the Board

1. Bi-monthly 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** — **10 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*** *(8 min)*

- HCHP June 2026 Operational Update
- National Board Appointment of HCHP Director

B. Consideration of Approval of a HCHP Board Authority Report ***– Dr. Jennifer Small and Ms. Tracey Burdine*** *(1 min)*

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

XII. Executive Session — **Dr. Andrea Caracostis** — **20 min**

F. Review of the Health Care for the Homeless Program (HCHP) Quality Management Report, Pursuant to Tex. Occ. Code Ann. §151.002 and Tex. Health & Safety Code §161.032, Including Consideration of Approval of the HCHP Quality Management Report Upon Return to Open Session ***Dr. Jennifer Small and Ms. Tracey Burdine*** *(5 min)*

G. Discussion Regarding Committee Reviewed Reports, Pursuant to Tex. Govt 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 Four Months Ending April 30, 2026, 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, 2025, Pursuant to Tex. Gov't Code Ann. §551.085 ***– Ms. Lisa Wright, CEO, Ms. Anna Mateja, CFO, Community Health Choice***

H. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements, Including Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §551.071, and Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Carolynn Jones*** *(10 min)*

XIII. Reconvene — **Dr. Andrea Caracostis** — **4 min**

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

MINUTES OF THE HARRIS HEALTH BOARD OF TRUSTEES
Board Meeting
Wednesday, May 13, 2026
9:00 A.M.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
I. Call to Order and Record of Attendance	The meeting was called to order at 9:01 AM by Ms. Carol Paret, Presiding Officer. A quorum was present. Some Board members attended in person, while others joined via video conference in accordance with state law and Harris Health's videoconferencing policy. Only participants scheduled to speak were provided with dial-in information. All others wishing to view the meeting were advised to access the meeting online through the Harris Health website: http://harrishealthtx.swagit.com/live. Attendance was recorded and is appended to the archived minutes.	**A copy of the attendance is appended to the archived minutes.**
II. Approval of the Minutes of Previous Meeting • Board Meeting – April 8, 2026	Ms. Carol Paret, Presiding Officer, presented the minutes of the Board meeting held on April 8, 2026 for approval. A copy of the minutes is available in the permanent record.	**Motion No. 26.05-59** **Moved by Ms. Sima Ladjevardian, seconded by Ms. Libby Viera – Bland, and unanimously passed that the Board approve the minutes of April 8, 2026, Board meeting. Motion carried.**
III. Announcements/ Special Presentations		
	A. CEO Report Including Special Announcements • Go-Live of Harris Health's Patient Flow Command Center • Spring 2026 Leapfrog Quality and Patient Safety Scores Update • New Harris Health Leadership Dr. Esmaeil Porsa, President and Chief Executive Officer, presented the CEO Report and provided special announcements. Dr. Porsa recognized Ms. Julie Cromeens as the new Senior Vice President, Corporate Communications and Brand Strategy, and Ms. Lindsey Lanagan, Vice President, Local Public Policy and Governmental Relations. Dr. Porsa announced the go-live of the Harris Health Patient Flow Command Center (PFCC) and stated that the system represents a major operational advancement designed to centralize real-time patient flow management across Harris Health facilities.	**As Presented.**

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
	Dr. Porsa explained that the PFCC integrates bed management, transfer coordination, and hospital capacity oversight across Ben Taub Hospital, LBJ Hospital, and affiliated sites, and stated that the system is expected to improve throughput, reduce emergency department boarding times, and enhance system-wide efficiency. Dr. Porsa further presented the Spring 2026 Leapfrog Quality and Patient Safety Scores and stated that Lyndon B. Johnson (LBJ) Hospital received an "A" rating while Ben Taub Hospital received a "B" rating.	
	B. Board Member Announcements Regarding Board Member Advocacy and Community Engagements There were no Board member announcements.	
IV. Public Comment	Ms. Amy Zachmeyer, Executive director, New Economy for Working Houston, addressed the Board and stated concerns regarding alleged wage theft, worker intimidation, and retaliation on construction projects, and urged stronger enforcement of labor protections. Mr. Hany Khalil, Executive Director, Texas Gulf Coast AFL-CIO, addressed the Board and stated that contractors on Harris Health projects were allegedly engaging in systemic wage violations and called for enhanced oversight. Mr. Lacy Wolf, Business Manager, Heat & Frost Insulators & Allied Workers, Local 22, stated concerns regarding apprenticeship classification, wage compliance, and worker protections, and requested stronger accountability measures. Mr. Rafael Rivas, SMART local union 54, alleged prevailing wage underpayment affecting multiple workers on Harris Health construction sites. Mr. Rico Sanchez, SMART local union 54, expressed support for contractor accountability measures and recommended increased inspection of subcontractor selection practices. Ms. Kathryn Mecredy, Labor Advocate Law Firm, stated that she represented a worker alleging unpaid wages and requested expanded payroll review and enforcement action.	**As Presented.**
V. Executive Session	At 9:22 AM, Dr. Andrea Caracostis stated that the Board would enter Executive Session for Items V. A through D 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.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATION
	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, Including 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 the Harris Health Medical Staff Upon Return to Open Session	**No action taken.**
	C. Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, with 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, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session	**No action taken.**
	D. Consultation with Attorney Regarding Prevailing Wages, 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	**No action taken.**
VI. Reconvene to Open Meeting	At 10:08 AM, Dr. Andrea Caracostis reconvened the meeting in open session, noting that a quorum was present and no action was taken during 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. Asim Shah, Vice Chair of the Medical Executive Board, presented credentialing changes for members of the Harris Health Medical Staff for May 2026. He reported that there were 23 initial appointments, zero reappointments, 5 changes of privileges and 9 resignations. Copies of the credentialing report were available in the permanent record.	**Motion No. 26.05-60** **Moved by Ms. Carol Paret, seconded by Ms. Sima Ladjevardian, 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 of Harris Health Correctional Health, presented credentialing changes for Correctional Health Medical Staff and stated 4 initial appointments and no resignations. Copies of the credentialing report were available in the permanent record.	**Motion No. 26.05-61** **Moved by Mr. Paul Puente, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda item VII.B.1. Motion carried.**
VIII. Strategic Discussion		
	A. Harris Health Strategic Plan Initiatives	
	1. Presentation Regarding Skilled Trade Protections for Bond-Funded Construction Contracts Mr. Louis Smith, Senior Vice President, Chief Operating Officer, delivered a presentation regarding updates related to skilled trade protections and prevailing wage compliance. He stated that Harris Health requires prevailing wage compliance, OSHA safety adherence, apprenticeship utilization, and certified payroll reporting for all bond-funded projects. Mr. Smith further stated that compliance monitoring is conducted through internal oversight and external monitoring partners. He shared that ongoing monitoring systems are in place to track contractor compliance and that corrective action processes are utilized when issues are identified. Additionally, Mr. Smith mentioned that wage compliance concerns raised through reporting channels are under continued review and evaluation.	**As Presented.**

	2. Update Regarding Prevailing Wage Matters Mr. Louis Smith provided an update regarding the Prevailing Wages Matter. Dr. Porsa reaffirmed Harris Health's continued commitment to prevailing wage enforcement and contractor accountability. He stated that oversight mechanisms remain active and that enhancements to monitoring processes are under consideration.	**As Presented.**
	3. Presentation Regarding Harris Health Second Quarter Capital Projects Update Ms. Victoria Nikitin, Executive Vice President, Chief Financial Officer, presented the Second Quarter Capital Projects Update. She stated that the bond-funded capital program remains financially stable and that approximately $819 million has been expended to date. Ms. Nikitin stated that the next bond issuance is scheduled for June 2026, subject to market conditions. Mr. Smith provided an overview of major capital projects, including hospital expansion, facility modernization, and infrastructure improvements across Harris Health campuses. Copies of the presentations were included in the permanent record. **Note:** Items VIII.A.1 through A.3. were presented together.	**As Presented.**
	4. Presentation Regarding an Overview of the Harris Collaborative, a Multi-Organizational Governance and Alignment Body Designed to Advance Prevention-Focused Health Improvements Dr. Amy Smith, Senior Vice President, Chief Health Officer, and Dr. Himika Rahman, Director, Health Disparities, presented an Overview of the Harris Collaborative initiative. Dr. Rahman stated that the initiative is a cross-sector governance structure designed to align healthcare and public health organizations to improve population health outcomes. She stated that participating organizations include Harris Health, Harris County Public Health, Houston Health Department, The Harris Center, and Community Health Choice. Dr. Rahman stated that the initial Integrated Care Cohort will focus on cardiovascular health in Northeast Houston, with an emphasis on hypertension prevention and management. Dr. Rahman further stated that performance metrics are in development. Dr. Porsa stated that initial measurable outcomes are expected within approximately one year. A copy of the presentation is available in the permanent record.	**As Presented.**

	5. Presentation Regarding Harris Health Human Resources Updates Mr. Keith Manis, Senior Vice President, HR Strategy & Talent Management, presented the Human Resources update and stated that the Harris Health employee health plan continues to demonstrate strong cost containment performance relative to industry benchmarks. He stated that utilization trends show increased costs in oncology, gastrointestinal care, and pharmacy expenditures, though overall performance remains stable due to governance oversight. Mr. Manis presented the "Cashable" employee financial wellness program and stated that more than 5,400 loans totaling approximately $20.6 million have been issued since program inception, supporting employee financial stability and reducing reliance on high-interest lending. Ms. Jamie Lard, Vice President, HR Operations & Service Delivery, further presented workplace safety and violence prevention initiatives and stated that Harris Health maintains a multidisciplinary governance structure addressing workplace violence prevention, incident response, and employee support systems. She stated that support resources include crisis intervention teams, Code Lavender rooms, chaplaincy services, peer support programs, and employee assistance resources. Ms. Jai McBride, Administrative Director, Employee Experience & Culture, concluded with employee engagement survey results and stated that the survey achieved a 78 percent response rate with an overall engagement score of 81. She stated that leadership action plans were developed across departments to address feedback themes, including communication, engagement, and workplace transparency. A copy of the presentation is available in the permanent record.	**As Presented.**
	B. Committee Reports • April 21, 2026 – Governance Committee • April 21, 2026 – Quality Committee • April 23, 2026 – Joint Conference Committee Ms. Sima Ladjevardian reported that the Governance Committee met on April 21, 2026. The Committee received updates regarding improved Board attendance, consistent quorum achievement, and the positive impact of moving regular Board meetings to the second Wednesday of each month. The Committee also reviewed videoconferencing requirements and discussed measures to strengthen compliance with state law, including clearer instructions for remote participation, voting procedures, and attendance verification. Ms. Sara Thomas, Chief Legal Officer, provided an educational presentation regarding fiduciary and legal duties of hospital district trustees, emphasizing the Board's responsibilities related to care, loyalty, oversight, and obedience.	**As Presented.**

	The Committee also discussed upcoming governance education opportunities, including the Texas Healthcare Trustees Conference and trustee certification programs, and recognized Dr. Andrea Caracostis for receiving the Texas Healthcare Trustees Founders Award. Dr. Caracostis reported that the Quality Committee met on April 21, 2026. The Committee reviewed educational materials regarding hand hygiene and its role in preventing healthcare-associated infections and protecting patient safety. Members also received an update on the revised Harris Health Quality Manual, which has been aligned with the 2026–2030 Strategic Plan to strengthen quality governance, oversight, and organizational readiness for regulatory surveys. Dr. Caracostis further reported that the Joint Conference Committee met on April 23, 2026. The Committee received Physician Leadership and Chiefs of Staff reports highlighting continued collaboration among Harris Health administration, physician leaders, and academic partners with a focus on patient safety, operational excellence, and physician engagement. Leadership also provided updates on major capital projects, including the new LBJ Hospital campus and the Ben Taub Hospital expansion, both of which are expected to enhance healthcare access and delivery throughout the community. Additional discussions included efforts to improve supervision and communication practices, expand ambulatory and specialty care services, improve patient throughput, advance health equity initiatives, and strengthen community outreach. The Committee also reviewed innovation and technology initiatives, including Epic system enhancements, AI-assisted clinical documentation tools, and workforce development strategies intended to improve both patient care and provider experience.	
IX. New Items for Board Consideration		
	A. Approval for Funding of $73,000,000 for the Harris County Hospital District Pension Plan for Calendar Year 2026 Ms. Victoria Nikitin presented the request for approval of funding in the amount of $73,000,000 for the Harris County Hospital District Pension Plan for Calendar Year 2026. She explained that the annual contribution is necessary to support the long-term solvency of the pension fund and is consistent with actuarial requirements and the organization's financial stewardship practices. Ms. Nikitin noted that the pension plan experiences annual inflows and outflows and that the District has historically supplemented the fund through annual contributions to ensure that benefit distributions and plan obligations can be met while maintaining the fund's financial stability. She further stated that the proposed contribution amount reflects the District's ongoing commitment to preserving the health of the pension plan and that there are no material changes from the prior year's funding request.	**<u>Motion No. 26.05-62</u>** **Moved by Ms. Libby Viera - Bland, seconded by Ms. Sima Ladjevardian, and unanimously passed that the Board approve agenda item IX.A. Motion carried.**

X. Consent Agenda Items		
	A. Consent Purchasing Recommendations	
	1. Approval of Purchasing Recommendations (Items A1 through A20 of the Purchasing Matrix) A copy of the purchasing agenda is available in the permanent record.	**<u>Motion No. 26.05-63</u>** **Moved by Mr. Paul Puente, seconded by Ms. Carol Paret, and unanimously passed that the Board approve the purchasing recommendations (Items A1 through A20 of the Purchasing Matrix). Motion carried.**
	B. Consent Contract Recommendations	
	1. Approval of the 2026 Harris Health Quality Manual	**<u>Motion No. 26.05-64</u>** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**
	C. Consent Grant Recommendations	
	1. Approval of a Grant Recommendation (Item C1 of the Grant Matrix)	**<u>Motion No. 26.05-64</u>** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**
	D. Consent Contract Recommendations	
	1. Approval of Contract Recommendations (Items D1 – D5 of the Contract Matrix)	**<u>Motion No. 26.05-64</u>** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**

	E. New Consent Items for Board Approval	
	1. Acceptance of the Harris Health March 2026 Quarterly Financial Report Subject to Audit	**Motion No. 26.05-64** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**
	2. Approval to Acquire Real Property for the New Greenspoint Health Center	**Motion No. 26.05-64** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**
	3. Approval of the Memorialization and Recognition of a Petition Provided by The Metropolitan Organization (TMO) Houston in Support of the Ben Taub Expansion	**Motion No. 26.05-64** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera - Bland, and unanimously passed that the Board approve agenda items X.B. through E. Motion carried.**
XI. Item(s) Related to the Health Care for 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 May 2026 Operational Update Ms. Tracey Burdine, Director of Ambulatory Care Services (ACS), presented the HCHP May 2026 Operational Update, which included the Productivity Report, proposed change in scope for dental services, the 2026 Quality Management Plan, the 2026 Service Area Analysis Report, the 2026 Needs Assessment Report, and the First Quarter 2026 Budget Summary.	**Motion No. 26.05-65** **Moved by Ms. Libby Viera – Bland, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda items XI.A. Motion carried.**

Ms. Burdine reported that through March 2026, HCHP served 2,295 unduplicated patients and completed 6,456 visits. She stated that service utilization continued to demonstrate the significant healthcare needs of individuals experiencing homelessness and other vulnerable populations throughout Harris County.

Dr. Jennifer Small, Chief Executive Officer, ACS, provided an update regarding dental services and reported that the existing dental mobile unit was no longer operational. She stated that HCHP remains committed to maintaining dental services for individuals experiencing homelessness and plans to replace the unit using non-federal funding sources. Dr. Small explained that the replacement mobile unit would expand access to dental services throughout Harris County while maintaining services for the homeless population. She emphasized that the proposed changes would not reduce services to existing patients but would allow the organization to broaden its community impact and address ongoing dental care needs.

Ms. Burdine presented a request to remove the dental mobile unit from the Health Resources and Services Administration (HRSA), approved scope and Form 5B while replacement plans are pursued. She reported that dental services will temporarily be provided at fixed-site locations, including Army House and Star of Hope Cornerstone, to ensure continuity of care.

Ms. Burdine also presented the 2026 Quality Management Plan and reported that the plan includes enhancements to governance, oversight, reporting structures, and patient safety initiatives. She stated that the plan strengthens accountability, reinforces high-reliability principles, and supports continuous quality improvement efforts throughout the program.

Ms. Burdine presented the 2026 Service Area Analysis Report, noting that the annual review confirmed HCHP's strategic placement of services within areas of greatest need and demonstrated effective service coverage without duplication of services provided by other organizations. She reported that the largest concentration of patients continued to be located in the Sunnyside area and downtown Houston, with the top service areas accounting for a majority of the patient population served.

Ms. Burdine further reviewed demographic and utilization findings, reporting that HCHP continues to serve a population experiencing significant poverty, lack of insurance coverage, housing instability, and a high prevalence of chronic medical and behavioral health conditions. She stated that these factors continue to reinforce the importance of HCHP's role as a safety-net healthcare provider.

Ms. Burdine presented the findings of the 2026 Needs Assessment and reported that ongoing barriers to healthcare access include financial hardship, transportation limitations, lack of

	insurance coverage, provider shortages, limited dental and behavioral health capacity, and delays in specialty care referrals. She stated that dental services and behavioral health services remain the most significant unmet needs identified among the population served. She also reported that previously identified provider vacancies had been filled and that newly hired staff were completing credentialing and onboarding processes. During the discussion, Board members emphasized the importance of strengthening partnerships with community organizations and workforce development programs to connect individuals experiencing homelessness with employment opportunities and supportive services that may improve long-term outcomes and self-sufficiency. In response to the assessment findings, Ms. Burdine outlined HCHP's strategic priorities, including expanding clinical access through outreach and mobile services, evaluating extended clinic hours, assessing provider capacity at high-volume locations, strengthening care coordination efforts, expanding behavioral health services, and pursuing funding opportunities to support replacement of the dental mobile unit. She also reported plans to enhance referral navigation and patient support services through the addition of care coordination resources. Ms. Burdine concluded with the First Quarter 2026 Budget Summary and reported that expenditures remain aligned with operational expectations and approved budget priorities. She stated that personnel and fringe benefits continue to represent the largest expenditure category and that overall spending remains consistent with planned program activities and service delivery needs. Copies of the presentations and supporting documentation were included in the permanent record. **Note:** Items XI. A through F were presented together and considered separately for Board action.	
	B. Approval of an HCHP Change in Scope to Remove the Dental Mobile Unit from the Health Resources and Services Administration (HRSA) Form B	**Motion No. 26.05-66** **Moved by Ms. Carol Paret, seconded by Ms. Libby Viera – Bland, and unanimously passed that the Board approve agenda items XI.B. Motion carried.**
	C. Approval of the HCHP 2026 Quality Management Plan	**Motion No. 26.05-67** **Moved by Mr. Paul Puente, seconded by Ms. Libby Viera – Bland, and unanimously passed that the Board approve agenda items XI.C. Motion carried.**

	D. Approval of the HCHP 2025 Service Area Analysis Report	**Motion No. 26.05-68** **Moved by Mr. Paul Puente, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda items XI.D. Motion carried.**
	E. Approval of the HCHP 2026 Needs Assessment Report	**Motion No. 26.05-69** **Moved by Ms. Libby Viera – Bland, seconded by Mr. Paul Puente, and unanimously passed that the Board approve agenda items XI.E. Motion carried.**
	F. Approval of the HCHP First Quarter Calendar Year 2026 Budget Summary Report	**Motion No. 26.05-70** **Moved by Ms. Libby Viera – Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda items XI.F. Motion carried.**
XII. Executive Session	At 11:49 AM, Dr. Andrea Caracostis stated that the Board would enter Executive Session for Items XII. 'E through I' as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Gov't Code Ann. §§551.071 and 551.085.	
	E. Consultation with Attorney, Pursuant to Tex. Gov't Code Ann. §551.071, Including Possible Action Regarding Ratification and/or Approval to Participate in the Remnant Defendants National Opioid Settlement Upon Return to Open Session ***Motion:*** *Approval to authorize the ratification and/or approval for Harris Health to Participate in the Remnant Defendants National Opioid Settlement. President/CEO of Harris Health or his designee is authorized to execute any agreement, release, or any other necessary documents to effectuate this Ratification/Approval.*	**Motion No. 26.05-71** **Moved by Ms. Libby Viera – Bland, seconded by Ms. Carol Paret, and unanimously passed that the Board approve agenda items XII.E. Motion carried.**
	F. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Unaudited Financial Performance for the Three Months Ending March 31, 2026, Pursuant to Tex. Gov't Code Ann. §551.085	**No action taken.**
	G. Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Investment Report for the Three Months Ending March 31, 2026, Pursuant to Tex. Gov't Code Ann. §551.085	**No action taken.**

	H. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements, Including Status of Fraud and Abuse Investigations, Pursuant to Tex. 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	**No action taken.**
	I. Consultation with Attorney Regarding Litigation and Claims, Pursuant to Tex. Gov't Code Ann. §551.071, and Possible Action Upon Return to Open Session	**No action taken.**
XIII. Reconvene	At 12:29 P.M., Dr. Andrea Caracostis reconvened the meeting in open session and confirmed that a quorum remained present. She noted that no action was taken in Executive Session. The Board took action on item XII. E of the Executive Session Agenda. No action was taken on Items XII. F, G, H, or I.	
XIV. Adjournment	There being no further business to come before the Board; without objection, the meeting was adjourned at 12:30 P.M.	

I certify that the foregoing are the Minutes of the Harris Health Board of Trustees Meeting held on May 13, 2026.

Respectfully Submitted,

Andrea Caracostis, MD, MPH, Chair

Libby Viera – Bland, AICP, Secretary

Minutes transcribed by Cherry A. Joseph, MBA

Board of Trustees
Board Meeting Attendance
Wednesday, May 13, 2026

PRESENT BOARD MEMBERS: IN PERSON	PRESENT BOARD MEMBERS: VIRTUAL	ABSENT BOARD MEMBERS:
Dr. Andrea Caracostis *(Chair)*	Philip Sun	Dr. Shubhada Hooli
Carol Paret *(Vice Chair)*	Ingrid Robinson *(10:40 AM – 12:28 PM)*	
Libby Viera-Bland *(Secretary)*		
Dr. Marlen Trujillo		
Paul Puente		
Sima Ladjevardian		

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Alexander Barrie	Jeff Dansdill *(Harris County Purchasing Office)*
Amy Smith	Jennifer Small
Amy Zachmeyer *(Public Comment Speaker: Executive Director, New Economy for Working Houston)*	Jennifer Zarate
Anna Mateja *(CFO, Community Health Choice)*	Jerry Summers
Armando Aguirre *(Business Manager, Sheet Metal - Local Union 54)*	Jessey Thomas
Dr. Asim Shah	John Matcek
Brandon Cannaday	Julie Cromeens
Carolynn Jones	Kathryn Mecredy *(Public Comment Speaker: Labor Advocate Law Firm)*
Cherry Joseph	Keith Manis
Daniel Smith	Kiki Teal
DeWight Dopslauf	Lacy Wolf *(Public Comment Speaker: Business Manager, Insulators - Local 22)*
Ebon Swofford *(Harris County Attorney's Office)*	Lindsay Lanagan
Elizabeth Hanshaw Winn *(Consultant)*	Louis Smith
Dr. Esmaeil Porsa *(President & CEO, Harris Health)*	Manuel Hernandez
Dr. Glorimar Medina	Maria Cowles
Hany Khalil *(Public Comment Speaker: Executive Director, Texas Gulf Coast Area Labor Federation)*	Melvinia McClain *(Deputy Administrator, AFSCME - Local Union 1550)*
Jack Adger *(Harris County Purchasing Office)*	Micah Rodriguez
Jack Nichols *(Managing Attorney, Labor Advocate Law Firm)*	Michael Fritz *(Harris County Attorney's Office)*
Jai McBride	Mustafa Tameez *(Founder & CEO, Outreach Strategists)*
Jamie Lard	Nathan Bac *(Harris County Attorney's Office)*

Virtual Attendee Notice: *If you joined as a group and would like your attendance to be officially counted, please submit an email to: BoardofTrustees@harrishealth.org before the close of business on the day of the meeting.*

HARRISHEALTH

EXECUTIVE LEADERSHIP/STAFF/ SPECIAL INVITED GUESTS	
Dr. O. Reggie Egins	Dr. Sandeep Markan
Olga Rodriguez	Sara Thomas *(Harris County Attorney's Office)*
Omar Reid	Shaneece Flax *(Communications Coordinator, AFSCME - Local Union 1550)*
Patrick Casey	Taylor McMillan
R. King Hillier	Dr. Thomas Cummins
Rafael Rivas *(Public Comment Speaker: SMART - Local Union 54)*	Dr. Tien Ko
Rico Sanchez *(Public Comment Speaker: SMART - Local Union 54)*	Tracey Burdine
Ryan Bert *(Associate, Norton Rose Fulbright)*	Valerie Smith *(Harris County Auditor's Office)*
Sam Karim	Victoria Nikitin

Virtual Attendee Notice: *If you joined as a group and would like your attendance to be officially counted, please submit an email to: BoardofTrustees@harrishealth.org before the close of business on the day of the meeting.*

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 that the Board will discuss, review, take action upon, or regarding a subject related to healthcare or patient care rendered at Harris Health. Public comment will occur prior to the consideration of all agenda items.

If you have signed up to attend as a virtual Public Speaker, 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. To register, members of the public may contact the Board of Trustees Office during core business hours, Monday through Friday between 8:00 a.m. to 4:00 p.m. 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
   2a. A hard copy may be emailed to BoardofTrustees@harrishealth.org
   2b. A hard copy may be mailed to 4800 Fournace Pl., Ste. E618, Bellaire, TX 77401
3. 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.

Time Limits

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 with 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 be provided with one (1) minute 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.

BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, June 10, 2026

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, the Harris Health Quality and Safety Performance Measures, Good Catch Recipients, Centers for Medicare and Medicaid Services Quality Reporting, and Possible Action Regarding this Matter Upon Return to Open Session.

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

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BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, June 10, 2026

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 the Harris Health Medical Staff Upon Return to Open Session.

Dr. Yashwant Chathampally
Associate Chief Medical Officer & SVP
Quality & Patient Safety

- Pages 26 – 39 Were Intentionally Left Blank -

Wednesday, June 10, 2026

Executive Session

Report Regarding Harris Health Correctional Health Quality of Medical and Healthcare, with 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, Including Consideration of Approval of Credentialing Changes for Members of the Correctional Health Medical Staff Upon Return to Open Session.

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

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BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

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 12, 2026.

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

June 2026 Medical Staff Credentials Report

Medical Staff Initial Appointments: 24
BCM Medical Staff Initial Appointments - 6
UT Medical Staff Initial Appointments - 18
HCHD Medical Staff Initial Appointments - 0

Medical Staff Reappointments: 0
BCM Medical Staff Reappointments - 0
UT Medical Staff Reappointments - 0
HCHD Medical Staff Reappointments - 0

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Changes in Clinical Privileges: 7

BCM/UT/HCHD Medical Staff Resignations: 10

For Information
Leave of Absence - 1
Temporary Privileges Awaiting Board Approval - 16
Urgent Patient Care Need Privileges Awaiting Board Approval - 3

BCM/UT/Harris County Hospital District (Harris Health) Medical Staff Files for Discussion: 3
Medical Staff Initial Appointment Files for Discussion - 3
Medical Staff Reappointment Files for Discussion - 0

BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, June 10, 2026

Consideration of Approval of Changes to the
Nurse Practitioner (NP) / Physician Assistant (PA) General Clinical Privileges

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A request was made to add the following language to the NP / PA General Clinical Privileges.

SPECIAL NONCORE PRIVILEGES
- Provide family planning counseling and services
- Insertion/ removal of Intrauterine devices
- Insertion/removal of implantable devices* (i.e., Nexplanon)
  *With documentation of successful completion of an approved course

The Chiefs of Service at BT and LBJ have reviewed and agreed with the addition to the Special Noncore Privileges.

The Medical Executive Board has approved the revision to the NP / PA General Clinical Privileges and requests the approval of the Board of Trustees.

Dr. Yashwant Chathampally
Associate CMO & Senior Vice President

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**

SPECIAL NONCORE PRIVILEGES (See Specific Criteria)
If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore 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.

☐ Provide family planning counseling and services
☐ Insertion/ removal of Intrauterine devices
☐ Insertion/removal of implantable devices* (i.e., Nexplanon)
***With documentation of successful completion of an approved course**

☐**SPECIAL PRIVILEGES REQUESTED**

Wednesday, June 10, 2026

Consideration of Approval of Changes to the Obstetrics/Gynecology (OB/GYN) Clinical Privileges

A request was made to add the following language to the OB/GYN Clinical Privileges.

SPECIAL NONCORE PRIVILEGES
- Provide family planning counseling and services
- Insertion/ removal of Intrauterine devices
- Insertion/removal of implantable devices* (i.e., Nexplanon)
  *With documentation of successful completion of an approved course

The Chiefs of Service at BT and LBJ have reviewed and agreed with the addition to the Special Noncore Privileges.

The Medical Executive Board has approved the revision to the OB/GYN Clinical Privileges and requests the approval of the Board of Trustees.

Dr. Yashwant Chathampally
Associate CMO & Senior Vice President

Applicant Name: ____

SPECIAL NONCORE PRIVILEGES (See Specific Criteria)
If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore 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.

☐ Provide family planning counseling and services
☐ Insertion/ removal of Intrauterine devices
☐ Insertion/removal of implantable devices* (i.e., Nexplanon)
***With documentation of successful completion of an approved course**

☐SPECIAL PRIVILEGES REQUESTED

QUALIFICATIONS FOR GYNECOLOGIC ONCOLOGY

To be eligible to apply for core privileges in gynecologic oncology, the initial applicant must meet the following criteria:

Meet criteria for obstetrics and gynecology, plus an American Board of Obstetrics and Gynecology (ABOG)- or American Osteopathic Association (AOA)- approved fellowship in gynecologic oncology.

AND/OR

Specialty Board Certified by the AOA, an ABMS affiliated Specialty Board or one of the affiliated Boards of the Royal College of Physicians and Surgeons of Canada.

Required previous experience: Applicants for initial appointment must be able to demonstrate performance of at least 12 gynecologic oncology procedures, reflective of the scope of privileges requested, in the past 12 months, or demonstrate successful completion of an ACGME- or AOA- accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Reappointment requirements: To be eligible to renew core privileges in gynecologic oncology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience five (5) gynecologic oncology procedures with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing performance data review (OPDR) and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

GYNECOLOGIC ONCOLOGY CORE PRIVILEGES

Admit, evaluate, diagnose, treat, and provide consultation and surgical and therapeutic treatment to female patients with gynecologic cancer and the resulting complications, including carcinomas of the cervix, ovary, and fallopian tubes, uterus, vulva, and vagina and the performance of procedures on the bowel, urethra, and bladder as indicated. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

Gynecologic Oncology Core Privileges

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Staffing Advisory Committees Semi- Annual Evaluation of the Nurse Staffing Plan and Aggregate Staffing Variance

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In accordance with the Texas Administrative Code Title 26, Part 1, Chapter 505, Hospital Licensing, Subchapter C, Operational Requirements, Rule §505.41; the Staffing Advisory Committee reports semi-annually to the Board of Trustees its evaluation of the effectiveness of the official nursing services staffing plan and aggregate staffing variance.

This report is being presented for informational purposes only.

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

Harris Health Board of Trustees
Staffing Advisory Committee Evaluation of the FY26 Nurse Staffing Plans
Summary
Board Date: June 10, 2026

I. Overview

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

II. FY 2026 Staffing Plans

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

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

*Presence or number of clerical staff varies by hospital, area, and shift.

III. Evaluation of the Nurse Staffing Plans – June 2026

A. Ben Taub Hospital

<table>
<tr><th>Evaluators</th><th>Total Surveyed</th><th>% Strongly agree or agree with the plans</th><th>% Disagree or strongly disagree*</th></tr>
<tr><td rowspan="2">Nurse Clinician Members</td><td rowspan="2">14</td><td rowspan="2">92%</td><td>8% - Disagreed</td></tr>
<tr><td>0 – Strongly disagreed</td></tr>
</table>

*There was no clearly defined or concentrated area of disagreement identified.

B. Lyndon B. Johnson Hospital

<table>
<tr><th>Evaluators</th><th>Total Surveyed</th><th>% Strongly agree or agree with the plans</th><th>% Disagree or strongly disagree*</th></tr>
<tr><td rowspan="2">Nurse Clinician Members</td><td rowspan="2">15</td><td rowspan="2">85%</td><td>13% - Disagreed</td></tr>
<tr><td>2% – Strongly disagreed</td></tr>
</table>

*The statements with the highest level of disagreement were:

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

IV. Aggregate RN Staffing Variance (Clinical Areas)

(April 2026)

	Actual RN FTEs Worked	Budgeted RN FTEs Flexed	RN FTE Variance
BT – Nursing Services	919.67	878.93	40.74
LBJ – Nursing Services	493.81	495.59	1.78

V. Patient Care Outcomes

A review of fall, central line–associated bloodstream infection (CLABSI), and catheter-associated urinary tract infection (CAUTI) data from January 2025 through December 2025 showed that both hospitals' CLABSI and CAUTI rates met or remained below the National Database of Nursing Quality Indicators (NDNQI) mean for at least six of the twelve months.

One unit's patient fall rate exceeded the NDNQI mean for seven of the twelve months. A correlation analysis was conducted to examine the relationship between patient falls and nursing hours per patient day (HPPD). The analysis demonstrated an extremely weak correlation between the two variables.

Thank you.

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

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 Medical Staff on May 11, 2026.

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

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

Board of Trustees

HARRISHEALTH

June 2026 Correctional Health Credentials Report

Medical Staff Initial Appointments: 5

Medical Staff Reappointments: 0

Medical Staff Resignations: 1

Medical Staff Files for Discussion: 0

Wednesday, June 10, 2026

Consideration of Approval of Payment for the Contracted Services Specified in the Harris Health Operating and Support Agreement with Baylor College of Medicine (BCM) for the Contract Year Ended June 30, 2027

Harris Health and Baylor College of Medicine (BCM) entered into an Operating and Support Agreement effective July 1, 2020 (the "Agreement") to provide funding to support faculty staff member positions at Harris Health facilities and program support for BCM residency programs at the Harris Health facilities.

The funding for the annual staffing plan for all services under the Agreement for the contract year of July 1, 2026 through June 30, 2027, is projected to be approximately $293.1 million, considering historical position vacancy rates. If the vacancy rates decline in the new contract year, or if programs are modified to respond to patient demand, the net cost of physician services could be as much as $305.9 million (approximately 4% variance).

Administration recommends that the Board of Trustees approve the funding for the Harris Health Operating and Support Agreement with Baylor College of Medicine in an amount not to exceed $305.9 million for the period July 1, 2026 through June 30, 2027.

Victoria Nikitin
EVP – Chief Financial Officer

Wednesday, June 10, 2026

Consideration of Approval of Payment for the Contracted Services Specified in the Harris Health Affiliation and Support Agreement with the University of Texas Health Science Center at Houston (UT Health) for the Contract Year Ended June 30, 2027

Harris Health and UT Health entered into an Affiliation and Support Agreement effective July 1, 2020 (the "Agreement") to provide funding to support faculty staff member positions at Harris Health facilities and program support for UT Health residency programs at the Harris Health facilities.

The funding for the annual staffing plan for all services under the Agreement for the contract year of July 1, 2026 through June 30, 2027, is projected to be approximately $209.6 million, considering historical position vacancy rates. If the vacancy rates decline in the new contract year, or if programs are modified to respond to patient demand, the net cost of physician services could be as much as $219.0 million (approximately 4% variance).

Administration recommends that the Board of Trustees approve the funding for the Harris Health Affiliation and Support Agreement with UT Health in an amount not to exceed $219.0 million for the period July 1, 2026 through June 30, 2027.

Victoria Nikitin
EVP – Chief Financial Officer

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Approval of a Resolution Setting the Rate of Mandatory Payment for the Harris County Hospital District Local Provider Participation Fund

---

Pursuant to Harris County Hospital District's Participation in a Local Provider Participation Fund, a mandatory payment may be required by the District from an institutional health care provider to fund certain intergovernmental transfers for supplemental Medicaid payment programs or Medicaid managed care rate enhancements.

Management recommends the approval of the attached Resolution Authorizing Harris County Hospital District to set the amount of the mandatory payment to be invoiced during the time frame of July 1, 2026 through June 30, 2027 as up to 6.00 percent of the net patient revenue of an institutional health care provider located in the district. This would grant Harris Health the flexibility to invoice any portion of this amount in installments at any point through the end of June 2027 (i.e. the authority to send invoices expires on July 1, 2027).

Enclosed is a copy of the Texas Health and Safety Code Chapter 299 which authorizes the Local Provider Participation Fund. Section 299.151(c) (highlighted for reference) allows the Board to assess up to 6.00 percent of net patient revenue from hospital services provided in the district.

Victoria Nikitin
EVP – Chief Financial Officer

Resolution Setting Rate of Mandatory Payment

WHEREAS, pursuant to Chapter 299 of the Texas Health and Safety Code, the Board of Trustees (the "Board") of Harris County Hospital District (the "District") on June 27, 2019 authorized the District to participate in a Local Provider Participation Fund;

WHEREAS, the purpose of participation in a Harris County health care provider participation program is to generate revenue from a mandatory payment that may be required by the District from an institutional health care provider to fund certain intergovernmental transfers for a supplemental Medicaid payment program or Medicaid managed care rate enhancements;

WHEREAS, pursuant to Section 299 of the Texas Health and Safety Code, the Board on June 27, 2019 authorized the District to collect a mandatory payment from each institutional health care provider located in Harris County; and

WHEREAS, pursuant to Section 299.151(c) of the Texas Health and Safety Code, the Board must set the amount of the mandatory payment.

Be it hereby resolved by the Board of Trustees of the Harris County Hospital District that:

1. The District sets the amount of the mandatory payment to be invoiced during the time frame of July 1, 2026 through June 30, 2027 as up to 6.00 percent of the net patient revenue of an institutional health care provider located in the District.

2. The District may invoice any portion of the mandatory payment in installments, so long as the total rate invoiced during July 1, 2026 through June 30, 2027 does not exceed 6.00 percent.

3. This Resolution shall be in full force and effect from and after the date of its adoption.

PASSED AND APPROVED this 10th day of June, 2026.

HEALTH AND SAFETY CODE

TITLE 4. HEALTH FACILITIES

SUBTITLE D. HOSPITAL DISTRICTS

For expiration of this chapter, see Section 299.004.

CHAPTER 299. HARRIS COUNTY HOSPITAL DISTRICT HEALTH CARE PROVIDER PARTICIPATION PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 299.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of hospital managers of the district.

(2) "District" means the Harris County Hospital District.

(3) "Institutional health care provider" means a nonpublic hospital located in the district that provides inpatient hospital services.

(4) "Paying provider" means an institutional health care provider required to make a mandatory payment under this chapter.

(5) "Program" means the health care provider participation program authorized by this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.002. APPLICABILITY. This chapter applies only to the Harris County Hospital District.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.003. HEALTH CARE PROVIDER PARTICIPATION PROGRAM; PARTICIPATION IN PROGRAM. The board may authorize the district to participate in a health care provider participation program on the affirmative vote of a majority of the board, subject to the provisions of this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.004. EXPIRATION. (a) Subject to Section 299.153(d), the authority of the district to administer and operate a program under this chapter expires December 31, 2023.

(b) This chapter expires December 31, 2023.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 316 (H.B. 1338), Sec. 1, eff. June 7, 2021.

SUBCHAPTER B. POWERS AND DUTIES OF BOARD

Sec. 299.051. LIMITATION ON AUTHORITY TO REQUIRE MANDATORY PAYMENT. The board may require a mandatory payment authorized under this chapter by an institutional health care provider in the district only in the manner provided by this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.052. RULES AND PROCEDURES. The board may adopt rules relating to the administration of the program, including collection of the mandatory payments, expenditures, audits, and any other administrative aspects of the program.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.053. INSTITUTIONAL HEALTH CARE PROVIDER REPORTING. If the board authorizes the district to participate in a program under this chapter, the board shall require each institutional health care provider to submit to the district a copy of any financial and utilization data as reported in the provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

SUBCHAPTER C. GENERAL FINANCIAL PROVISIONS

Sec. 299.101. HEARING. (a) In each year that the board authorizes a program under this chapter, the board shall hold a public hearing on the amounts of any mandatory payments that the board intends to require during the year and how the revenue derived from those payments is to be spent.

(b) Not later than the fifth day before the date of the hearing required under Subsection (a), the board shall publish notice of the hearing in a newspaper of general circulation in the district and provide written notice of the hearing to each institutional health care provider in the district.

(c) A representative of a paying provider is entitled to appear at the public hearing and be heard regarding any matter related to the mandatory payments authorized under this chapter.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.102. DEPOSITORY. (a) If the board requires a mandatory payment authorized under this chapter, the board shall designate one or more banks as a depository for the district's local provider participation fund.

(b) All funds collected under this chapter shall be secured in the manner provided for securing other district funds.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.103. LOCAL PROVIDER PARTICIPATION FUND; AUTHORIZED USES OF MONEY. (a) If the district requires a mandatory payment authorized under this chapter, the district shall create a local provider participation fund.

(b) The local provider participation fund consists of:

(1) all revenue received by the district attributable to mandatory payments authorized under this chapter;

(2) money received from the Health and Human Services Commission as a refund of an intergovernmental transfer under the program, provided that the intergovernmental transfer does not receive a federal matching payment; and

(3) the earnings of the fund.

(c) Money deposited to the local provider participation fund of the district may be used only to:

(1) fund intergovernmental transfers from the district to the state to provide the nonfederal share of Medicaid payments for:

(A) uncompensated care payments to nonpublic hospitals, if those payments are authorized under the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315);

(B) uniform rate enhancements for nonpublic hospitals in the Medicaid managed care service area in which the district is located;

(C) payments available under another waiver program authorizing payments that are substantially similar to Medicaid payments to nonpublic hospitals described by Paragraph (A) or (B); or

(D) any reimbursement to nonpublic hospitals for which federal matching funds are available;

(2) subject to Section 299.151(d), pay the administrative expenses of the district in administering the program, including collateralization of deposits;

(3) refund a mandatory payment collected in error from a paying provider;

(4) refund to paying providers a proportionate share of the money attributable to mandatory payments collected under this chapter that the district:

(A) receives from the Health and Human Services Commission that is not used to fund the nonfederal share of Medicaid supplemental payment program payments; or

(B) determines cannot be used to fund the nonfederal share of Medicaid supplemental payment program payments; and

(5) transfer funds to the Health and Human Services Commission if the district is legally required to transfer the funds to address a disallowance of federal matching funds with respect to programs for which the district made intergovernmental transfers described by Subdivision (1).

(d) Money in the local provider participation fund may not be commingled with other district funds.

(e) Notwithstanding any other provision of this chapter, with respect to an intergovernmental transfer of funds described by Subsection (c)(1) made by the district, any funds received by the state, district, or other entity as a result of the transfer may not be used by the state, district, or any other entity to:

(1) expand Medicaid eligibility under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152); or

(2) fund the nonfederal share of payments to nonpublic hospitals available through the Medicaid disproportionate share hospital program or the delivery system reform incentive payment program.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

SUBCHAPTER D. MANDATORY PAYMENTS

Sec. 299.151. MANDATORY PAYMENTS BASED ON PAYING PROVIDER NET PATIENT REVENUE. (a) If the board authorizes a health care provider participation program under this chapter, the board may require a mandatory payment to be assessed, either annually or periodically throughout the year at the discretion of the board, on the net patient revenue of each institutional health care provider located in the district. The board shall provide an institutional health care provider written notice of each assessment under this subsection, and the provider has 30 calendar days following the date of receipt of the notice to pay the assessment. In the first year in which the mandatory payment is required, the mandatory payment is assessed on the net patient revenue of an institutional health care provider, as determined by the provider's Medicare cost report submitted for the previous fiscal year or for the closest subsequent fiscal year for which the provider submitted the Medicare cost report. If the mandatory payment is required, the district shall update the amount of the mandatory payment on an annual basis and may update the amount on a more frequent basis.

(b) The amount of a mandatory payment authorized under this chapter must be uniformly proportionate with the amount of net patient revenue generated by each paying provider in the district as permitted under federal law. A health care provider participation program authorized under this chapter may not hold harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w).

(c) If the board requires a mandatory payment authorized under this chapter, the board shall set the amount of the mandatory payment, subject to the limitations of this chapter. The aggregate amount of the mandatory payments required of all paying providers in the district may not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying providers in the district.

(d) Subject to Subsection (c), if the board requires a mandatory payment authorized under this chapter, the board shall set the mandatory payments in amounts that in the aggregate will generate sufficient revenue to cover the administrative expenses of the district for activities under

this chapter and to fund an intergovernmental transfer described by Section 299.103(c)(1). The annual amount of revenue from mandatory payments used for administrative expenses by the district for activities under this chapter is $600,000, plus the cost of collateralization of deposits, regardless of actual expenses.

(e) A paying provider may not add a mandatory payment required under this section as a surcharge to a patient.

(f) A mandatory payment assessed under this chapter is not a tax for hospital purposes for purposes of Section 4, Article IX, Texas Constitution, or Section 281.045.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 316 (H.B. 1338), Sec. 2, eff. June 7, 2021.

Sec. 299.152. ASSESSMENT AND COLLECTION OF MANDATORY PAYMENTS. (a) The district may designate an official of the district or contract with another person to assess and collect the mandatory payments authorized under this chapter.

(b) The person charged by the district with the assessment and collection of mandatory payments shall charge and deduct from the mandatory payments collected for the district a collection fee in an amount not to exceed the person's usual and customary charges for like services.

(c) If the person charged with the assessment and collection of mandatory payments is an official of the district, any revenue from a collection fee charged under Subsection (b) shall be deposited in the district general fund and, if appropriate, shall be reported as fees of the district.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

Sec. 299.153. PURPOSE; CORRECTION OF INVALID PROVISION OR PROCEDURE; LIMITATION OF AUTHORITY. (a) The purpose of this chapter is to authorize the district to establish a program to enable the district to collect mandatory payments from institutional health care providers to fund the nonfederal share of a Medicaid supplemental payment program or the Medicaid managed care rate enhancements for nonpublic hospitals to support the

provision of health care by institutional health care providers to district residents in need of health care.

(b) This chapter does not authorize the district to collect mandatory payments for the purpose of raising general revenue or any amount in excess of the amount reasonably necessary to:

(1) fund the nonfederal share of a Medicaid supplemental payment program or Medicaid managed care rate enhancements for nonpublic hospitals; and

(2) cover the administrative expenses of the district associated with activities under this chapter and other uses of the fund described by Section 299.103(c).

(c) To the extent any provision or procedure under this chapter causes a mandatory payment authorized under this chapter to be ineligible for federal matching funds, the board may provide by rule for an alternative provision or procedure that conforms to the requirements of the federal Centers for Medicare and Medicaid Services. A rule adopted under this section may not create, impose, or materially expand the legal or financial liability or responsibility of the district or an institutional health care provider in the district beyond the provisions of this chapter. This section does not require the board to adopt a rule.

(d) The district may only assess and collect a mandatory payment authorized under this chapter if a waiver program, uniform rate enhancement, or reimbursement described by Section 299.103(c)(1) is available to the district.

Added by Acts 2019, 86th Leg., R.S., Ch. 208 (H.B. 3459), Sec. 1, eff. May 24, 2019.

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Presentation of the Harris County Hospital District 401(k) and Pension Plan Independent Auditors Reports and Overview for the Fiscal Year Ended December 31, 2025

Representatives from the external audit firm Forvis Mazars, LLP, will provide an overview of the results of the Harris County Hospital District 401(k) and Pension Plan audit engagements and audit reports for the Board of Trustees' consideration and approval.

A copy of the presentation is attached.

Victoria Nikitin
EVP – Chief Financial Officer

Harris County Hospital District d/b/a
Harris Health

Harris County Hospital District 401(k) Plan

Harris County Hospital District Pension Plan

Year Ended December 31, 2025

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REQUIRED COMMUNICATIONS

- Forvis Mazars Responsibilities
  - Draft financial statements and related notes are being presented and we are prepared to issue unmodified opinions
- Accounting Policies and Practices
  - Consistent with accounting and industry standards
- There were no
  - Difficulties encountered by our team when conducting the audit
  - Disagreements with management
  - Contentious accounting issues
  - Consultations with other accountants
  - Identified material weaknesses or significant deficiencies in internal controls
- Material Written Communications
  - Audit communication letter
  - Management representation letter

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Risk Area	Comments
• Management override of controls	• No matters are reportable.
• Related-party disclosures	• No matters are reportable; however, refer to related-party disclosure in the Plan’s financial statements.
• Management estimates	
➢ Fair value of investments	• No matters are reportable
➢ Actuarial methods and assumptions used in calculating amounts recorded or disclosed in supplementary information	• No matters are reportable

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Thank You!

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BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Acceptance of the Harris County Hospital District 401(k) Plan Independent Auditors Report and Financial Statements for the Years Ended December 31, 2025 and 2024

Representatives from the external audit firm Forvis Mazars, LLP, will provide an overview of the results of the audit engagement for the Harris County Hospital District 401(k) Plan for the Board of Trustees' consideration and approval.

A copy of the draft report is attached.

Management recommends the acceptance of the Harris County Hospital District 401(k) Plan Independent Auditor's Report and Financial Statements for the Years Ended December 31, 2025 and 2024.

Victoria Nikitin
EVP – Chief Financial Officer

Harris County Hospital District 401(k) Plan

Independent Auditor's Report and Financial Statements

December 31, 2025 and 2024

Harris County Hospital District 401(k) Plan
Contents
December 31, 2025 and 2024

Independent Auditor's Report 1

Management's Discussion and Analysis (Unaudited) 3

Financial Statements

Statements of Net Position Available for Benefits 5

Statements of Changes in Net Position Available for Benefits 6

Notes to Financial Statements 7

As management of the Harris County Hospital District, d/b/a Harris Health (System), we offer readers of the financial statements of the Harris County Hospital District 401(k) Plan (Plan), this narrative overview and analysis of the financial activities of the Plan for the years ended December 31, 2025, 2024, and 2023.

Financial Highlights

- The Plan reported net investment income for 2025 of $127,348,104, an increase of $32,442,197 from 2024. The Plan reported net investment income for 2024 of $94,905,907, a decrease of $12,899,330 from 2023.
- The Plan's net position available for benefits increased by $152,157,617 in 2025, increased by $125,467,645 in 2024, and increased by $131,888,582 in 2023.
- The Plan's employer contributions were $31,447,225, $29,493,067, and $26,738,228 in 2025, 2024, and 2023, respectively. Participant contributions were $68,591,373, $64,753,463, and $60,956,298 in 2025, 2024, and 2023, respectively.
- Benefit payments were $75,925,875, $64,312,529, and $63,849,741 in 2025, 2024, and 2023, respectively. Administrative expenses were $937,552, $794,006, and $711,696 in 2025, 2024, and 2023, respectively. Combined benefit payments and administrative expenses increased by $11,756,892, $545,098, and $16,222,332 in 2025, 2024, and 2023, respectively.

Overview of the Financial Statements

Our discussion and analysis is intended to serve as an introduction to the Plan's financial statements. The Plan's financial statements are composed of financial statements and notes to the financial statements. The financial statements consist of two statements: (1) statements of net position available for benefits and (2) statements of changes in net position available for benefits. These statements present information on all the Plan's assets and liabilities with the difference between the two reported as net position. Over time, increases or decreases in net position may serve as a useful indicator of whether the financial position of the Plan is improving or deteriorating. The statements of changes in net position available for benefits present information showing how the Plan's net position changed during the year. The notes provide additional information that is essential to a full understanding of the data provided in the financial statements.

Financial Analysis

The Plan's assets include investments reported at fair value as of December 31, 2025 and 2024. These assets are held in trust for Plan benefits. Fidelity Management Trust Company serves as trustee and custodian for the Plan.

- The net appreciation in fair value of investments for 2025 totaled $122,387,573 compared to net appreciation of $86,481,716 in 2024. Dividend income decreased by $3,463,660 to $4,960,531 in 2025. Dividend income increased by $746,422 to $8,424,191 in 2024.
- The Plan's net investment income in 2025 was $127,348,104, net investment income in 2024 was $94,905,907, and net investment income in 2023 was $107,805,237. Net investment income consists of interest, dividend income, and net appreciation in the fair value of investments.

Statements of Net Position Available for Benefits

	2025	2024	2023
Mutual funds and common trust funds	$ 963,591,968	$ 813,584,667	$ 689,394,475
Notes receivable from participants	21,571,713	19,421,397	18,143,944
Net position available for benefits	$ 985,163,681	$ 833,006,064	$ 707,538,419

Statements of Changes in Net Position Available for Benefits

	2025	2024	2023
Net position available for benefits, beginning of year	$ 833,006,064	$ 707,538,419	$ 575,649,837
Net appreciation in fair value of investments	122,387,573	86,481,716	100,127,468
Interest and dividends	4,960,531	8,424,191	7,677,769
Interest income on notes receivables from participants	1,634,342	1,421,743	950,256
Contributions	100,038,598	94,246,530	87,694,526
Benefits paid to participants	(75,925,875)	(64,312,529)	(63,849,741)
Administrative expenses	(937,552)	(794,006)	(711,696)
Net position available for benefits, end of year	$ 985,163,681	$ 833,006,064	$ 707,538,419

Request for Information

This financial report is designed to provide a general overview of the Plan's finances. Questions about this report and requests for additional financial information should be directed to the Harris County Hospital District, d/b/a Harris Health, Attention: Benefits Department, 4800 Fournace Place, Bellaire, Texas 77401.

Harris County Hospital District 401(k) Plan
Statements of Net Position Available for Benefits
December 31, 2025 and 2024

	2025	2024
ASSETS		
Investments, At Fair Value	$ 963,591,968	$ 813,584,667
Notes Receivable From Participants	21,571,713	19,421,397
Net Position Available for Benefits	$ 985,163,681	$ 833,006,064

Harris County Hospital District 401(k) Plan
Statements of Changes in Net Position Available for Benefits
Years Ended December 31, 2025 and 2024

	2025	2024
Additions		
Investment Income		
Net appreciation in fair value of investments	$ 122,387,573	$ 86,481,716
Interest and dividends	4,960,531	8,424,191
Net Investment Income	127,348,104	94,905,907
Interest Income on Notes Receivables From Participants	1,634,342	1,421,743
Contributions		
Employer	31,447,225	29,493,067
Participant	68,591,373	64,753,463
Total Contributions	100,038,598	94,246,530
Total Additions	229,021,044	190,574,180
Deductions		
Benefits paid to participants	75,925,875	64,312,529
Administrative expenses	937,552	794,006
Total Deductions	76,863,427	65,106,535
Net Increase	152,157,617	125,467,645
Net Position Available for Benefits, Beginning of Year	833,006,064	707,538,419
Net Position Available for Benefits, End of Year	$ 985,163,681	$ 833,006,064

Note 1. Description of the Plan

The Harris County Hospital District 401(k) Plan (Plan) was established on January 1, 1985. The Plan is a defined-contribution plan open to all full-time and part-time employees of the Harris County Hospital District, d/b/a Harris Health (System) who meet the Plan's requirements on the date on which the employee becomes an eligible employee. The Plan is a governmental plan and, as such, is specifically exempt from the reporting and disclosure requirements of the *Employee Retirement Income Security Act of 1974*. Fidelity Management Trust Company (Fidelity) serves as the trustee and custodian for all Plan assets.

The following brief description of the Plan is provided for general information purposes only. For more complete information, participants should refer to the *Summary Plan Description*, a copy of which is available from the System.

The Plan is administered by an Administrative Committee appointed by the System's Board of Trustees, whose members are responsible for administering the Plan under the terms established. The Board of Trustees approves amendments to the Plan.

Contributions and Vesting

Each year, participants may contribute a portion of their annual compensation to either a pretax contribution or Roth 401(k) contribution, as defined by the Plan, subject to certain Internal Revenue Code (IRC) limitations. The limitation was $23,500 and $23,000 in 2025 and 2024, respectively, for all participants. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Effective July 2007, the System enhanced the Plan with an employer match up to 5% of the participant's compensation for eligible employees, which is 100% vested with three or more years of service. Participant rollover contributions are also permitted.

Forfeited Accounts

Forfeitures under the Plan for a Plan year will be applied to reduce the System's obligation to make future matching contributions or to pay Plan administrative expenses for the Plan year. At December 31, 2025 and 2024, the balance of the forfeiture account was $16,993 and $16,991, respectively. During the years ended December 31, 2025 and 2024, employer contributions were reduced by $3,288,112 and $2,679,757, respectively, from forfeited nonvested accounts.

Participant Investment Account Options

Participants direct the investment of their contributions into various investment options offered by the Plan. The System's matching contribution is allocated to the same investment options as the participant's contributions. The Plan currently offers a variety of mutual funds and common trust funds as investment options for participants.

The Plan Document also includes an automatic deferral feature whereby a participant is treated as electing to defer a certain percentage of eligible compensation unless the participant made an affirmative election otherwise. The automatic deferral feature also provides for the percentage deferred at 3%.

Participant Accounts

Individual accounts are maintained for each Plan participant. Each participant's account is credited with the participant's contribution, the System's matching contribution and allocations of Plan earnings, and charged with withdrawals and an allocation of Plan losses and administrative expenses. Allocations are based on participant account balances. The benefit to which a participant is entitled is the benefit that can be provided from the participant's account. Participants are vested immediately in their voluntary and employee contributions, plus actual earnings thereon.

Notes Receivable from Participants

Participants may borrow, subject to approval, as much as one-half of their respective accounts, up to a maximum amount of $50,000. The minimum loan amount is $1,000. Loans are charged at a rate of interest equal to the current prime lending rate, plus 1%. Interest paid is credited to the participant's account. The loans are generally repaid by payroll deduction within five years, except in the case of a loan used to purchase a principal residence.

Payment of Benefits

Benefit payments will normally be made in one lump sum, as soon as practicable, after the employee's severance from employment with the System. However, employees whose benefits at the date of severance are in excess of $1,000 may elect to have the benefit payment made at any time prior to attaining age 72. The participants or their beneficiaries may also receive benefit payments from the Plan upon the participants' permanent disability or death.

Note 2. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of net position available for benefits and changes in net position available for benefits and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

Valuation of Investments and Income Recognition

Investments are reported at fair value. Quoted market prices, if available, are used to value investments. Mutual funds are valued at the net asset value (NAV) of shares held by the Plan at year-end. Estimated fair value of the common trust funds is NAV, which is based on the market value of its underlying investments. Since the NAV of the common trust funds is determined and published daily and is the basis for current transactions, the NAV is considered a readily determinable fair value.

Purchases and sales of securities are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Net appreciation in fair value of investments includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Management fees and operating expenses charged to the Plan for investments in mutual and common trust funds are deducted from income earned on a daily basis and are not separately reflected. Consequently, management fees and operating expenses are reflected as a reduction (addition) of investment return (loss) for such investments.

Notes Receivable from Participants

Notes receivable from participants are measured at their unpaid principal balance, plus any accrued but unpaid interest. Delinquent participant loans are reclassified as distributions based upon the terms of the Plan Document.

Payment of Benefits

Benefit payments to participants are recorded upon distribution.

Administrative Expenses

Certain administrative expenses were paid by the System and excluded from the financial statements. Trustee fees, record-keeping fees, loan initiation and maintenance fees, and legal fees are paid by the Plan and are represented as administrative expenses within the statements of changes in net position available for benefits.

Revisions

Certain immaterial revisions have been made to the 2024 financial statements for classification level within the fair value hierarchy table in Note 3. The revision related to one investment presentation from level 1 to level 2. These revisions did not have a significant impact on the financial statement line items impacted.

Note 3. Investments

The fair value of individual investment options that represented 5% or more of the Plan's net position available for benefits as of December 31, 2025 and 2024, were as follows:

	2025	2024
Spartan 500 Index Pool Fund (Class C)	$ 148,147,398	$ 115,945,797
T. Rowe Price Retirement 2040 Trust (Class B)	78,569,196	63,692,994
T. Rowe Price Retirement 2050 Trust (Class B)	76,986,618	60,553,352
T. Rowe Price Retirement 2030 Trust (Class B)	75,573,429	66,467,137
T. Rowe Price Retirement 2035 Trust (Class B)	72,454,200	57,774,209
T. Rowe Price Retirement 2045 Trust (Class B)	72,086,962	57,001,535
T. Rowe Price Retirement 2055 Trust (Class B)	62,184,883	49,111,135
William Blair Large Cap Growth Fund	61,518,954	62,443,293
Invesco Stable Value Trust (Class B1)	48,202,572	47,043,617

The Plan categorizes its fair value measurements within the fair value hierarchy established by accounting principles generally accepted in the United States of America. The hierarchy is based on the valuation inputs used to measure fair value of the assets. Level 1 are quoted prices in an active market for identical assets; Level 2 are significant other observable inputs and Level 3 are significant unobservable inputs.

The following is a summary of the hierarchy of fair value of investments of the Plan as of December 31, 2025 and 2024:

	Fair Value Measurement Using		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total
December 31, 2025			
Mutual funds:			
Domestic equities	$ 298,421,502	$ -	$ 298,421,502
International equities	37,978,362	-	37,978,362
Balanced and target date	2,088,881	-	2,088,881
U.S. fixed income funds	7,842,096	48,202,572	56,044,668
Common trust funds:			
Balanced and target date	-	569,058,555	569,058,555
Investment at fair value	$ 346,330,841	$ 617,261,127	$ 963,591,968
December 31, 2024			
Mutual funds:			
Domestic equities	$ 273,256,499	$ -	$ 273,256,499
International equities	25,832,986	-	25,832,986
Balanced and target date	1,526,077	-	1,526,077
U.S. fixed income funds	5,877,359	47,043,617	52,920,976
Common trust funds:			
Balanced and target date	-	460,048,129	460,048,129
Investment at fair value	$ 306,492,921	$ 507,091,746	$ 813,584,667

Investment Policy

The investment guidelines for the Plan provide a framework for the selection of investment alternatives made available under the Plan to ensure that Plan participants have available high-quality investment alternatives that span the risk and return spectrum, and enable the Plan participants to diversify their Plan accounts consistent with their individual circumstances, goals, and risk and reward objectives. The administrative committee is responsible for selecting the investment options that are made available under the Plan and monitoring the investment options' performance. A variety of investment options are offered to include domestic equities, international equities, asset allocation, fixed income, and short-term alternatives.

The available investment options as of December 31, 2025 and 2024, are as follows:

- U.S. fixed-income:
  - Vanguard Total Bond Market Index (Institutional Class)
  - Invesco Stable Value Fund (Class B1)

- Balanced and target date:
  - PIMCO Inflation Response Multi-Asset Institutional
  - T. Rowe Price Retirement 2005 Trust (Class B)
  - T. Rowe Price Retirement 2010 Trust (Class B)
  - T. Rowe Price Retirement 2015 Trust (Class B)
  - T. Rowe Price Retirement 2020 Trust (Class B)
  - T. Rowe Price Retirement 2025 Trust (Class B)
  - T. Rowe Price Retirement 2030 Trust (Class B)
  - T. Rowe Price Retirement 2035 Trust (Class B)
  - T. Rowe Price Retirement 2040 Trust (Class B)
  - T. Rowe Price Retirement 2045 Trust (Class B)
  - T. Rowe Price Retirement 2050 Trust (Class B)
  - T. Rowe Price Retirement 2055 Trust (Class B)
  - T. Rowe Price Retirement 2060 Trust (Class B)
  - T. Rowe Price Retirement 2065 Trust (Class B)

- U.S. equity:
  - Diamond Hill Large Cap Fund
  - Meridian Growth Institutional Fund
  - DFA US Target Value
  - Vanguard Extended Market Index
  - Principal Global Real Estate Securities
  - Baird Core Plus Bond Institutional Fund
  - William Blair Large Cap Growth Fund
  - Spartan 500 Index Pool Fund (Class C)
  - Principal Global Real Estate Fund
  - Diamond Hill Large Cap Value Fund (Class R2)
  - Westfield Small/Mid Cap Growth Fund (Class D)

- Non-U.S. equity:
  - Dodge & Cox International Stock Fund (Class X)
  - Vanguard Total International Stock (Institutional Class)

Custodial Credit Risk

Custodial credit risk for deposits is the risk that, in the event of failure of a depository financial institution, the Plan will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, the Plan will not be able to recover the value of its investment or collateral securities that are in the possession of another party. As of December 31, 2025 and 2024, the Plan does not hold deposits or investments exposed to custodial credit risk.

Interest-Rate Risk

The Plan offers participants two U.S. fixed-income funds as investment options at December 31, 2025 and 2024, respectively. The following is a summary of the fair value of the fixed-income funds as of December 31, 2025 and 2024, prorated for maturity distribution as disclosed by the fund managers:

Maturity Distribution	2025 Fair Value	2024 Fair Value
Less than 1 Year	$ 2,195,786	$ 23,509
3-5 Years	3,550,117	2,521,387
Greater than 5 Years	50,298,765	50,376,080
	$ 56,044,668	$ 52,920,976

The Plan also provides investment options in balanced and target date common trust funds. The target date common trust funds provide a single-fund diversified portfolio that is automatically adjusting with an age-based asset allocation. The common trust funds are offered in five-year increments. As of December 31, 2025 and 2024, respectively, the fixed-income asset allocation of the common trust funds range from 55% and 55% for an anticipated year of retirement in the near future to 2.0% and 2.0% for those participants with longer opportunities for investment. The fund manager notes the interest rate sensitivity for these common trust funds as moderate. As of December 31, 2025 and 2024, approximately $69,754,000 and $62,286,000, respectively, were invested in fixed-income strategies in the balanced and target date common trust funds. The maturity distribution of these common trust funds is not available.

The Plan's investment policy does not specifically address limits on maturities as a means of managing its exposure to fair value losses arising from increasing interest rates. Each participant is responsible for determining the maturity and commensurate returns of their portfolio.

Credit Risk

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. The Plan's investment policy does not specifically address the quality rating of the investments. Each participant is responsible for determining the risks and commensurate returns on their portfolio. The Plan's core U.S. fixed-income funds were rated based on the average quality of the fixed-income investments as of December 31, 2025 and 2024, as noted below:

Quality Allocation	2025 Fair Value	2024 Fair Value
U.S. Government	$ 5,424,378	$ 4,020,114
Short Term Investments (Cash & Cash Equiv)	(1,368,953)	(780,924)
AAA	13,818,748	37,137,305
AA	24,444,027	2,016,899
A	8,084,003	5,784,821
BBB and below	5,556,599	4,648,674
Not Rated	85,866	94,087
	$ 56,044,668	$ 52,920,976

The Plan's balanced and target date common trust funds were noted by the fund manager as being invested in securities with an average credit rating of low.

Foreign Currency Risk

Foreign currency risk is the risk that fluctuations in the exchange rate will adversely affect the value of investments denominated in a currency other than the U.S. dollar. The Plan offers investments in international equities through an international equity mutual fund. These investments are denominated in U.S. dollars and accounted for at fair value. The Plan has no exposure to foreign currency fluctuations.

Note 4. Plan Termination

Although it has not expressed any intent to do so, the System has the right under the Plan to discontinue its contributions at any time and to terminate the Plan. In the event of Plan termination, participants would become 100% vested in their accounts.

Note 5. Related-Party Transactions

Certain Plan investments are shares of mutual funds managed by Fidelity, which is the trustee of the Plan. Fees incurred by the Plan for the investment management services are included in net appreciation in fair value of investments, as they are paid through revenue sharing, rather than a direct payment. The Plan paid $937,552 and $794,006 in administrative expenses to Fidelity during the years ended December 31, 2025 and 2024, respectively.

Note 6. Plan Tax Status

The Internal Revenue Service (IRS) has determined and informed the System by a letter dated June 10, 2014, that the Plan and related trust are designed in accordance with applicable sections of the IRC. Although the Plan has been amended since receiving the determination letter, the Plan Administrator and the Plan's tax counsel believe that the Plan is designed, and is currently being operated, in compliance with the applicable requirements of the IRC and, therefore, believe that the Plan is qualified, and the related trust is tax exempt.

Note 7. Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term. Such changes could materially affect the participants' account balances and the amounts reported in the statements of net position available for benefits.

Note 8. Subsequent Events

Subsequent events have been evaluated through June xx, 2026, which is the date the financial statements were available to be issued.

Wednesday, June 10, 2026

Consideration of Acceptance of the Harris County Hospital District Pension Plan Independent Auditors Report and Financial Statements for the Years Ended December 31, 2025 and 2024

Representatives from the external audit firm Forvis Mazars, LLP, will provide an overview of the results of the audit engagement for the Harris County Hospital District Pension Plan for the Board of Trustees' consideration and approval.

A copy of the draft report is attached.

Management recommends the acceptance of the Harris County Hospital District Pension Plan Independent Auditor's Report and Financial Statements for the Years Ended December 31, 2025 and 2024.

Victoria Nikitin
EVP – Chief Financial Officer

Harris County Hospital District Pension Plan

Independent Auditor’s Report and Financial Statements

December 31, 2025 and 2024

Forvis Mazars, LLP
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Independent Auditor's Report 1

Management's Discussion and Analysis (Unaudited) 3

Financial Statements

Statements of Fiduciary Net Position 7

Statements of Changes in Fiduciary Net Position 8

Notes to Financial Statements 9

Required Supplementary Information (Unaudited)

Schedule of Changes in Net Pension Liability and Related Ratios 21

Notes to Schedule of Changes in Net Pension Liability and Related Ratios 22

Schedule of Investment Returns 23

Schedule of Employer Contributions 24

Notes to Required Supplementary Information 25

Supplementary Information (Unaudited)

Schedule Of Investment Expenses and Investment Manager Information 26

Forvis Mazars, LLP is an independent member of Forvis Mazars Global Limited

As management of the Harris County Hospital District, d/b/a Harris Health (System), we offer readers of the financial statements of Harris County Hospital District Pension Plan (Plan), this narrative overview and analysis of the financial activities of the Plan for the years ended December 31, 2025, 2024, and 2023.

Financial Highlights

- Net position of the Plan as of December 31, 2025, 2024, and 2023, was $1,191,556,058, $1,043,567,505, and $948,342,881, respectively. The net position is restricted for use for the payment of future employee pension benefits.

- The Plan's net position restricted for pensions increased $147,988,553 for the year ended December 31, 2025, increased $95,224,624 for the year ended December 31, 2024, and increased $127,140,238 for the year ended December 31, 2023.

- Contributions to the Plan are made solely by the employer, the System, as determined by the Plan's actuaries based on future obligations and required funding to meet those obligations. These contributions totaled $71,000,004, $69,000,000, and $68,000,000 for the years ended December 31, 2025, 2024, and 2023, respectively.

- The Plan's total investment income in 2025, 2024, and 2023 was $146,654,968, $94,027,580, and $125,600,849, yielding a total return on investment of 13.1%, 9.5%, and 14.3%, respectively. Investment income consists of interest, dividend income, and net appreciation in the fair value of investments. In 2025, 2024 and 2023, the U.S. economic activity firmed and strengthened. A detail of the asset allocation for the years ended December 31, 2025, 2024, and 2023, was as follows:

	2025	2024	2023
Domestic equities (common stocks and common collective trust)	38 %	37 %	36 %
International equities (common collective trust and mutual funds)	22	20	27
Fixed income investment (fixed income securities and mutual funds)	32	35	29
Hedge funds (common collective trusts)	4	4	4
REIT (common collective trusts)	4	4	4
Total	100 %	100 %	100 %

- Benefit payments are the primary expense of the Plan. Such payments totaled $67,150,083, $65,337,726, and $64,129,382 for the years ended December 31, 2025, 2024, and 2023, respectively.

- Other expenses of the Plan include administrative and investment management expenses, which totaled $2,516,336, $2,465,230 and $2,331,229 for the years ended December 31, 2025, 2024, and 2023, respectively.

Overview of the Financial Statements

Our discussion and analysis is intended to serve as an introduction to the Plan's basic financial statements. The Plan's financial statements are composed of financial statements and notes to the financial statements. The financial statements consist of two statements: (1) statement of fiduciary net position and (2) statement of changes in fiduciary net position. These statements present information on all the Plan's assets and liabilities with the difference between the two reported as net position restricted for pensions. Over time, increases or decreases in net position restricted for pensions may serve as a useful indicator of whether the financial position of the Plan is improving or deteriorating. The statement of changes in fiduciary net position presents information showing how the Plan's net position restricted for pensions changed during the year. The notes provide additional information that is essential to a full understanding of the data provided in the financial statements.

Investment Policy

The Plan's investment policy requires the Plan to maintain target asset allocation and ranges for the total fund. The asset allocation and ranges are as follows:

	Target	Range
Domestic equity	25 %	20–46 %
International equity	30	15–39
Fixed income	37	23–47
Hedge funds	4	3–7
Real estate funds	4	3–7
Total	100 %	

The Plan's investment policy was adhered to during the years ended December 31, 2025, 2024, and 2023.

Fiduciary Net Position

	2025	2024	2023
Cash	$ 26,220,998	$ 25,042,476	$ 28,895,596
Common stocks	393,662,185	337,733,141	338,076,110
Mutual funds	256,946,637	218,401,912	258,609,351
Collective investment trusts	380,511,391	331,310,571	203,658,006
Fixed income securities	147,349,995	148,177,803	139,957,937
Short-term investments	671,310	693,502	2,993,473
Receivables from accrued income and other	3,182,263	1,295,746	9,507,424
	1,208,544,779	1,062,655,151	981,697,897
Liabilities from accrued expenses and other	(16,988,721)	(19,087,646)	(33,355,016)
Net position restricted for pensions	$ 1,191,556,058	$ 1,043,567,505	$ 948,342,881

Changes in Fiduciary Net Position

	2025	2024	2023
Beginning balance	$ 1,043,567,505	$ 948,342,881	$ 821,202,643
Contributions	71,000,004	69,000,000	68,000,000
Investment income	146,654,968	94,027,580	125,600,849
Deductions	(69,666,419)	(67,802,956)	(66,460,611)
	$ 1,191,556,058	$ 1,043,567,505	$ 948,342,881

Request for Information

This financial report is designed to provide a general overview of the Plan's finances. Questions about this report and requests for additional financial information should be directed to the Harris County Hospital District, d/b/a Harris Health, Attention: Benefits Department, 4800 Fournace Place, Bellaire, Texas 77401.

Harris County Hospital District Pension Plan
Statements of Fiduciary Net Position
December 31, 2025 and 2024

	2025	2024
ASSETS		
Cash	$ 26,220,998	$ 25,042,476
Investments, At Fair Value		
Fixed income securities	147,349,995	148,177,803
Mutual funds:		
Fixed income	182,027,891	165,070,611
International equity	74,918,746	53,331,301
Common stocks	393,662,185	337,733,141
Collective investment trusts:		
Domestic equity	48,313,833	45,120,441
International equity	189,440,253	154,502,336
Fixed income	53,353,063	49,073,028
Multistrategy	51,049,640	45,581,644
Real estate	38,354,602	37,033,122
Short-term investments	671,310	693,502
Total investments	1,179,141,518	1,036,316,929
Receivables		
Due from broker for securities sold	1,741,988	58,854
Accrued interest and dividends	1,440,275	1,236,892
Total receivables	3,182,263	1,295,746
Total assets	1,208,544,779	1,062,655,151
LIABILITIES		
Accrued administrative expenses	587,835	530,580
Due to broker for securities purchased	16,400,886	18,557,066
Total liabilities	16,988,721	19,087,646
Net Position Restricted for Pensions	$ 1,191,556,058	$ 1,043,567,505

See Notes to Financial Statements

Harris County Hospital District Pension Plan
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2025 and 2024

	2025	2024
Employer Contributions	$ 71,000,004	$ 69,000,000
Investment Income		
Net appreciation in fair value of investments	126,631,617	76,377,087
Interest	6,183,330	6,404,847
Dividends	13,670,747	11,065,549
Other loss	169,274	180,097
Total Investment Income	146,654,968	94,027,580
Total Additions	217,654,972	163,027,580
Deductions		
Benefits paid to participants and beneficiaries	67,150,083	65,337,726
Administrative expenses	2,516,336	2,465,230
Total Deductions	69,666,419	67,802,956
Net Increase in Net Position Restricted for Pensions	147,988,553	95,224,624
Net Position Restricted for Pensions, Beginning of Year	1,043,567,505	948,342,881
Net Position Restricted for Pensions, End of Year	$ 1,191,556,058	$ 1,043,567,505

See Notes to Financial Statements

Note 1. Description of the Plan

The following description of Harris County Hospital District Pension Plan (Plan) provides only general information. Participants should refer to the *Summary Plan Description* for more complete information, a copy of which is available from the Harris County Hospital District, d/b/a Harris Health (System).

General

The Plan is a noncontributory, single-employer defined-benefit pension plan covering all full-time employees of the System who meet the Plan's service requirements. As a governmental plan, it is exempt from the reporting and disclosure requirements of the *Employee Retirement Income Security Act of 1974,* and follows the reporting requirements as dictated by the Governmental Accounting Standards Board (GASB).

In October 2006, the System Board of Trustees (Board) amended the Plan to close enrollment to new hires effective January 1, 2007. The amended plan offers employees hired prior to January 1, 2007, a choice to either (1) continue with their current pension plan or (2) elect to participate in the System's enhanced 401(k) retirement savings plan with a match, effective July 2007, of up to 5% of participant's compensation provided by the System. All new hires and rehires after December 31, 2006, are only eligible for the System's 401(k) retirement savings plan with a match up to 5%.

The Plan is administered by an administrative committee (Committee) appointed by the Board of the System. The Committee comprises nine members who are responsible for administering the Plan under the terms that are established. The Board, as authorized in the *Plan Document*, approves amendments to the Plan. State Street (Trustee) serves as trustee and custodian for the Plan.

Contributions

Contributions to provide benefits under the Plan are made solely by the System. The System makes annual contributions based on an actuarial valuation of the Plan. The actuarial recommended contribution includes normal cost, plus amortization of the expected unfunded liability, if any.

Pension Benefits

Active employees with one or more years of service, who meet eligibility requirements, are entitled to a monthly pension payment beginning at normal retirement age (65) equal to the benefit accrued based on compensation and years of service. The Plan permits early retirement at ages 55 to 64, provided 10 years of service has been completed. If employees terminate after five years of service, they retain the right to vested benefits. Participants become 100% vested in their accrued benefits after five years of service. Each participant shall have a monthly benefit payable for life that is equal to the greater of (a) the number of years of service multiplied by 1.5% of the average monthly compensation (average base compensation received in the five highest consecutive calendar years out of the 10 complete calendar years prior to retirement) or (b) the accrued monthly retirement benefit determined as of January 1, 1989, plus the number of years of future service earned after January 1, 1989, multiplied by 1.5% of the average monthly compensation, subject to a minimum equal to the benefit earned under the Plan prior to the adoption of the sixth amendment as of September 30, 1991 (applies to non-highly compensated employees only). Monthly benefit payments are subject to a minimum based on the number of years of service multiplied by $6 and a maximum provision permitted to be paid under Section 415 of the Internal Revenue Code (the IRC). Participants may also elect to receive their benefits in other optional forms.

If the present value of a terminating participant's vested benefit is $1,000 or less, the benefit will automatically be paid in a lump sum. In 2025 and 2024, there were no lump-sum payments made to terminated participants.

Death and Disability Benefits

If an active employee dies, a benefit equal to one-half of the normal pension benefit will be due to the spouse of the participant if the participant has attained 10 years of service. The beneficiary of a deceased retired participant is entitled to a lump-sum payment of $5,000. If a participant becomes disabled, the participant will be paid 55% of his/her average monthly compensation, less 64% of the monthly primary social security benefit at the time of disability. Disability benefits will be paid during the participant's disability or until retirement age is reached, whichever is shorter.

Plan Membership

Membership of the Plan consisted of the following as of January 1, 2025 and 2024, respectively:

	2025	2024
Inactive Plan members or beneficiaries currently receiving benefits	3,706	3,672
Inactive Plan members entitled to but not yet receiving benefits	1,227	1,264
Active Plan members	1,399	1,484
Total Plan members	6,332	6,420

Note 2. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting. The Plan applies the Governmental Accounting Standards Board pronouncements applicable to benefit plan accounting and reporting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, disclosure of contingent assets and liabilities and the actuarial present value of accumulated Plan benefits at the date of the financial statements and changes therein. Actual results could differ from those estimates.

Risks and Uncertainties

The Plan utilizes various investment securities, including U.S. Government securities, corporate debt instruments, mutual funds, common stocks, collective investment trusts, and real estate investment trusts. Investment securities, in general, are exposed to various risks, such as interest rate, credit risk, and overall market volatility risks. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

The actuarial present value of accumulated Plan benefits is calculated based on economic and demographic assumptions, including investment return rates, inflation rates, salary increases, retirement ages and mortality rates. Due to uncertainties inherent in the estimations and assumptions processes, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would-be material to the financial statements.

Valuation of Investments and Income Recognition

Investments are reported at fair value. Quoted market prices, if available, are used to value investments. Mutual funds, including short-term investments, are valued at the net asset value (NAV) of shares held by the Plan at year-end. Common stocks are valued at the closing price reported on the active market on which the individual securities are traded. Fixed income securities are valued on the basis of yields currently available on comparable securities of issuers with similar credit ratings. Units of collective investment trusts are stated at fair value using NAV practical expedient.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation in fair value of investments includes the Plan's gains and losses on investments bought and sold, as well as held during the year.

Certain management fees and operating expenses charged to the Plan for investments in mutual funds are deducted from income earned on a daily basis and are not separately reflected. Consequently, management fees and operating expenses are reflected as a reduction of investment return for such investments.

Administrative Expenses

All administrative expenses incurred in the operation of the Plan are paid by the Plan as provided in the Plan Document. The System provides accounting and certain other administrative services to the Plan at no charge.

Payment of Benefits

Benefit payments to participants are recorded upon distribution.

Note 3. Investments

The fair value of investments as of December 31, 2025 and 2024, is presented in the following table (in thousands):

	2025	2024
Common stocks	$ 393,662	$ 337,733
Mutual funds	256,948	218,403
Collective investment trusts	380,511	331,311
Fixed income securities	147,350	148,178
Short-term investments	671	694
Total	$ 1,179,142	$ 1,036,317

The Plan categorizes its fair value measurements within the fair value hierarchy established by GAAP. The hierarchy is based on the valuation inputs used to measure fair value of the assets. Level 1 are quoted prices in an active market for identical assets, Level 2 are significant other observable inputs, and Level 3 are significant unobservable inputs.

The mutual funds held by the Plan are actively traded and valued at the daily closing price as reported by the fund and are disclosed as investments in Registered Investment Companies. The collective investment trusts held by the Plan are valued at NAV of the respective investments as a practical expedient to estimate fair value. This practical expedient would not be used if it is determined to be probable that the investment will be sold for an amount different from the reported NAV.

The following is a summary of the hierarchy of the fair value of investments of the Plan as of December 31, 2025 (in thousands):

	Fair Value Measurement Using		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total
Debt securities:			
U.S. Treasury securities	$ -	$ 78,117	$ 78,117
Asset backed	-	4,576	4,576
Agencies	-	20,613	20,613
Commercial mortgage-backed securities	-	5,204	5,204
Corporate bonds	-	26,071	26,071
Mortgages	-	8,236	8,236
Municipals	-	929	929
Eurobonds	-	3,604	3,604
Fixed income mutual funds	182,028	-	182,028
Total debt securities	182,028	147,350	329,378
Equity securities:			
Domestic	393,662	-	393,662
International	74,919	-	74,919
Total equity securities	468,581	-	468,581
Short-term investment funds	671	-	671
Total investments by fair value level	$ 651,280	$ 147,350	798,630
Collective investment trusts measured at the NAV practical expedient:			
Domestic equity			48,314
International equity			189,440
Fixed income			53,353
Hedge funds - multistrategy			51,050
Real estate			38,355
Total investments at NAV			380,511
Total investments measured at fair value			$ 1,179,142

The following is a summary of the hierarchy of the fair value of investments of the Plan as of December 31, 2024 (in thousands):

	Fair Value Measurement Using		
	Quoted Prices in Active Markets for Identical Assets (Level 1)	**Significant Other Observable Inputs (Level 2)**	**Total**
Debt securities:			
U.S. Treasury securities	$ -	$ 89,067	$ 89,067
Asset backed	-	3,464	3,464
Agencies	-	3,372	3,372
Commercial mortgage-backed securities	-	17,581	17,581
Corporate bonds	-	32,778	32,778
Mortgages	-	1,256	1,256
Municipals	-	661	661
Fixed income mutual funds	165,071	-	165,071
Total debt securities	165,071	148,177	313,248
Equity securities:			
Domestic	337,733	-	337,733
International	53,331	-	53,331
Total equity securities	391,064	-	391,064
Short-term investment funds	694	-	694
Total investments by fair value level	$ 556,829	$ 148,177	705,006
Collective investment trusts measured at the NAV practical expedient:			
Domestic equity			45,120
International equity			154,502
Fixed income			49,073
Hedge funds - multistrategy			45,582
Real estate			37,033
Total investments at NAV			331,311
Total investments measured at fair value			$ 1,036,317

Investments Measured Using the NAV per Share Practical Expedient

The following table summarizes investments for which fair value is measured using the NAV per share practical expedient as of December 31, 2025 and 2024. There are no participant redemption restrictions for these investments; the redemption notice period is applicable only to the Plan.

	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice
December 31, 2025 (in thousands):				
Domestic equity	$ 48,314	None	Daily	None
International equity	189,440	None	Daily	None
Fixed income	53,353	None	Monthly	30 days
Hedge funds - multistrategy	51,050	None	Monthly	95 days
Real estate	38,355	None	Quarterly	45 days
Total investments at NAV	$ 380,511			
December 31, 2024 (in thousands):				
Domestic equity	$ 45,120	None	Daily	None
International equity	154,502	None	Daily	None
Fixed income	49,073	None	Monthly	30 days
Hedge funds - multistrategy	45,582	None	Monthly	95 days
Real estate	37,033	None	Quarterly	45 days
Total investments at NAV	$ 331,311			

For collective investment trusts that are measured at NAV per share, the valuation provided by the fund manager is used. All partnerships provide audited financial statements, along with unaudited quarterly reports.

International equity – The trust's investment is an international equity and the investment objective is to seek long-term capital appreciation above the MSCI All Country World Ex-U.S. Investable Market Index (net), by investing at least 80% of its total assets in a diversified portfolio of common stocks and in securities convertible into, exchangeable for or having the right to buy such common stocks that issued by companies of all sizes domiciled outside the United States.

Hedge funds – multistrategy - This type invests in hedge funds that pursue multiple strategies to diversify risks and reduce volatility, primarily through limited partnerships. The fund is organized by investing substantially all assets through a master feeder structure and may use a wide range of investment strategies.

Real estate – This type invests in institutional quality real estate private equity funds to provide income, low-correlation to other investments and a hedge against inflation.

During the Plan years ended December 31, 2025 and 2024, the Plan's investments (including investments bought, sold and held during the Plan year) appreciated in value by $126,631,617 and $76,377,087, respectively, as follows (in thousands).

	2025	2024
Common stocks	$ 55,929	$ 65,628
Mutual funds	21,503	250
Collective investment trusts	49,201	10,500
Total	$ 126,632	$ 76,377

Note 4. Investment Risk Disclosures

Investment Policy

Substantially all of the Plan's investments are held by the Trustee. The Committee authorizes various portfolio managers to manage investments within the guidelines of the Plan's statement of investment policy (the Policy) set forth by the Committee. The Policy mandates a diversified portfolio, which includes investments in collective investment trusts, fixed income securities and equity securities. GAAP requires disclosure of common deposit and investment risks, including credit risk, concentration of credit risk, custodial credit risk, interest rate risk and foreign currency risk of investments.

The Policy in regard to the allocation of invested assets is established and may be amended by the System's Board of Trustees by a majority vote of its members. It is the policy of the Plan Board to pursue an investment strategy that reduces risk through the prudent diversification of the portfolio across a broad selection of distinct asset classes. The Policy discourages the use of cash equivalents, except for liquidity purposes and aims to refrain from dramatically shifting asset class allocations over short time spans. The following was the Board of Trustee's adopted asset allocation as of December 31, 2025 and 2024:

Asset Class	2025 Target Allocation	2024 Target Allocation
Domestic equity	25 %	22 %
International equity	30	35
Fixed income	37	33
Hedge funds	4	5
Real estate funds	4	5
	100 %	100 %

Money-Weighted Rate of Return

For the years ended December 31, 2025 and 2024, the annual money-weighted rate of return on pension plan investments, net of pension investment expenses, was 13.84% and 9.65%, respectively. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Credit Risk and Concentration of Credit Risk

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. The Policy establishes minimum acceptable credit ratings for certain investment instruments. Fixed income investment managers are expected to invest in a well-diversified mix of debt instruments, including U.S. Treasury, agency, mortgage-backed, asset-backed, corporate and Eurodollar issue. The Core Plus Fixed Income Investment manager may also invest in derivative instruments such as options, future contracts, or swap agreements. With the exception of the U.S. Treasury and its agencies, no more than 5% of the market value of the portfolio should be invested in the securities of a single issuer. No more than 15% of the Fixed Income Investment Manager's portion of the Plan or 120% of the benchmark's allocation, whichever is greater, shall be rated less than "A" quality. Bonds of foreign issuers are permitted to comprise up to 30% of a Fixed Income Investment Manager's portfolio. The duration of the portfolio is expected to be within 50% of the index's duration. Guidelines for diversification and risk tolerance are detailed within the Policy. Additionally, the Policy includes specific investment strategies for fund groups that address each group's investment options and describes the priorities for suitable investments. GAAP does not require disclosure of U.S. Government obligations explicitly guaranteed. As of December 31, 2025 and 2024 below are the Plan's fixed income investments, excluding U.S. Government obligations, at fair value (in thousands):

	2025		2024	
Security Type	**Fair Value**	**Quality**	**Fair Value**	**Quality**
Fixed income securities:				
Asset backed	$ 4,576	AA	$ 3,464	AA+
Agencies	20,613	AA+	3,372	AAA
Commercial mortgage-backed securities	5,204	AAA	17,581	AAA
Mortgages	8,236	A	1,256	A
Corporate	26,071	A-	32,778	A-
Municipal	929	AA+	661	AA+
Erobonds	3,604	A-		
Mutual funds	182,028	A+	165,071	A-
Total	$ 251,261		$ 224,183	

Concentration of credit risk is the risk of loss attributed to the magnitude of an investment in a single issuer. The System mitigates these risks by emphasizing the importance of a diversified portfolio. All funds must be sufficiently diversified to eliminate the risk of loss resulting from overconcentration of assets in a specific maturity, a specific issuer, or a specific class of securities. In particular, no more than 5% of an equity portfolio may be invested in a single company without consent of the Committee. Holdings in any one industry or sector are not to exceed the greater of 150% of the benchmark's allocation or 30% of the portfolio market value. No more than 20% of the portfolio may be invested in cash equivalents and fixed income securities with fixed income securities not exceeding 15%. Concentration by issuer for other investment instruments is limited to 5%. The Policy does specify that acceptable investment instruments must have high-quality credit ratings and, consequently, risk is minimal.

As of December 31, 2025 and 2024, the Plan did not hold more than 5% of assets in any single issuer other than mutual funds, U.S. Government obligations, collective investment trusts or obligations of U.S. Government chartered entities.

The Plan maintained no investments in derivatives as of December 31, 2025 and 2024.

Custodial Credit Risk

Custodial credit risk for deposits is the risk that, in the event of failure of a depository financial institution, the Plan will not be able to recover its deposits or will not be able to recover collateral securities that are in possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty to a transaction, the Plan will not be able to recover the value of its investment or collateral securities that are in possession of another party.

The Plan does not have a formal policy for custodial credit risk. As of December 31, 2025 and 2024, all investments are held in a nominee name of the custodian for the benefit of the Plan.

Interest Rate Risk

All investments carry the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater is the sensitivity of its fair market value to changes in market interest rates. The Plan does not have a formal investment policy that limits investment maturities as a means of managing its exposure to fair value losses arising from changing interest rates. Interest rate risk is limited by the short-term nature of the investments.

As of December 31, 2025 and 2024, the Plan had the following investments in its fixed income accounts (in thousands):

	2025		2024	
Security Type	**Fair Value**	**Weighted-average Maturity in Years**	**Fair Value**	**Weighted-average Maturity in Years**
Fixed income securities:				
Asset backed	$ 4,576	3.21	$ 3,464	13.10
Agencies	20,613	7.26	3,372	22.80
Commercial mortgage-backed securities	5,204	3.39	17,581	29.30
Mortgages	8,236	2.89	1,256	17.60
Corporate	26,071	4.40	32,778	10.50
Municipal	929	5.31	661	4.40
Eurobonds	3,604	3.52	-	N/A
U.S. Treasury	78,117	4.54	89,067	4.60
Mutual funds	182,028	7.48	165,071	7.96
Total	$ 329,378		$ 313,248	

Foreign Currency Risk

Foreign currency risk is the risk that fluctuations in the exchange rate will adversely affect the value of investments denominated in a currency other than the U.S. dollar.

The Plan holds investments in collective investment trusts and mutual funds that are invested in international equities. These investments are denominated in U.S. dollars and accounted for at fair value. The Plan has no exposure to foreign currency fluctuations.

Note 5. Net Pension Liability of the System

The components of the net pension liability of the System as of December 31, 2025 and 2024, were as follows (in thousands):

	2025	2024
Total pension liability	$ 1,220,614	$ 1,213,086
Plan net position restricted for pensions	1,191,556	1,043,568
System net pension liability	$ 29,058	$ 169,518
Plan net position restricted for pensions as a percentage of the total pension liability	97.62%	86.03%

Actuarial Assumptions

The total pension liability was determined by an actuarial valuation as of December 31, 2025 and 2024, using the following actuarial assumptions:

	2025	2024
Actuarial cost method	Entry age normal	Entry age normal
Inflation	2.5%	2.5%
Investment rate of return - net of expenses	5.75%	5.75%
Projected salary increases (ultimate rate)	3.0%	3.0%
Assumed retirement age	Various retirement age rates were assumed for ages 55 through 70	Various retirement age rates were assumed for ages 55 through 70
Mortality rate:	Pre-Decrement: Pub-2010 general employee below-median, amount-weighted	Pre-Decrement: Pub-2010 general employee below-median, amount-weighted
	Post-Decrement (Non-Disabled) Pub-2010 general retiree below-median, amount weighted	Post-Decrement (Non-Disabled) Pub-2010 general retiree below-median, amount weighted
	Disabled: Pub-2010 general disabled retiree, amount weighted	Disabled: Pub-2010 general disabled retiree, amount weighted
	Contingent Survivor: Pub-2010 contingent survivor below-median, amount weighted	Contingent Survivor: Pub-2010 contingent survivor below-median, amount weighted
	Mortality improvement: The mortality tables include fully generational mortality improvement projected after year 2010 using Scale MP-2021	Mortality improvement: The mortality tables include fully generational mortality improvement projected after year 2010 using Scale MP-2021

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation.

Best estimates of arithmetic real rates of return for each major asset class included in the Plan's target asset allocation as of December 31, 2025 and 2024 (see the discussion of the Plan's investment policy), are summarized in the following table:

	Expected Real Rate of Return	
	2025	**2024**
Asset class:		
Domestic equity - large cap	7.05 %	7.05 %
Domestic equity - small cap	7.62	7.62
International equity	7.72	7.72
Fixed income	4.30	4.30
Hedge funds	6.13	6.13
Real estate	6.24	6.24
Cash	2.00	0.00

Discount Rate

The discount rate used to measure the total pension liability was 5.75% for 2025 and 2024, respectively. The projection of cash flows used to determine the discount rate assumed that employer contributions will be made at rates equal to the actuarially determined contribution rates. Based on those assumptions, the Plan's net position restricted for pensions was projected to be available to make all projected future benefit payments of current Plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability. The foregoing actuarial assumptions are based on the presumption that the Plan will continue. If the Plan were to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of accumulated Plan benefits.

Sensitivity of the Net Pension Liability to Changes in the Discount Rate

The following represents the net pension liability calculated using the stated discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current rate:

System Net Pension Liability	1% Decrease (4.75%)	Discount Rate (5.75%)	1% Increase (6.75%)
		(In Thousands)	
December 31, 2025	$ 165,599	$ 29,058	$ (86,718)
December 31, 2024	$ 308,064	$ 169,519	$ 52,285

Note 6. Tax Status

The Plan has received a determination letter from the Internal Revenue Service dated June 10, 2014, stating that the Plan and related trust, as then designed, were in compliance with the applicable requirements of the IRC and therefore not subject to tax. The Plan Administrator believes that the Plan and related trust are currently designed and being operated in compliance with the applicable requirements of the IRC.

Note 7. Related-party Transactions

Certain Plan investments are managed by State Street, which is the trustee and custodian as defined by the Plan. Fees incurred by the Plan for the investment management services are included in net appreciation in fair value of the investment, as they are paid through revenue sharing, rather than a direct payment. Management fees and other investment service fees paid by the Plan were $2,516,336 and $2,465,230 for the years ended December 31, 2025 and 2024, respectively. The System provides certain administrative services at no cost to the Plan.

Note 8. Plan Termination

Although it has not expressed any intention to do so, the System has the right under the Plan, in certain circumstances, to discontinue contributions to the Plan and to terminate the Plan. In the event that the Plan is terminated, the net position of the Plan will be allocated generally to provide the following benefits in the order indicated:

- Benefits due to participants who have reached the age of 65 and to beneficiaries of deceased participants
- Benefits due to participants qualified for early retirement, as defined by the Plan
- Benefits due to other participants in proportion to the actuarial value of their accumulated benefits

In the event the assets are not sufficient to carry out any of the foregoing purposes in full, the allocations to the accounts of individuals thereunder shall be made in the proportion that the assets available bear to the assets required to carry out the purpose in full.

Note 9. Subsequent Events

Subsequent events have been evaluated through July 1, 2026, which is the date the financial statements were available to be issued.

Required Supplementary Information (Unaudited)

Harris County Hospital District Pension Plan
Schedule of Changes in Net Pension Liability and Related Ratios– Unaudited
Last 10 Fiscal Years
Years Ended December 31, 2025 Through 2016

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Total pension liability:										
Service cost	$ 9,237	$ 9,795	$ 9,705	$ 9,567	$ 8,601	$ 8,036	$ 8,057	$ 8,280	$ 6,803	$ 7,232
Interest	68,396	67,925	66,288	65,269	64,147	64,307	63,183	60,495	61,427	59,397
Changes of benefit terms:										
Difference between expected and actual experience	(2,955)	16,924	6,480	28,224	1,782	3,807	243	8,000	1,718	(4,063)
Changes of assumptions	-	-	-	(2,611)	61,527	50,545	23,528	15,748	10,709	-
Benefit payments	(67,150)	(65,338)	(64,129)	(56,576)	(53,264)	(50,184)	(47,367)	(44,712)	(42,563)	(40,178)
Net change in total pension liability	7,528	29,307	18,343	43,873	82,793	76,511	47,644	47,811	38,094	22,388
Total pension liability - beginning	1,213,086	1,183,781	1,165,437	1,121,564	1,038,771	962,260	914,616	866,805	828,711	806,323
Total pension liability - ending	1,220,614	1,213,086	1,183,781	1,165,437	1,121,564	1,038,771	962,260	914,616	866,805	828,711
Plan net position restricted for pensions:										
Contributions - employer	71,000	69,000	68,000	60,000	57,000	53,778	33,621	30,984	29,433	32,693
Net investment income (loss)	146,654	94,028	125,601	(146,104)	88,725	138,087	119,362	(35,426)	107,519	39,529
Benefit payments	(67,150)	(65,338)	(64,129)	(56,576)	(53,264)	(50,184)	(47,367)	(44,712)	(42,563)	(40,178)
Administrative expenses	(2,516)	(2,465)	(2,331)	(2,491)	(2,725)	(2,366)	(3,010)	(2,442)	(2,478)	(2,360)
Net change in plan net position restricted for pensions	147,988	95,225	127,141	(145,171)	89,736	139,315	102,606	(51,596)	91,911	29,684
Plan net position restricted for pensions - beginning	1,043,568	948,343	821,202	966,373	876,637	737,322	634,716	686,312	594,401	564,717
Plan net position restricted for pensions - ending	1,191,556	1,043,568	948,343	821,202	966,373	876,637	737,322	634,716	686,312	594,401
System net pension liability - ending	$ 29,058	$ 169,518	$ 235,438	$ 344,235	$ 155,191	$ 162,134	$ 224,938	$ 279,900	$ 180,493	$ 234,310
Plan net position restricted for pensions as a percentage of the total pension liability	97.62%	86.03%	80.11%	70.46%	86.16%	84.39%	76.62%	69.40%	79.18%	71.73%
Covered payroll	$ 123,035	$ 130,224	$ 126,784	$ 150,963	$ 148,657	$ 156,479	$ 163,835	$ 169,885	$ 173,272	$ 182,060
System net pension liability as a percentage of covered payroll	23.62%	130.17%	185.70%	228.03%	104.40%	103.61%	137.30%	164.76%	104.17%	128.70%

Harris County Hospital District Pension Plan
Notes to Schedule of Changes in Net Pension Liability and Related Ratios– Unaudited
Last 10 Fiscal Years
Years Ended December 31, 2025 Through 2016

Notes to schedule:

Changes of assumptions – In 2017, amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the MP-2017 scale and rate of return on investments from 7.5% to 7.0%.

Changes of assumptions – In 2018, amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the RP-2014 total dataset mortality tables with generational mortality improvement projected after 2006 using Scale MP-2018 for purposes of developing mortality rates and change in inflation rate from 3.0% to 2.5%.

Changes of assumptions – In 2019, amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the Pri-2012 total dataset mortality tables with generational mortality improvement projected after 2012 using Scale MP-2019 for purposes of developing mortality rates and change in investment return rate from 7.0% to 6.75%.

Changes of assumptions – In 2020, amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the Pri-2012 total dataset mortality tables with generational mortality improvement projected after 2012 using Scale MP-2020 for purposes of developing mortality rates and change in investment return rate from 6.75% to 6.25%.

Changes of assumptions – In 2021, amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the Pri-2012 total dataset mortality tables with generational mortality improvement projected after 2012 using Scale MP-2021 for purposes of developing mortality rates and change in investment return rate from 6.25% to 5.75%.

Changes of assumptions – In 2022, 2023, 2024, and 2025 amounts reported as changes of assumptions resulted primarily from adjustments to assumed life expectancies as a result of adopting the Pub-2010 total dataset mortality tables, changes in withdrawal rates from disclosed as in prior year to 75% of prior rates, changes in retirement rates from disclosed as in prior year to rates as disclosed in valuation section of the report and changes in salary increases from rates based on service disclosed amounts in prior year to rates based on age as disclosed in valuation section of the report.

This schedule is presented to illustrate the requirement to show information for 10 years. Information presented in this schedule has been determined as of Harris County's fiscal year end (December 31) in accordance with GASB 68.

Harris County Hospital District Pension Plan
Schedule of Investment Returns– Unaudited
Last 10 Fiscal Years
Years Ended December 31, 2025 Through 2016

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Annual money-weighted rate of return, net of investment expense	13.84%	9.65%	15.04%	(15.39)%	9.84%	18.29%	18.71%	(5.56)%	17.93%	6.65%

This schedule is presented to illustrate the requirement to show information for 10 years. Information presented in this schedule has been determined as of Harris County's fiscal year end (December 31) in accordance with GASB 68.

Harris County Hospital District Pension Plan
Schedule of Employer Contributions – Unaudited
Last 10 Fiscal Years
Years Ended December 31, 2025 Through 2016
(Dollar Amounts in Thousands)

	Actuarially Determined Contribution	Actual Annual Contribution	Actual Annual Contribution as a Percentage of Actuarially Determined Contribution	Covered Payroll	Contributions as a Percent of Covered Payroll
Plan year ended:					
December 31, 2025	$ 32,931	$ 71,000	216.00 %	$ 123,035	57.71 %
December 31, 2024	36,930	69,000	187.00	130,224	53.00
December 31, 2023	38,610	68,000	176.00	126,784	53.63
December 31, 2022	38,858	60,000	154.00	150,963	39.74
December 31, 2021	36,225	57,000	157.00	148,657	38.34
December 31, 2020	36,056	53,778	149.00	156,479	34.37
December 31, 2019	33,621	33,621	100.00	163,835	20.52
December 31, 2018	30,984	30,984	100.00	169,885	18.24
December 31, 2017	29,433	29,433	100.00	173,272	16.99
December 31, 2016	32,693	32,693	100.00	182,060	17.96

The information on the required supplementary information was computed as part of the actuarial valuations at the dates indicated.

Additional information as of the latest actuarial valuation is as follows:

Valuation date	December 31, 2025
Actuarial cost method	Entry age normal
Amortization method	Level dollar amortization of unfunded liabilities
Asset valuation method	Market value
Inflation	2.50%
Salary increase (ultimate rate)	3.00%
Investment rate of return	5.75%
Mortality	

Pre-Decrement:

Pub-2010 General Employee Below-Median, Amount-Weighted

Post-Decrement (Non-Disabled):

Pub-2010 General Retiree Below-Median, Amount-Weighted

Disabled:

Pub-2010 General Disabled Retiree, Amount-Weighted

Contingent Survivor:

Pub-2010 Contingent Survivor Below-Median, Amount-Weighted

Mortality Improvement:

The mortality tables include fully generational mortality improvement projected after year 2010 using Scale MP-2021.

Supplementary Information (Unaudited)

Harris County Hospital District Pension Plan
Schedule of Investment Expenses and Investment Manager Information
Year Ended December 31, 2025

	Direct and Indirect Fees and Commissions					
	Management Fees Paid from Trust	**Management Fees Netted from Returns**	**Total Management Fees**	**Brokerage Fees/ Commissions**	**Profit Share/Carried Interest**	**Total**
Equity securities	$ 1,740,373	$ -	$ 1,740,373	$ -	$ -	$ 1,740,373
Fixed income	341,310	-	341,310	-	-	341,310
Total direct and indirect fees and commissions	$ 2,081,683	$ -	$ 2,081,683	$ -	$ -	2,081,683

Investment Services	
Custodial	281,777
Foreign income tax	16,841
Investment consulting	128,385
Legal	7,650
Total investment services	434,653
Total administrative expenses	$ 2,516,336

List of Investment Manager Names

Dodge and Cox
Jennison Associates
JP Morgan
State Street Corporation
TCW Asset Management Co.
William Blair & Company LLC

Strategic Pillar Update

2026 Board Meeting Strategic Discussion Timeline*												
STRATEGIC PILLAR	**JAN** 2026	**FEB** 2026	**MAR** 2026	**APR** 2026	**MAY** 2026	**JUN** 2026	**JUL** 2026	**AUG** 2026	**SEP** 2026	**OCT** 2026	**NOV** 2026	**DEC** 2026
Pillar 1: Quality & Patient Safety						X						
Quality & Leapfrog Update						X						
Pillar 2: People					X							
Retention, Workplace Safety, and/or Comm. Partnerships					X							
Pillar 3: Resiliency										X		
Strategic Financial Plan									X			
Legislative Agenda										X		
Pillar 4: Health Promotion & Disease Prevention								X				
Disease Prevention (TBD)								X				
Pillar 5: System Optimization		X			X	X		X	X	X		X
Strategic Capital and Financial Plan		X			X			X				X
Big Rocks						X						
Cybersecurity												X
Enterprise Risk Management									X			
AI Update										X		
Pillar 6: Access	X	X			X	X	X		X	X		
Harris Collaborative					X							
ACS Facilities Strategic Plan	X					X						
Financial Assistance and Eligibility Programs Overview		X										
Hospital at Home									X			
ACS Community Partnerships							X					
ACS Initiatives (TBD)										X		

***Subject to Change**
Revised: 5.28.26

Full Board
Committee Meeting

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Presentation Regarding the Harris Health Leapfrog Spring Update
[Strategic Pillar 1: Quality and Patient Safety]

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

Strategic Plan Update
Pillar 1 Quality and Safety

MAINTAINING LEAPFROG A

Thomas Cummins, MD, MMM
EVP, Chief Medical Executive

June 10, 2026

HARRISHEALTH

THE LEAPFROG GROUP

What is Leapfrog?

- The Leapfrog Group is a national nonprofit organization founded in 2000 by large employers and private healthcare experts. Its primary mission is to drive forward improvement in the safety, quality of U.S. health care by promoting data transparency.
- Leapfrog Hospital Safety Grade is a key initiative that assigns consumer-friendly letter grades (A, B, C, D, or F) to nearly 3,000 U.S. hospitals twice a year, based on their performance in preventing medical errors, injuries, accidents, and infections

Leapfrog Hospital Survey Measures

27 Measures in 5 Categories

HOSPITAL ACQUIRED INFECTIONS

- MRSA Infection
- C. Diff Infection
- Infection in the blood
- Infection in the urinary tract
- Surgical Site infection after Colon Surgery

PATIENT SAFETY

- Dangerous Bed Sores
- Patient falls and injuries
- Air or gas bubble in blood

PATIENT SAFETY INDICATORS

- Dangerous Object left in body
- Surgical wound splits open
- Death from treatable serious complications
- Collapsed Lung
- Serious Breathing Problem
- Dangerous Blood Clot
- Accidental cuts and tears in abdomen or pelvis

PRACTICES TO PREVENT ERRORS

- Doctors order medications through a computer
- Safe Medication Administration
- Handwashing
- Communication about Medicines
- Communication about Discharge
- Staff work together to prevent errors

PATIENT SATISFATION

- Enough qualified nurses
- Specially trained doctors care for ICU patients
- Communication with Doctors
- Communication with Nurses
- Responsiveness of Hospital Staff

SPRING 2026 Hospital Safety Grade

Ben Taub Hospital (45-0289)
1504 Taub Loop, Houston, TX 77030

My Score	My Letter Grade
3.0195	B

Lyndon Baines Johnson Hospital (45-0289)
5656 Kelley St., Houston, TX 77026

My Score	My Letter Grade
3.2630	A

SPRING 2026 Safety Score Criteria

Grade	Safety Grade Criteria *(at or above cut point)*	Percentage of Hospitals
A	≥ 3.202	33%
B	≥ 2.991	26%
C	≥ 2.401	23%
D	≥ 1.837	2%
F	< 1.837	<1%
GNA		16%

HARRISHEALTH

SPRING 2026 Hospital Safety Grade
Score Improvement

HARRISHEALTH

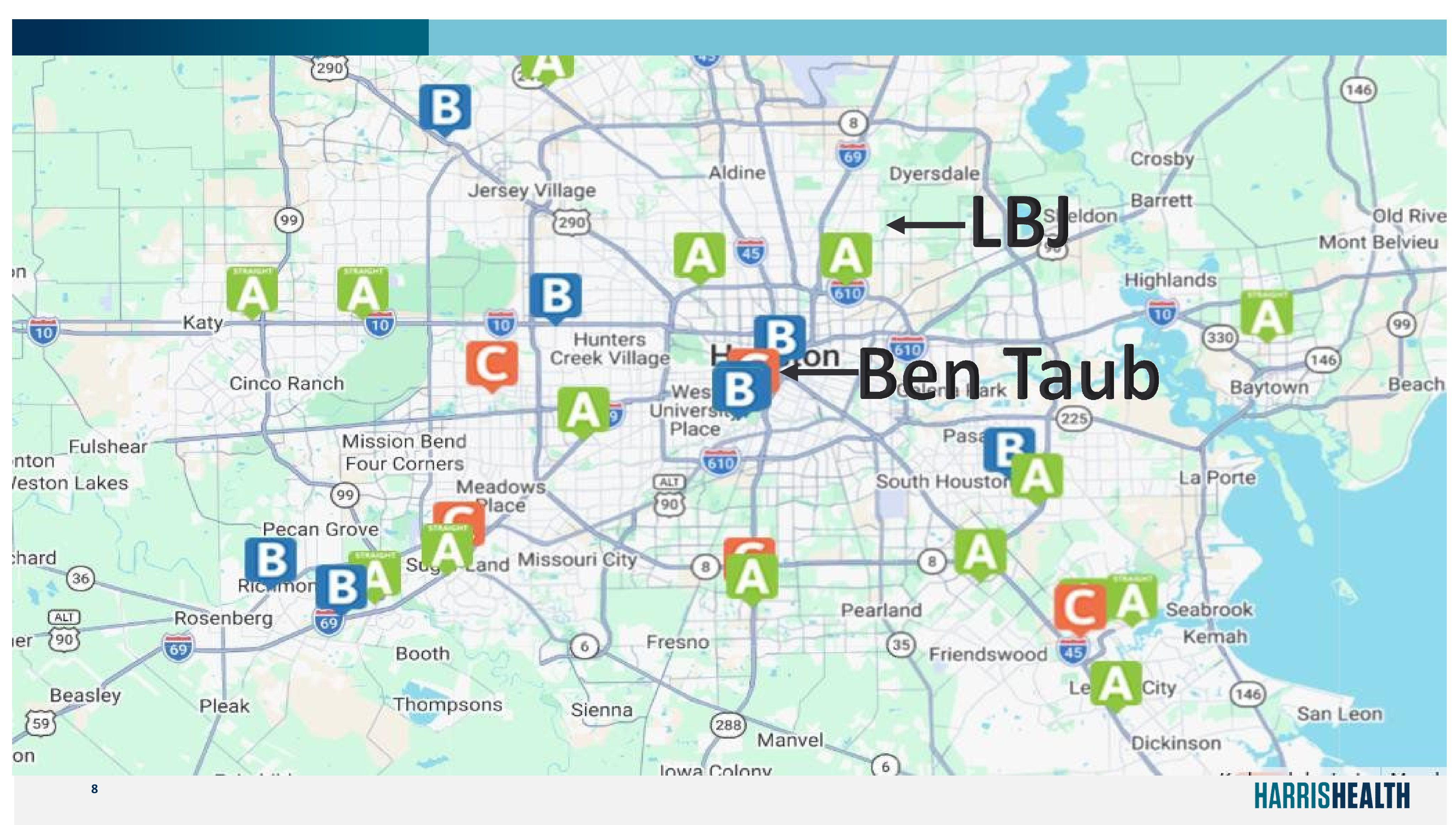
SPRING 2026 Hospital Safety Grade

Measure Domain	Measure	Weight	Reporting Period	National Mean	BT SPRING 2026-FINAL	LBJ SPRING 2026-FINAL
FINAL: LEAPFROG SAFETY SCORE - SPRING 2026						
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	6.10%	Leapfrog Survey 2025	83.55	100	100
	Bar Code Medication Administration (BCMA)	5.93%	Leapfrog Survey 2025	86.14	100	100
	ICU Physician Staffing (IPS)	6.80%	Leapfrog Survey 2025	68.99	100	100
	Safe Practice 1: Culture of Leadership Structures & Systems	3.10%	Leapfrog Survey 2025	117.78	120	120
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	3.18%	Leapfrog Survey 2025	117.68	120	120
	Total Nursing Hours Per Patient Day	4.73%	Leapfrog Survey 2025	79.73	100	100
	Hand Hygiene	4.86%	Leapfrog Survey 2025	78.21	100	100
	H-COMP-1: Nurse Communication	3.03%	1/1/2024 - 12/31/2024	90.55	90	90
	H-COMP-2: Doctor Communication	3.03%	1/1/2024 - 12/31/2024	90.11	92	92
	H-COMP-3: Staff Responsiveness	3.08%	1/1/2024 - 12/31/2024	82.06	83	83
	H-COMP-5: Communication about Medicines	3.09%	1/1/2024 - 12/31/2024	74.83	78	78
	H-COMP-6: Discharge Information	3.06%	1/1/2024 - 12/31/2024	85.65	87	87
Outcome Measures	Foreign Object Retained	4.18%	07/01/2022-06/30/2024	0.011	0.000	0.000
	Air Embolism	2.39%	07/01/2022-06/30/2024	0.001	0.000	0.000
	Falls and Trauma	4.93%	07/01/2022-06/30/2024	0.339	0.000	0.000
	CLABSI	4.58%	07/01/2024-6/30/2025	0.550	0.895	1.558
	CAUTI	4.69%	07/01/2024-6/30/2025	0.497	0.877	0.000
	SSI: Colon	3.36%	07/01/2024-6/30/2025	0.819	2.959*	0.231
	MRSA	4.44%	07/01/2024-6/30/2025	0.657	1.229	0.569
	C. Diff.	4.51%	07/01/2024-6/30/2025	0.347	0.352	0.183
	PSI 4: Death Rate Surgical Inpts w/ Serious Treatable Conditions	1.96%	07/01/2022-06/30/2024	173.37	175.71	175.71
	CMS Medicare PSI 90: Patient Safety Composite Score	14.96%	07/01/2022-06/30/2024	1.00	1.08	1.08
Process Measure Domain Score					0.2500	0.2500
Outcome Measure Domain Score					-0.2305	0.0130
Process/Outcome Domains - Combined Score					0.0195	0.263
Normalized Numerical Score					3.0195	3.2630
Hospital Safety Grade (Letter Grade)					B	A

*Measure Score has been trimmed to 99th percentile. Our Actual Colo SIR for BT=3.120

Celebrate!

https://www.hospitalsafetygrade.org



HARRISHEALTH

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Presentation Regarding Harris Healths Technology Roadmap
[Strategic Pillar 5: System Optimization]

Ron Fuschillo
SVP & Chief Information Officer

HARRIS HEALTH TECHNOLOGY ROADMAP

Ron Fuschillo, SVP CIO

June 2026

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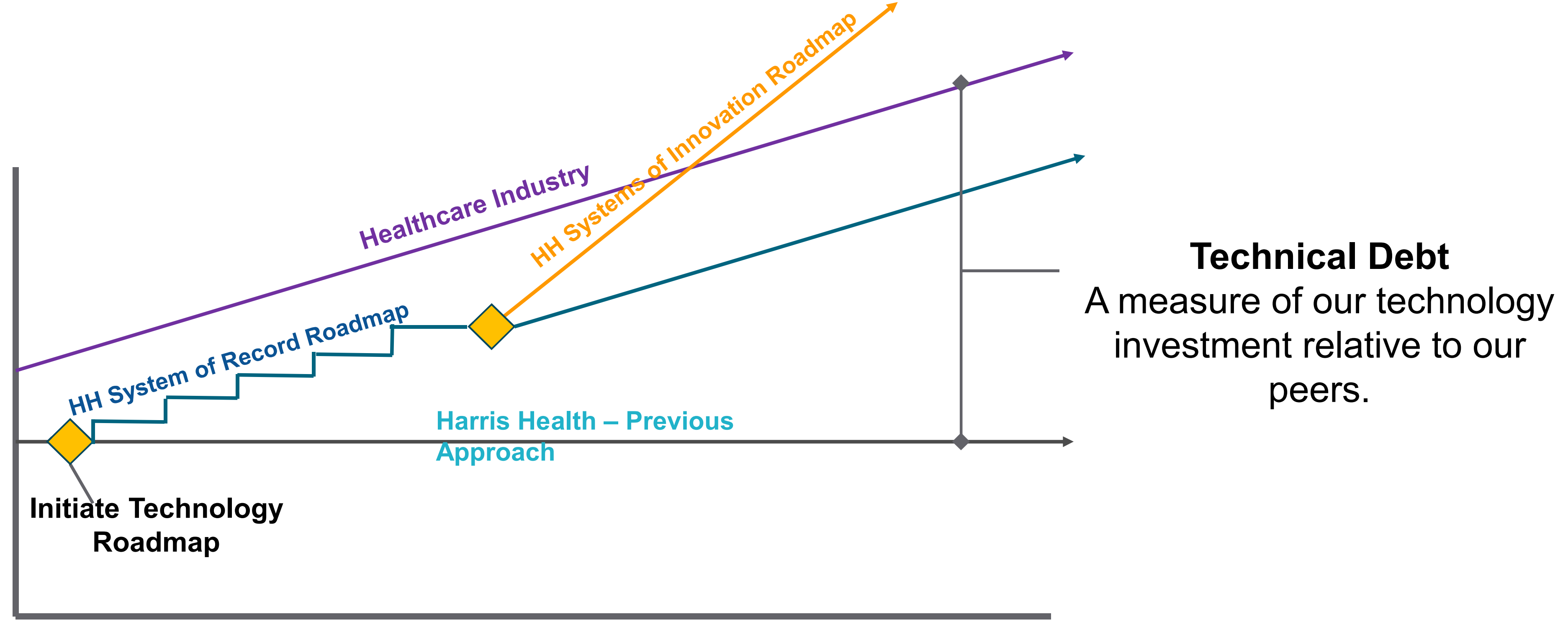
Tech Debt - 2024



Shared in 2025

The Future Ahead for Healthcare Industry & Harris Health's Position

- Leveraging technologies to improve quality of care
- Application Rationalization – reducing complexity
- Digitization of workflows
- Automation
- Artificial Intelligence
- Data drives predictive analytics (Non-Medical Determinants of Health)
- Cloud & mobility
- Security

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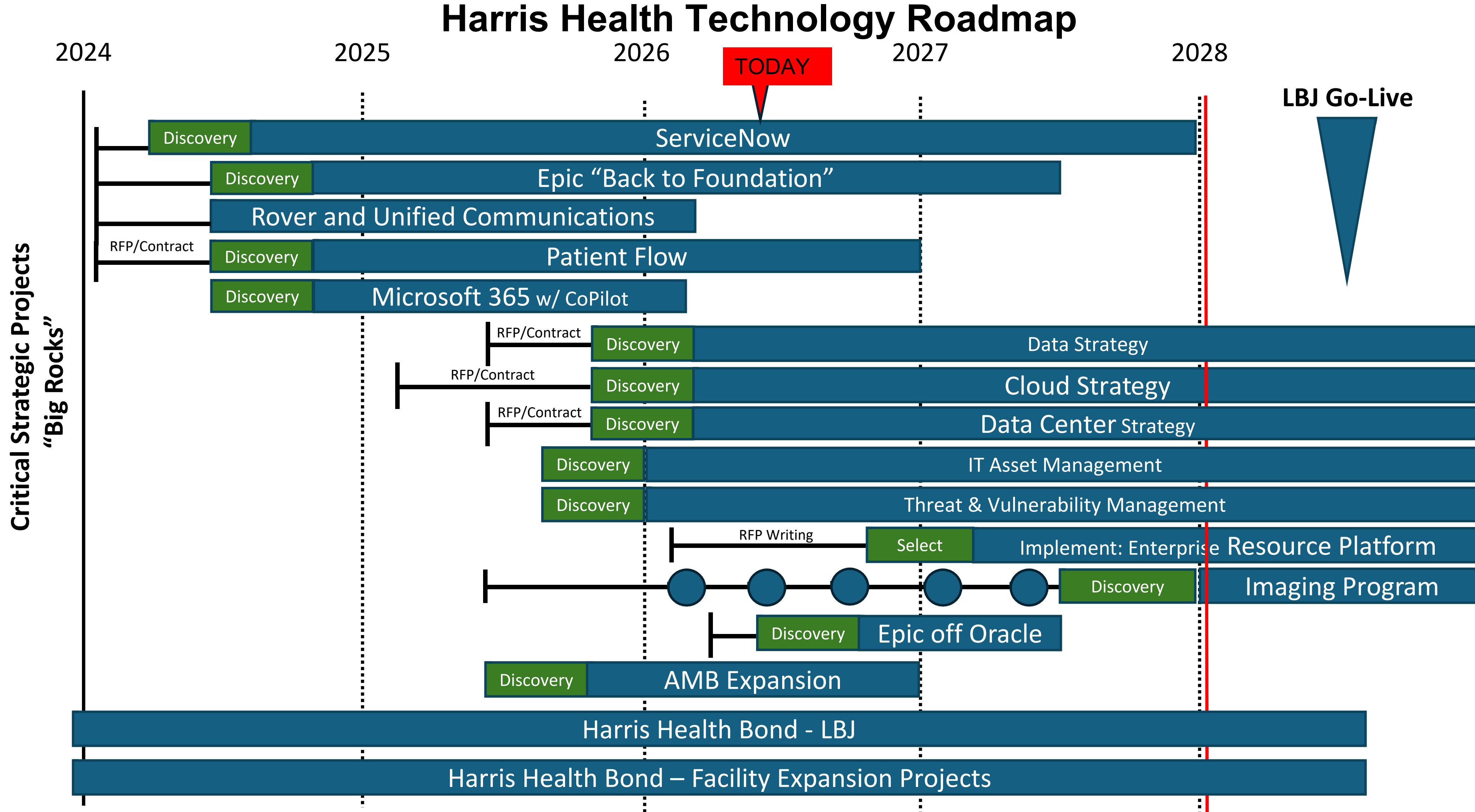

Harris Health Technology Roadmap
2024
2025
2026
2027
2028
TODAY
LBJ Go-Live
Critical Strategic Projects
"Big Rocks"
Discovery
ServiceNow
Discovery
Epic "Back to Foundation"
Rover and Unified Communications
RFP/Contract
Discovery
Patient Flow
Discovery
Microsoft 365 w/ CoPilot
RFP/Contract
Discovery
Data Strategy
RFP/Contract
Discovery
Cloud Strategy
RFP/Contract
Discovery
Data Center Strategy
Discovery
IT Asset Management
Discovery
Threat & Vulnerability Management
RFP Writing
Select
Implement: Enterprise Resource Platform
Discovery
Imaging Program
Discovery
Epic off Oracle
Discovery
AMB Expansion
Harris Health Bond - LBJ
Harris Health Bond – Facility Expansion Projects

Strategic Alignment Check

In 2024

- **Cloud Big Rock**
- **M365 Phase 2 - Security**
- **Bought not Built**
- **Data Strategy with MS Fabric**
- **Enhancing IT Maturity**

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Strategic Alignment Check

In 2026

- **Cloud Big Rock**
- **M365 Phase 2 - Security**
- **Bought not Built**
- **Data Strategy with MS Fabric**
- **Enhancing IT Maturity**

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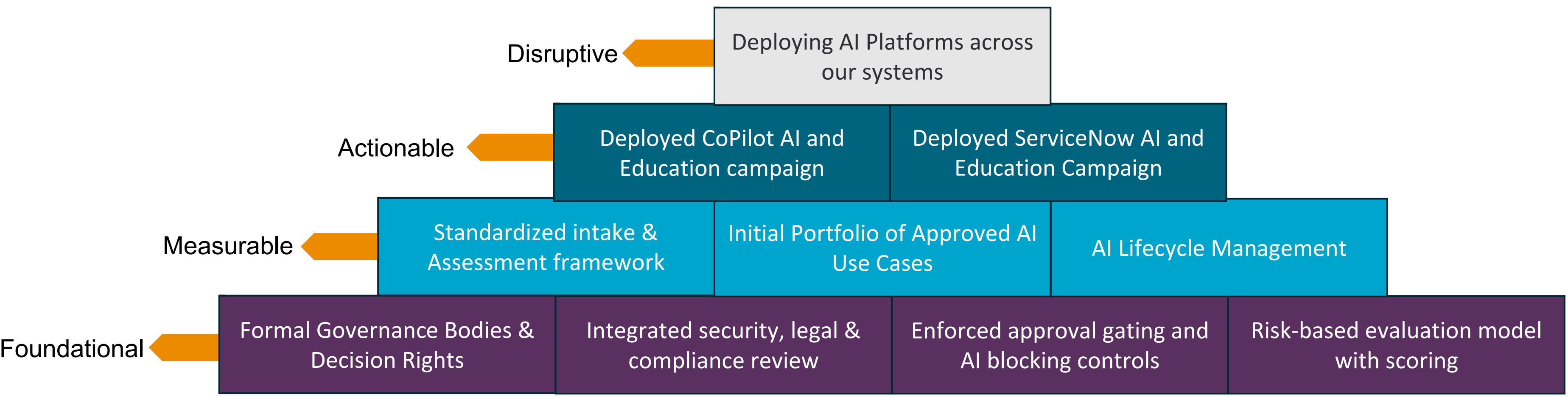
Key Partners

- **ServiceNow** – 86% Fortune 500 companies
- **Epic** – 70% of Large Systems, we aim for top 25% for adoption
- **Microsoft Infrastructure** – 70% utilize
- **MS Security** – 85% adoption for identity security & 60% with endpoint security
- **ERP Vendor** - Coming Soon
  - **Summary:** Our Strategic System investments are on pace and in alignment with industry patterns.

Big Rock Impacts So Far

Rover	M365	Epic	Patient Flow	ServiceNow
• 2,700+ iPhones deployed • Bedside Charting • Barcode Scanning • Reduced documentation times • Care team communication • Highest VOIP user in country • Call Transfer	• Bring Your Own Device (BYOD) usage – 6,000+ • Legacy infrastructure migrated to M365 • 15,000+ hours saved by CoPilot AI each month • Deployed capabilities of agentic AI • Enabled Cloud	• Organizational adoption philosophy of Epic platform • Acute Teleconsult • MyChart Direct Scheduling • Tracking & Managing Heart Failure patients • Neonatal Sepsis Calculator	• Bed availability improved • Zoll Dispatch (ambulance dispatch integration) • Unified Patient Command Center (System-Wide) benefitting patient safety and experience	• Employee center live in April • 53% of all HR Cases addressed in Self-Service • 9,000+ Knowledge articles (tip sheets) reviewed in 1 month • AI Search and Summarization deployed

What Is Harris Health Doing With AI?

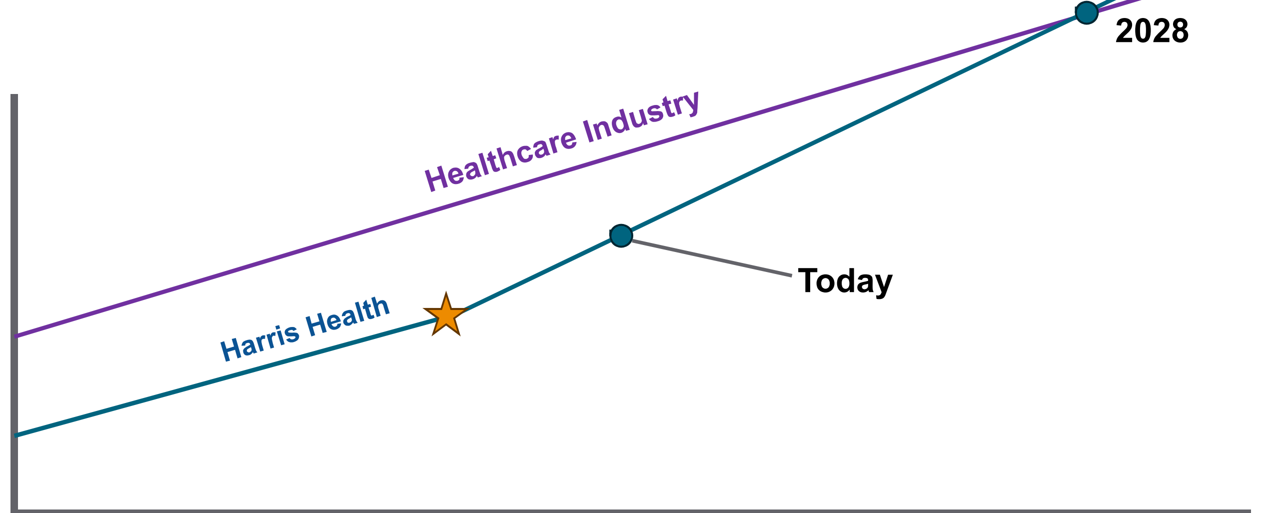


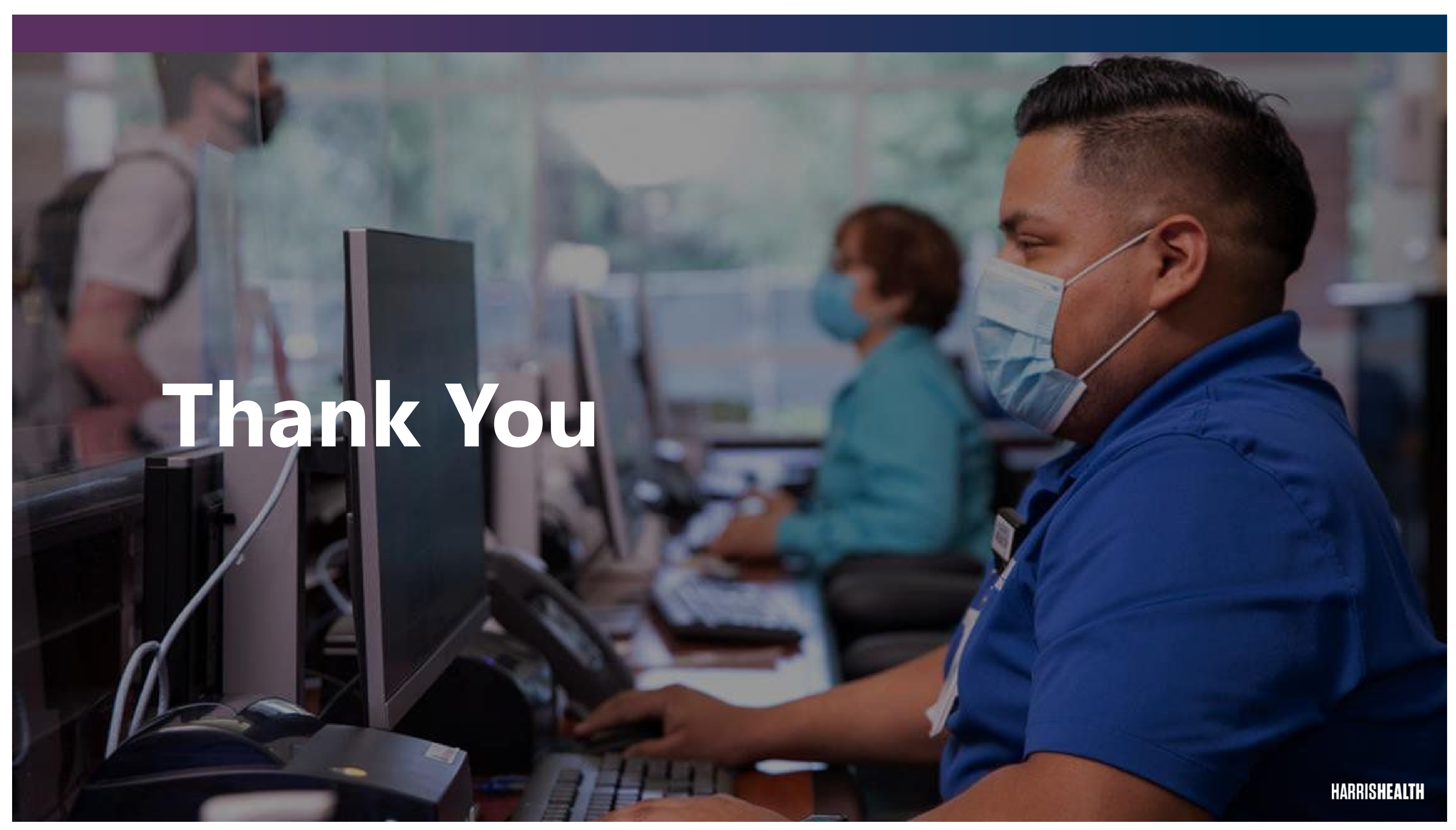
Our Continued Focus

- **Healthcare is entering an AI-enabled operating model**
  - From documentation to decisions to autonomous workflows
- **Workforce and financial pressure are forcing change**
  - Technology is the only scalable lever
- **Risk is rising alongside opportunity**
  - Cyber, AI governance & regulatory pressure
- **Winners will be platform-driven, data-driven, and consumer-friendly**
  - Integrated experience across patient & clinician journeys

Commitment to Leading in 2028

- Our mission as a senior team was to eradicate the technical debt.
- Were on a path to not just close the gap, but to be a leader in several spaces.




Thank You
HARRISHEALTH

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Presentation Regarding the Harris Health Ambulatory Care Services (ACS) Facilities Strategic Plan [Strategic Pillar 6: Access]

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

ACS Facilities Strategic Plan

Jennifer Small, AuD, MBA, CCC-A
Chief Executive Officer, Ambulatory Care Services
June 10, 2026

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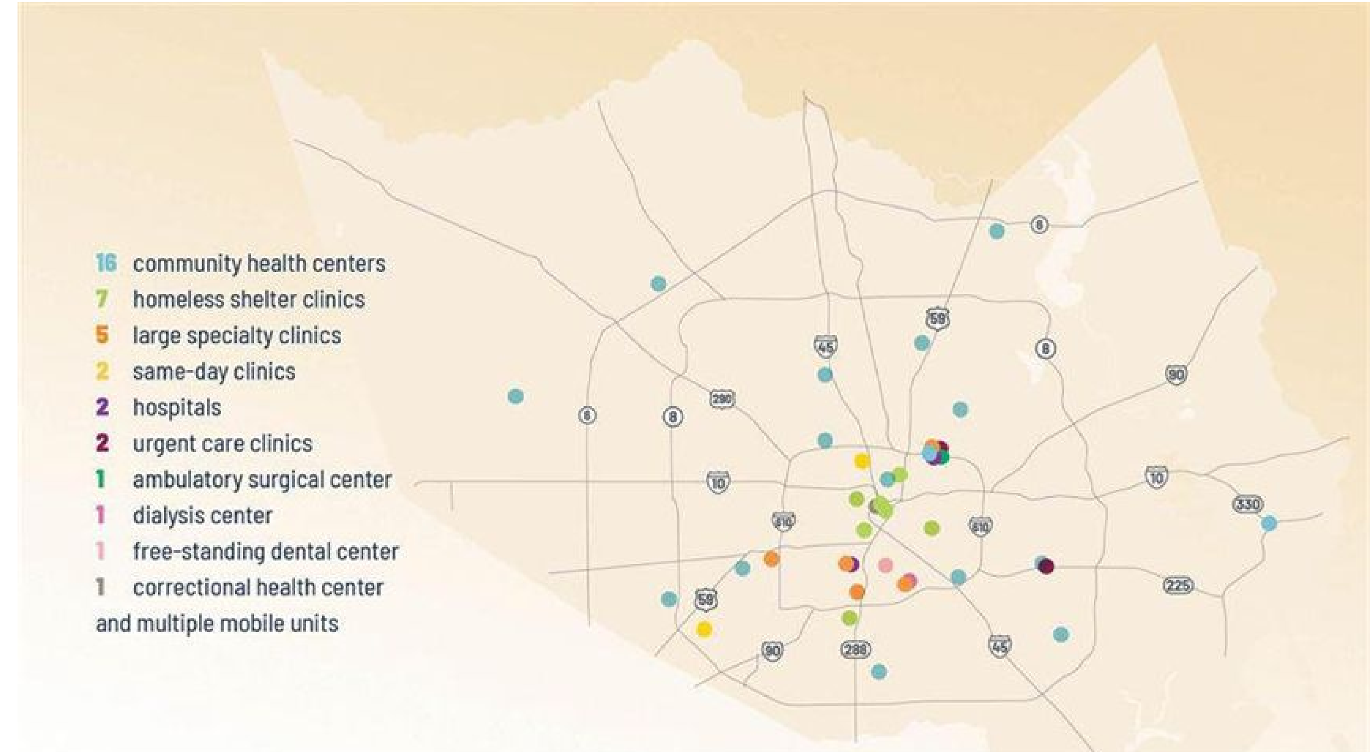
Overview

- ACS Facility Projects
- Infrastructure
- ACS Resiliency Plan

Summary of Harris Health Locations

Ben Taub Hospital

Lyndon B. Johnson Hospital



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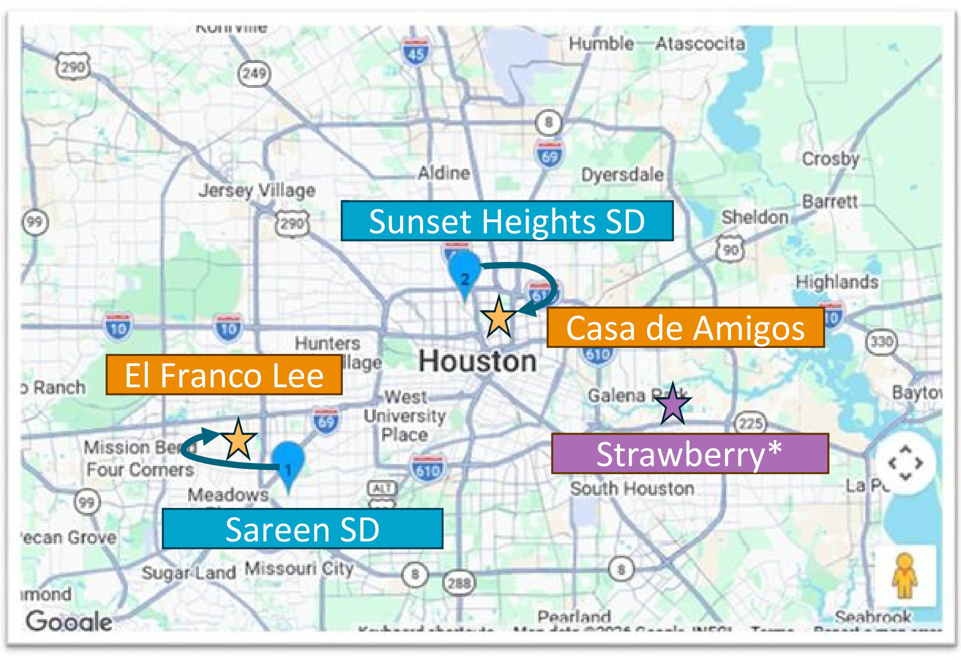
Transition Same Day Clinics to Urgent Care



Why Transition:

- Enhances access to fast, efficient care for non-emergency conditions by expanding services through onsite pharmacy, laboratory, and X-ray capabilities. Urgent care clinics operate without appointments, allowing patients to walk in and receive timely treatment without prior scheduling.

Same Day Location	Future Campus Location	Forecast Completion Date
Sunset Heights	Casa de Amigos	Q4 2027
Sareen	El Franco Lee	Q4 2030
Monroe	Strawberry (Pasadena Square)	Q4 2025 - Completed Q4 2028
Formerly Robindell	Vallbona	Q4 2030

Note: Urgent Care at Strawberry Health Center (formerly Monroe Clinic) will relocate to Pasadena Square in Q4 2028.
The former Robindell Clinic is forecasted to transition to an urgent care clinic on the Vallbona Health Center campus on Q4 2030. All current Same Day Clinics are located within six miles of their associated health center.

Renderings of the new Urgent Care Sites

Renderings of the Urgent Care at Casa de Amigos (formally Sunset Heights)

Renderings of the Urgent Care at El Franco Lee Campus (formally Sareen)

Health Center Replacements

Vallbona Health Center Replacement

60,000 SF the project includes renovation of the main Vallbona facility and addition of Robindell Urgent Care.

Forecast Completion Date: Q4 2030

Cypress Health Center Replacement

30,000 SF building to house current services with expansion for at least one nursing pod and ancillary services.

Forecast Completion Date: Q2 2029

Acres Homes Health Center Replacement & Expansion

A ~60,000 SF building applying new room standards to existing services and adding specialty campus needs.

Forecast Completion Date: Q2 2030

Northwest Health Center Replacement

40,000 SF (approximately) clinic to be built on 2.5 acres to current room standards and furnishings.

Forecast Completion Date: Q4 2033

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Net New Health Centers

Greater Alief

(Net New #1 – PCT 4)

- **16,218 SF** leased clinic in Precinct 4 offering primary care, behavioral health, psychiatry, and clinical pharmacy.
- Forecast Completion Date: Q1 2028

Greenspoint

(55k clinic + 15k ASC)
(Net New #2 – PCT 2)

- **70,000 SF** new build in Precinct 2 housing an Ambulatory Surgical Center (ASC), primary, and specialty care.
- Forecast Completion Date: Q3 2029

Net New Precinct 3 Health Center

(Net New #3 – PCT 3)

- SF TBD. Small (<15,000 SF) leased clinic offering primary care.
- Forecast Completion Date: Q1 2033

- These project remains in progress, currently undergoing land acquisition, finalizing lease agreements, or internal strategic planning.

Pasadena Square Health Center

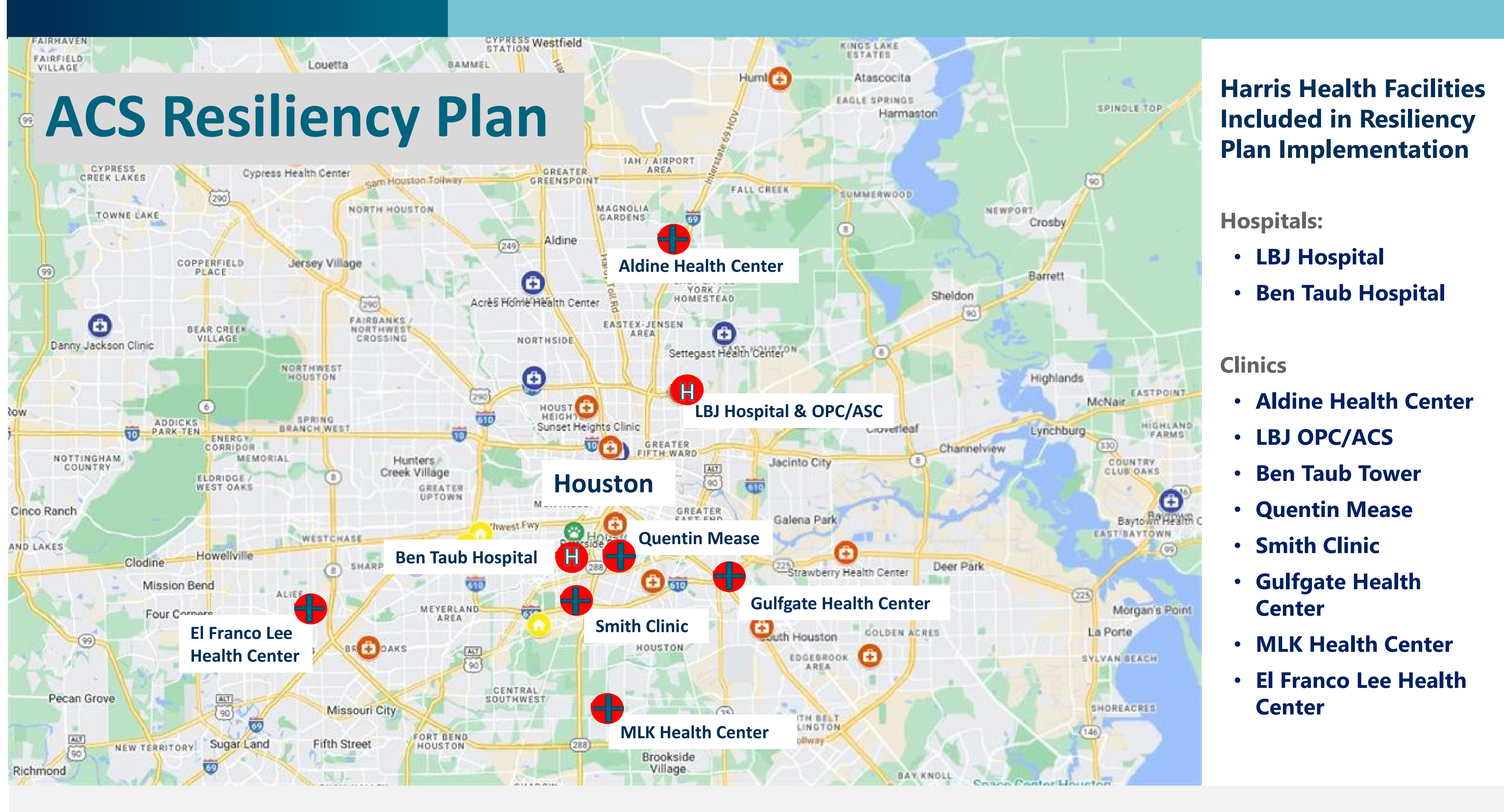
A **60,000 SF** facility is planned to open in Q4 2028, housing Urgent Care at Strawberry Health Center, Strawberry Health Center, and the Pediatric & Adolescent Health Center–Pasadena. The Health Center will include Physical Therapy, a Food Farmacy, and integrate the new ACS clinical design standards, serving as a model for future clinics across the system.

Pasadena Square Exterior Concept Rendering

Infrastructure

Strategic Capital Program Projects by Completion Date

Precinct	Pavilion	Forecast Completion Date	Project Name	Total Projected Bond as of 4/2026*	Bond Expenses Thru 3/2026	Total Other Funding Sources as of 4/2026**	Total Project Estimate as of 4/2026
1, 2, 4	ACS	2025 Q3	SCP ACS INFRASTRUCTURE REPLACE WATER HEATERS - EFL, ACRES, SETTEGAST & BAYTOWN	$ 152,417	$ 152,417	$ 2,500	$ 154,916
1	ACS	2025 Q3	SCP ACS INFRASTRUCTURE SC REPLACEMENT OF EXHAUST FANS (FY24)	$ -	$ -	$ 123,637	$ 123,637
1	ACS	2025 Q3	SCP ACS SC BONE DENSITY MACHINE	$ 93,887	$ 93,887	$ -	$ 93,887
1	ACS	2025 Q3	SCP ACS SC MAMMOGRAPHY UNIT REPLACEMENT (MAMMO 1-6)	$ -	$ -	$ 2,552,424	$ 2,552,424
1	ACS	2026 Q1	SCP ACS INFRASTRUCTURE NW RTUS 3 AND 6	$ 84,137	$ 84,137	$ -	$ 84,137
1	ACS	2026 Q2	SCP ACS INFRASTRUCTURE ALDINE ROOFTOP UNITS	$ 1,160,673	$ 844,284	$ 1,004,832	$ 2,165,504
1	ACS	2026 Q2	SCP ACS INFRASTRUCTURE MLK RTU AND LIEBERT UNIT REPLACEMENT (FY24)	$ 653,931	$ 541,278	$ 204,333	$ 858,264
1	ACS	2026 Q2	SCP ACS INFRASTRUCTURE NW FIRE ALARM PANEL AND RELATED EQUIPMENT	$ 163,575	$ 69,683	$ -	$ 163,575
1	ACS	2026 Q3	SCP ACS INFRASTRUCTURE SMITH CLINIC FIRE PANEL UPGRADE	$ 128,706	$ 1,047	$ -	$ 128,706
1	ACS	2026 Q3	SCP ACS SC PET CT REPLACEMENT AND MOBILE UNIT IMPROVEMENTS	$ 1,990,133	$ 737,654	$ 3,832,408	$ 5,822,541
1, 2	ACS	2027 Q1	SCP ACS INFRASTRUCTURE UPGRADE AT BY, GG, AC (COMBINED)	$ 694,281	$ 5,863	$ -	$ 694,281
1, 2, 3, 4	ACS	2027 Q4	SCP ACS LAND ACQUISITIONS (4 SITES)	$ -	$ -	$ -	$ -
1	ACS	2027 Q4	SCP ACS SC CT SCANS (1-3) AND CT SIMULATOR REPLACEMENT	$ 7,229,269	$ 121,553	$ 461,111	$ 7,690,380
2	ACS	2027 Q4	SCP ACS SUNSET HEIGHTS URGENT CARE CONSTRUCTION AND BUILDOUT	$ 13,211,250	$ 465,772	$ 61,007	$ 13,272,257
4	ACS	2028 Q1	SCP ACS GREATER ALIEF	$ 8,000,000	$ 714,128	$ -	$ 8,000,000
1	ACS	2028 Q1	SCP ACS SC MRI SCAN1.5T REPLACEMENT (MRI 1&3)	$ 7,096,834	$ 540,714	$ 263,166	$ 7,360,000
4	ACS	2028 Q2	SCP ACS SAREEN SAME DAY CLINIC CONSTRUCTION AND BUILDOUT ON EL FRANCO LEE CAMPU	$ 6,553,359	$ 297,481	$ -	$ 6,553,359
1	ACS	2028 Q2	SCP ACS SC LINEAR ACCELERATORS REPLACEMENT (LINEAR 1-2)	$ 20,401,343	$ 71,151	$ 795,172	$ 21,196,515
1	ACS	2028 Q2	SCP ACS SC RADIOGRAPHIC REPLACEMENT (RAD ROOM 1)	$ 422,793	$ -	$ 29,477	$ 452,270
1	ACS	2029 Q1	SCP ACS SC RAD FLUOROSCOPY REPLACEMENT (RF ROOMS 1,2)	$ 2,163,980	$ 130,972	$ 77,227	$ 2,241,207
3	ACS	2029 Q2	SCP ACS CYPRESS CLINIC	$ 35,472,436	$ 145,091	$ 527,564	$ 36,000,000
1	ACS	2029 Q2	SCP ACS HARRIS HEALTH GARAGE (SERVING BT, QM, SMITH)	$ 59,891,729	$ -	$ 108,271	$ 60,000,000
1	ACS	2029 Q2	SCP ACS RADIATION ONCOLOGY AT LBJ	$ 69,779,298	$ 181,513	$ 220,702	$ 70,000,000
2	ACS	2029 Q3	SCP ACS GREENSPOINT HEALTH CLINIC	$ 53,109,486	$ 71,044	$ 9,416,506	$ 62,525,992
1	ACS	2030 Q2	SCP ACS ACRES HOME AGE FACILITY REPLACEMENT AND EXPANSION	$ 21,921,780	$ 528,822	$ 35,978,220	$ 57,900,000
4	ACS	2030 Q4	SCP ACS VALLBONA MAIN RENOVATION, CAMPUS, ANNEX AND ROBINDELL SAME DAY CLINIC	$ 9,572,666	$ 276,534	$ 46,427,334	$ 56,000,000
1, 2, 3, 4	ACS	2032 Q2	SCP ACS MOBILE MAMMO VAN (REFRESH IN 7-8 YEARS)	$ -	$ -	$ 1,999,632	$ 1,999,632
3	ACS	2033 Q1	SCP ACS NET NEW HEALTH CENTER PRECINCT 3	$ -	$ -	$ 22,500,000	$ 22,500,000
1	ACS	2033 Q4	SCP ACS NORTHWEST AGE FACILITY REPLACEMENT	$ 2,603,504	$ 86,755	$ 40,896,496	$ 43,500,000
			ACS Total	**$ 322,551,467**	**$ 6,161,780**	**$ 167,482,017**	**$ 490,033,484**



ACS Resiliency Plan
Aldine Health Center
LBJ Hospital & OPC/ASC
Houston
Quentin Mease
Ben Taub Hospital
Gulfgate Health Center
Smith Clinic
El Franco Lee
Health Center
MLK Health Center
Harris Health Facilities
Included in Resiliency
Plan Implementation
Hospitals:
• LBJ Hospital
• Ben Taub Hospital
Clinics
• Aldine Health Center
• LBJ OPC/ACS
• Ben Taub Tower
• Quentin Mease
• Smith Clinic
• Gulfgate Health
Center
• MLK Health Center
• El Franco Lee Health
Center
HARRISHEALTH

Generator Implementation Strategy at Specialty Clinics

Quentin Mease Health Center

Milestone	Target Date
Construction Start	March 2026
Construction Completion	December 2026
Testing/Activation	December 2026

Ben Taub Tower

Milestone	Target Date
Construction Start	January 2026
Construction Completion	September 2026
Testing/Activation	June 2027

Smith Clinic

Milestone	Target Date
Construction Start	May 2026
Construction Completion	November 2026
Testing/Activation	December 2026

Note: Project goal are for emergency power distribution to provide full facility emergency back-up

Generator Implementation Strategy at ACS Clinics

Aldine Health Center

Target date for generator fabrication and installation: **July 2026**

Gulfgate Health Center

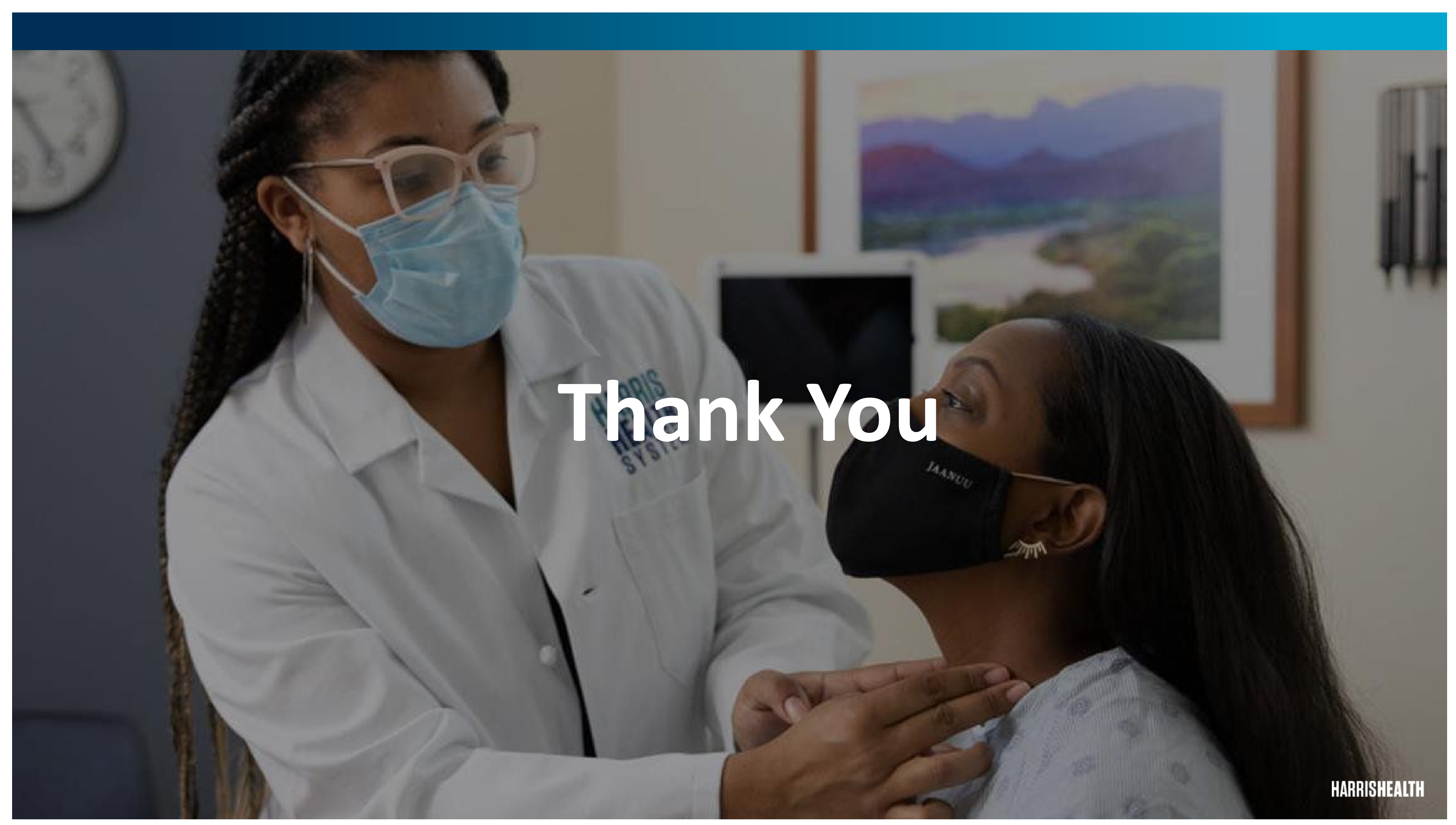
Target date for generator fabrication and installation: **July 2026**

Martin Luther King Jr. Health Center

Target date for generator fabrication and installation: **October 2026**

El Franco Lee Health Center

Target date for generator fabrication and installation: **October 2026**


Thank You
JAANUU
HARRISHEALTH

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Committee Reports

Committee Meetings:

- Quality Committee – May 26, 2026 (Open Session)
  - HRO Safety Message Video Regarding Antibiotics Before Surgery
  - Harris Health Leapfrog Spring 2026 Announcement
- Budget & Finance Committee – May 28, 2026 (Open Session)
  - Financial Matters
    - Harris Health Second Quarter Fiscal Year 2026 Investment Report
    - Harris Health First Quarter Calendar Year 2026 Pension Plan Report
  - Information Only
    - Annual Interest Rate Management Agreement Disclosure
    - 2025 Annual Report of the 401k and 457b Administrative Committee Activities
    - 2025 Annual Report of the Pension and Disability Committee Activities
- Compliance & Audit Committee – May 28, 2026 (Open Session)
  - Compliance and Audit Matters
    - Presentation Regarding the Harris Health Quarterly Internal Audit Update as of May 15, 2026
    - 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, 2025
  - Information Only
    - Independent Auditor's Pre-audit Communication for the Harris County Hospital District 401(k) Plan Year Ended December 31, 2025
    - Independent Auditor's Pre-audit Communication for the Harris County Hospital District Pension Plan Year Ended December 31, 2025

Kimberly J. Williams, JD
Harris County Purchasing Agent

May 28, 2026

Board of Trustees Office
Harris Health

Re: Board of Trustees Meeting – June 10, 2026
Budget and Finance Agenda Items

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

A. Approvals
B. Transmittals

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

Sincerely,

Kimberly J. Williams

Kimberly J. Williams, JD
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: June 10, 2026 (Approvals)

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A1	**Pivot Point Consulting (HCHD-1395)** MWBE Goal: 16%	**Information Technology Consulting and Staff Augmentation Services for Harris Health** - To continue providing information technology consulting and staff augmentation services for Harris Health. ***Job No. 240174***	Renewal August 21, 2026 through August 20, 2027	Antony Kilty	$ 8,307,120	**$ 15,292,304**
A2	**The Trevino Group** MWBE Goal: 100%	**Sunset Heights Urgent Care Construction and Buildout for Harris Health** - To provide all labor, materials, equipment and incidental for the Sunset Heights Urgent Care construction and buildout. The owner contingency provides for coverage of unanticipated costs throughout the construction project. ***Job No. 260055***	Award Best proposal meeting requirements	Babak Zare		**$ 10,906,900**
A3	**Southland Industries** MWBE Goal: 12%	**Installation of Generator and Associated Components at Ben Taub Hospital for Harris Health** - To provide all labor, materials, equipment, and incidentals for the installation of a generator and its associated components at Ben Taub Hospital. The owner contingency provides for coverage of unanticipated costs throughout the construction project. ***Job No. 260084***	Award Best proposal meeting requirements	Babak Zare		**$ 8,625,062**
A4	**Marsh USA LLC (HCHD-1454)** MWBE Goal: 5%	**Insurance Broker Services for Commercial Insurance Policies for Harris Health** - To continue providing insurance broker services for commercial insurance policies for Harris Health. ***Job No. 240179, Board Motion 24.09-135***	Ratify Renewal May 01, 2026 through April 30, 2027	Jay Camp	$ 6,450,212	**$ 7,750,000**
A5	**Houston Behavioral Healthcare Hospital** MWBE Goal: 0% Non-Divisible	**Inpatient Psychiatric Services for Harris Health** - To provide inpatient psychiatric services for patients of Harris Health. ***Job No. 260004***	Award Only proposal received One (1) year initial term with four (4) one-year renewal options	Ruth Russell		**$ 5,000,000**
A6	**TEKSYSTEMS, INC. (HCHD-1458)** MWBE Goal: 16%	**Information Technology Consulting and Staff Augmentation Services** - To continue providing information technology consulting and staff augmentation services for Harris Health. ***Job No. 240174***	Renewal August 21, 2026 through August 20, 2027	Antony Kilty	$ 860,000	**$ 3,711,330**
A7	**Bright Horizons Family Services, Inc. (HCHD-1399)** MWBE Goal: 15%	**Backup Child and Elderly Care Services for Harris Health** - Additional funds are needed due to an unexpected increase in out of network claims. ***Job No. 240155***	Ratify Additional Funds November 01, 2025 through October 31, 2026	Amanda Jones-Duncan	$ 1,208,550	**$ 2,791,450**
A8	**A-Rocket Moving & Storage, Inc. (HCHD-1878)** MWBE Goal: 100%	**Move Consulting and Move Services Support to Harris Health** - To provide move consulting and move services support for Harris Health. ***Job No. 250360***	Award Best proposal meeting requirements One (1) year initial term with six (6) one-year renewal options	Timothy Brown		*

No.	Vendor	Description Justification Contract	Action Basis of Recommendation Term	Project Owner	Previous Amount	Current Estimated Cost
A9	**Hoar Program Management, LLC (HPM) [HCHD-1204]** MWBE Goal: 20%	**Audit Servies for the Lyndon B. Johnson Expansion for Harris Health** - Additional funds are required to provide ongoing prevailing wage monitoring services which will include onsite representation to validate compliance to the current Agreement. HPM will conduct weekly certified payroll reviews along with reviewing apprenticeship participation and conducting worker interviews. ***Job No. 230332, Board Motion 24.01-10***	Additional Funds	Teong Cheah Chai	$ 767,275	**$ 890,016**
A10	**Intelligent Retinal Imaging Systems (HCHD-817)** MWBE Goal: 0% Non-Divisible	**Retinal Imaging Systems and Specialists Services for Harris Health** - Additional funds are required for the projected growth in the eligible Harris Health patients requiring annual retinal screening. There is also a continued need for professional reading services by Retina Specialists in order to maintain compliance with clinical standards of care and population health initiatives. The extension includes four (4) additional one-year renewal options. ***Professional Services Exemption***	Additional Funds Extension Professional Services Exemption July 14, 2026 through July 13, 2027	Leslie Bradley Gibson	$ 342,721	**$ 602,000**
A11	**Varian Medical Systems, Inc.** MWBE Goal: Exempt Sole Source	**Brachytherapy Afterloader System for Harris Health** - To purchase BRAVOS Afterloader system for brachytherapy treatment for the new Oncology department at Lyndon B. Johnson Hospital. ***Sole Source Exemption***	Award Sole Source Exemption	Teong Chai		**$ 507,000**
A12	**Benco Dental Supply Co. (HCHD-1447)** MWBE Goal: 5%	**Dental Supplies & Equipment for Harris Health** - Additional funds are required to purchase equipment used for dental services provided to Harris Health patients. ***Job No. 230380***	Additional Funds January 14, 2026 through January 13, 2027	Arun Mathew	$ 333,110	**$ 465,227**
A13	**HEIDELBERG ENGINEERING INC** MWBE Goal: Exempt Sole Source	**Optical Coherence Tomography Equipment for Harris Health** - To add two (2) Spectralis Tracking Optical Coherence Tomography (OCT) machines for Martin Luther King and Acres Home Health Centers. ***Sole Source Exemption***	Purchase Sole Source Exemption	Arun Mathew		**$ 370,300**
					Total Expenditures	$ 58,811,589
					Total Revenue	$ (0)

Wednesday, June 10, 2026

Consideration of Approval of Grant Recommendations
(Items B1 through B2 of the Grant Matrix)

Grant Recommendations:

B1. Interlocal Grant Agreement

- Grantor: Harris County Public Health
  Funded by Ryan White HIV/AIDS Treatment Extension Act of 2009 Part A
- Term: March 1, 2026 – February 28, 2027
- Award Amount: $ 11,027,446.00
- Project Owner: Dr. Jennifer Small

B2. Grant Agreement

- Grantor: Harris County Hospital District Foundation
- Term: Two Years
- Award Amount: $ 167,000.00
- Project Owner: Dr. Jackie Brock

Grant Agenda Items for the Harris County Hospital District dba Harris Health, Board of Trustees Report
Grant Matrix: June 10, 2026

No.	Grantor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Award Amount
B1	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 the Harris County Hospital District d/b/a 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, 2026 through February 28, 2027	Dr. Jennifer Small	$ 11,024,446.00
B2	Harris County Hospital District Foundation	Consideration of Approval a Grant Agreement Between Harris County Hospital District d/b/a Harris Health and the Harris County Hospital District Foundation, benefiting Harris Health's Reach for the Stars Nursing Scholarship Fund.	Grant Agreement	2 Years	Dr. Jackie Brock	$ 167,000.00
					TOTAL AMOUNT:	**$ 11,191,446.00**

Wednesday, June 10, 2026

Consideration of Approval of Contract Recommendations
(Items C1 through C4 of the Contract Matrix)

Contract Recommendations:

C1. Interlocal Agreement
- Contractor: Harris County, Texas *on behalf of Harris County Public Health*
- Project Owner: Ron Fuschillo
- Term: October 1, 2025 – September 30, 2026
- Amount: $ 4,000,000.00

C2. Fifth Amendment of an Interlocal Agreement
- Contractor: Harris County, Texas
- Project Owner: Sara Thomas
- Term: October 1, 2026 – September 30, 2027
- Amount: $ 5,376,000.00

C3. Third Amendment of an Affiliation and Support Agreement
- Contractor: The University of Texas Health Science Center at Houston (UTHSC)
- Project Owner: Sara Thomas
- Term: N/A
- Amount: N/A

C4. Interlocal Agreement
- Contractor: Harris County Public Health
- Project Owner: Dr. Amy Smith
- Term: FY2026-FY2027
- Amount: N/A

Contract Agenda Item(s) for the Harris County Hospital District dba Harris Health, Board of Trustees Report
Contract Matrix: June 10, 2026

No.	Contractor	Description/Justification	Action, Basis of Recommendation	Term	Project Owner	Amount
C1	Harris County, Texas *on behalf of Harris County Public Health*	Consideration of Approval for an Interlocal Agreement Between Harris County Hospital District d/b/a Harris Health and Harris County, Texas for In-Kind Support Services. If approved, the agreement would reduce the County's overall expenditures by $4,000,000 and would result in the waiver of payments owed to Harris Health by Harris County for: (1) Epic licenses and support services provided to The Harris Center and Harris County Sheriff's Office; (2) social work services provided to Harris County Public Health in connection with its Violence Interruption Program; and (3) data integration and analysis services provided to Harris County Public Health for the purpose of identifying shared clients. **This agreement will not affect any payments that are due to Harris Health in fiscal year 2027 under pre-existing contracts with Harris County.*	Interlocal Agreement	October 1, 2025 through September 30, 2026	Ron Fuschillo	$ 4,000,000.00
C2	Harris County, Texas	Consideration of Approval to Amend the Interlocal Agreement between Harris Health and Harris County, Texas for Legal Representation and Related Legal Support Provided by the Harris County Attorney's Office to Give the Harris Health President and CEO Certain Approval Rights and to Increase the Funding for Fiscal Year 2027.	5th Amendment of an Interlocal Agreement	October 1, 2026 through September 30, 2027	Sara Thomas	$ 5,376,000.00
C3	The University of Texas Health Science Center at Houston (UTHSC)	Consideration of Approval of a Third Amendment to the Affiliation and Support Agreement Between Harris County Hospital District d/b/a Harris Health and the University of Texas Health Science at Houston. **This amendment reflects changes to the medical leadership provisions of the agreement.*	3rd Amendment of an Affiliation and Support Agreement	N/A	Sara Thomas	$ -
C4	Harris County Public Health	Consideration of Approval of an Interlocal Agreement Between Harris Health and Harris County Public Health to Support the ACCESS Harris Program, a County Program Designed to Connect Vulnerable Harris County Residents to Resources that Address their Social Determinants of Health Needs. If approved, this agreement will replace the existing interlocal agreement for the ACCESS Harris Proram. Harris Health's primary obligation under the agreement is to urilize a Nurse Caase Manager to identify Harris Health patients that would benefit from enrollment in ACCESS Harris for up to eight (8) hours per week. **This agreement does not contemplate an exchange of funds between the parties or require the County to reimburse Harris Health for the use of the Nurse Case Manager.*	Interlocal Agreement	FY 2026 - FY 2027	Dr. Amy Smith	$ -
					TOTAL AMOUNT:	**$ 9,376,000.00**

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Acceptance of the Harris Health April 2026 Quarterly Financial Report Subject to Audit

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Attached for your review and consideration is the April 2026 Financial Report.

Administration recommends that the Board accept the quarterly financial report for the period ended April 30, 2026, subject to final audit.

Victoria Nikitin
EVP – Chief Financial Officer

Financial Statements

As of the Month Ended April 30, 2026
Subject to Audit

Table of Contents

HARRISHEALTH

Financial Highlights Review......3

FINANCIAL STATEMENTS

Income Statement......4

Balance Sheet......5

Cash Flow Summary......6

Performance Ratios......7

KEY STATISTICAL INDICATORS

Statistical Highlights......9

Statistical Highlights Graphs......10 – 21

Operating income for the month ended April 30, 2026 was $59.6 million compared to budgeted income of $25.9 million.

Total net revenue for the month ended April 30, 2026 of $277.6 million was $24.7 million or 9.8% more than budget. Net patient revenue was $6.6 million more than budget while Medicaid Supplement Programs and Net Tobacco Settlement Revenue was $6.8 million and $7.8 million, respectively, more than budget. Additional tobacco funding was received based on the pro rata distribution of 2025 unreimbursed health care expenditures performed by the Texas Department of State Health Services.

As of April 30, 2026, total expenses of $217.9 million were $9.0 million or 4.0% less than budget. Total supply and purchased services expenses were $2.6 million and $6.1 million, respectively, less than budget while total labor costs were $2.7 million less than budget. Benefits expense was lower due to a favorable pension expense adjustment required per the recently received actuarial report. Lower than expected patient volumes in certain service lines resulted in decreased utilization of planned labor and supply resources. These utilization reductions are currently estimated to continue through the balance of FY2026. Additional reductions in supply and pharmaceutical spend were driven by ongoing cost containment initiatives, including expanded enrollment in the Patient Medical Assistance Program (PMAP), formulary changes resulting in the use of lower-cost drug alternatives, and the standardization of supplies and implants. Further favorable variances resulted from timing differences associated with strategic projects, including delays in the onboarding of incremental FTEs and the procurement of supplies and outside services required to meet project demands. Lastly, lower enrollment in the ACA marketplace is driven primarily by recent rule changes at the federal level.

For the month ended April 30, 2026, total patient days and average daily census both increased by 3.2% compared to budget. Inpatient case mix index, a measure of patient acuity, was 1.0% lower than budget while length of stay was 0.8% higher than budget. Emergency room visits were 11.8% less than budget. Total clinic visits, including telehealth, were 12.3% higher compared to budget. Births were down 13.8%.

Total cash receipts for the month were $171.5 million. The System has $2,062.6 million in unrestricted cash, cash equivalents and investments, representing 304.2 days cash on hand. Days cash on hand continues to be impacted by reimbursement from the Series 2025 bond totaling $852.1 million as of April 30, 2026, for capital expenditures tied to the Strategic Capital Plan. The remainder of the $840 million issuance is recorded as an asset limited as to use within the balance sheet. The corresponding debt is shown within the long-term debt portion of the balance sheet.

Harris Health has $163.2 million in net accounts receivable, representing 68.6 days of outstanding patient accounts receivable at April 30, 2026. The April balance sheet reflects a combined net receivable position of $184.9 million under the various Medicaid Supplemental programs. The current portion of ad valorem taxes receivable is $28.5 million, which is offset by ad valorem tax collections as received. Accounts payable and accrued liabilities include $515.1 million in deferred ad valorem tax revenues that are released as ad valorem tax revenue is recognized. As of April 30, 2026, $1,202.7 million in ad valorem tax collections were received and $101.3 million in current ad valorem tax revenue was recognized.

Income Statement

HARRISHEALTH

As of April 30, 2026 and 2025 (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	$ 77.2	$ 70.6	9.3%	$ 504.7	$ 487.1	3.6%	$ 449.6	12.2%
Medicaid Supplemental Programs	61.4	54.6	12.4%	395.0	382.4	3.3%	403.7	-2.2%
Other Operating Revenue	7.6	4.5	71.6%	25.5	30.0	-15.1%	87.0	-70.7%
Total Operating Revenue	**$ 146.2**	**$ 129.7**	**12.8%**	**$ 925.2**	**$ 899.4**	**2.9%**	**$ 940.3**	**-1.6%**
Net Ad Valorem Taxes	101.3	101.3	0.0%	716.6	709.1	1.1%	598.3	19.8%
Net Tobacco Settlement Revenue	23.0	15.2	51.6%	23.0	15.2	51.6%	19.0	21.2%
Capital Gifts & Grants	-	0.8	0.0%	-	5.8	-100.0%	2.0	-100.0%
Interest Income & Other	7.0	5.9	19.8%	45.1	41.1	9.6%	36.9	22.0%
Total Nonoperating Revenue	**$ 131.3**	**$ 123.2**	**6.6%**	**$ 784.6**	**$ 771.2**	**1.7%**	**$ 656.2**	**19.6%**
Total Net Revenue	**$ 277.6**	**$ 252.9**	**9.8%**	**$ 1,709.8**	**$ 1,670.6**	**2.3%**	**$ 1,596.5**	**7.1%**
EXPENSE								
Salaries and Wages	$ 84.9	$ 88.9	4.5%	$ 585.1	$ 631.1	7.3%	$ 569.3	-2.8%
Employee Benefits	30.1	28.8	-4.5%	187.2	201.5	7.1%	186.5	-0.4%
Total Labor Cost	**$ 115.0**	**$ 117.7**	**2.3%**	**$ 772.4**	**$ 832.6**	**7.2%**	**$ 755.9**	**-2.2%**
Supply Expenses	26.2	28.8	9.2%	179.6	203.9	11.9%	186.8	3.9%
Physician Services	40.4	39.4	-2.7%	278.2	275.7	-0.9%	268.5	-3.6%
Purchased Services	22.7	28.8	21.2%	171.2	201.7	15.1%	176.2	2.8%
Depreciation & Interest	13.7	12.3	-11.5%	89.5	85.1	-5.1%	61.3	-45.9%
Total Operating Expense	**$ 217.9**	**$ 226.9**	**4.0%**	**$ 1,490.9**	**$ 1,598.9**	**6.8%**	**$ 1,448.8**	**-2.9%**
Operating Income (Loss)	**$ 59.6**	**$ 25.9**		**$ 218.9**	**$ 71.7**		**$ 147.8**	
Total Margin %	**21.5%**	**10.3%**		**12.8%**	**4.3%**		**9.3%**	

Balance Sheet

HARRISHEALTH

April 2026 and 2025 (in $ Millions)

	CURRENT YEAR	PRIOR YEAR
CURRENT ASSETS		
Cash, Cash Equivalents and Short Term Investments	$ 2,062.6	$ 1,717.1
Net Patient Accounts Receivable	163.2	138.6
Net Ad Valorem Taxes, Current Portion	28.5	21.1
Other Current Assets	273.4	243.1
Total Current Assets	**$ 2,527.7**	**$ 2,119.9**
CAPITAL ASSETS		
Plant, Property, & Equipment, Net of Accumulated Depreciation	$ 584.9	$ 574.8
Construction in Progress	1,128.2	370.1
Right of Use Assets	33.9	35.6
Total Capital Assets	**$ 1,746.9**	**$ 980.5**
ASSETS LIMITED AS TO USE & RESTRICTED ASSETS		
Debt Service & Capital Asset Funds	$ 34.7	$ 37.7
LPPF Restricted Cash	152.9	53.3
Capital Gift Proceeds	56.9	55.1
Other - Restricted	34.9	1.1
Total Assets Limited As to Use & Restricted Assets	**$ 279.4**	**$ 147.2**
Other Assets	46.8	42.6
Deferred Outflows of Resources	137.9	182.3
Total Assets & Deferred Outflows of Resources	**$ 4,738.8**	**$ 3,472.6**
CURRENT LIABILITIES		
Accounts Payable and Accrued Liabilities	$ 374.7	$ 251.0
Employee Compensation & Related Liabilities	166.2	151.4
Deferred Revenue - Ad Valorem	515.1	439.9
Estimated Third-Party Payor Settlements	59.3	31.3
Current Portion Long-Term Debt and Capital Leases	23.7	36.8
Total Current Liabilities	**$ 1,139.0**	**$ 910.3**
Long-Term Debt	1,102.8	264.1
Net Pension & Post Employment Benefits Liability	602.2	679.2
Other Long-Term Liabilities	5.5	7.9
Deferred Inflows of Resources	104.9	110.4
Total Liabilities	**$ 2,954.4**	**$ 1,971.9**
Total Net Assets	**$ 1,784.4**	**$ 1,500.7**
Total Liabilities & Net Assets	**$ 4,738.8**	**$ 3,472.6**

Cash Flow Summary

HARRISHEALTH

As of April 30, 2026 and 2025 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE	
	CURRENT YEAR	PRIOR YEAR	CURRENT YEAR	PRIOR YEAR
CASH RECEIPTS				
Collections on Patient Accounts	$ 91.5	$ 66.6	$ 544.6	$ 490.6
Medicaid Supplemental Programs	28.1	10.4	229.2	261.6
Net Ad Valorem Taxes	11.0	10.0	1,202.7	1,017.9
Tobacco Settlement	-	-	-	-
Other Revenue	40.9	57.4	507.7	107.8
Total Cash Receipts	**$ 171.5**	**$ 144.4**	**$ 2,484.1**	**$ 1,877.9**
CASH DISBURSEMENTS				
Salaries, Wages and Benefits	$ 124.2	$ 116.4	$ 854.3	$ 776.5
Supplies	28.4	27.4	210.5	206.5
Physician Services	39.8	37.9	268.0	254.1
Purchased Services	21.1	17.2	178.9	172.7
Capital Expenditures	63.3	11.9	556.4	217.6
Debt and Interest Payments	0.3	0.3	40.5	19.7
Other Uses	(24.6)	(19.8)	(39.3)	(22.8)
Total Cash Disbursements	**$ 252.4**	**$ 191.2**	**$ 2,069.4**	**$ 1,624.3**
Net Change	**$ (80.9)**	**$ (46.8)**	**$ 414.8**	**$ 253.7**

Unrestricted cash, cash equivalents and investments - Beginning of year	$ 1,647.8
Net Change	$ 414.8
Untrestricted cash, cash equivalents and investments - End of period	**$ 2,062.6**

Performance Ratios

HARRISHEALTH

As of April 30, 2026 and 2025 (in $ Millions)

	MONTH-TO-MONTH		YEAR-TO-DATE		
	CURRENT YEAR	CURRENT BUDGET	CURRENT YEAR	CURRENT BUDGET	PRIOR YEAR
OPERATING HEALTH INDICATORS					
Operating Margin %	21.5%	10.3%	12.8%	4.3%	9.3%
Run Rate per Day (In$ Millions)	$ 6.9	$ 7.3	$ 6.7	$ 7.3	$ 6.6
Salary, Wages & Benefit per APD	$ 2,627	$ 2,722	$ 2,512	$ 2,668	$ 2,419
Supply Cost per APD	$ 598	$ 667	$ 584	$ 653	$ 598
Physician Services per APD	$ 924	$ 911	$ 905	$ 883	$ 859
Total Expense per APD	**$ 4,981**	**$ 5,250**	**$ 4,849**	**$ 5,124**	**$ 4,636**
Overtime as a % of Total Salaries	2.7%	2.6%	2.9%	2.6%	3.5%
Contract as a % of Total Salaries	2.8%	2.8%	2.9%	2.8%	3.2%
Full-time Equivalent Employees	10,378	10,620	10,371	10,715	10,448
FINANCIAL HEALTH INDICATORS					
Quick Ratio			2.2		2.3
Unrestricted Cash (In $ Millions)			$ 2,062.6	$ 2,084.2	$ 1,717.1
Days Cash on Hand			304.2	286.5	260.1
Days Revenue in Accounts Receivable			68.6	65.8	65.4
Days in Accounts Payable			48.8		45.7
Capital Expenditures/Depreciation & Amortization			918.1%		391.2%
Average Age of Plant(years)			9.7		9.9

Harris Health Key Indicators

Statistical Highlights

HARRISHEALTH

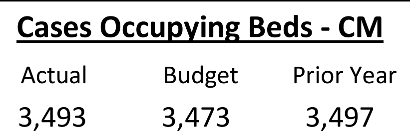
As of April 30, 2026 and 2025

	MONTH-TO-MONTH			YEAR-TO-DATE				
	CURRENT MONTH	CURRENT BUDGET	PERCENT CHANGE	CURRENT YEAR	CURRENT BUDGET	PERCENT CHANGE	PRIOR YEAR	PERCENT CHANGE
Adjusted Patient Days	43,756	43,224	1.2%	307,439	312,056	-1.5%	312,473	-1.6%
Outpatient % of Adjusted Volume	60.9%	62.8%	-3.0%	61.5%	62.9%	-2.2%	63.3%	-2.8%
Primary Care Clinic Visits	48,229	43,897	9.9%	311,193	318,575	-2.3%	319,591	-2.6%
Specialty Clinic Visits	22,892	19,831	15.4%	146,386	146,219	0.1%	146,011	0.3%
Telehealth Clinic Visits	11,373	9,763	16.5%	72,713	67,970	7.0%	71,898	1.1%
Total Clinic Visits	**82,494**	**73,491**	**12.3%**	**530,292**	**532,764**	**-0.5%**	**537,500**	**-1.3%**
Emergency Room Visits - Outpatient	10,762	12,496	-13.9%	77,822	84,158	-7.5%	82,209	-5.3%
Emergency Room Visits - Admitted	1,773	1,719	3.1%	12,900	12,497	3.2%	12,085	6.7%
Total Emergency Room Visits	**12,535**	**14,215**	**-11.8%**	**90,722**	**96,655**	**-6.1%**	**94,294**	**-3.8%**
Surgery Cases - Outpatient	1,109	992	11.8%	7,152	6,627	7.9%	7,149	0.0%
Surgery Cases - Inpatient	881	912	-3.4%	5,908	6,284	-6.0%	6,200	-4.7%
Total Surgery Cases	**1,990**	**1,904**	**4.5%**	**13,060**	**12,911**	**1.2%**	**13,349**	**-2.2%**
Total Outpatient Visits	**140,385**	**143,771**	**-2.4%**	**902,211**	**1,020,616**	**-11.6%**	**903,198**	**-0.1%**
Inpatient Cases (Discharges)	2,589	2,454	5.5%	17,845	18,205	-2.0%	17,364	2.8%
Outpatient Observation Cases	904	1,019	-11.3%	6,192	6,811	-9.1%	7,264	-14.8%
Total Cases Occupying Patient Beds	**3,493**	**3,473**	**0.6%**	**24,037**	**25,016**	**-3.9%**	**24,628**	**-2.4%**
Births	336	390	-13.8%	2,470	3,216	-23.2%	3,133	-21.2%
Inpatient Days	17,108	16,084	6.4%	118,482	115,914	2.2%	114,827	3.2%
Outpatient Observation Days	2,938	3,348	-12.2%	20,228	24,232	-16.5%	25,461	-20.6%
Total Patient Days	**20,046**	**19,432**	**3.2%**	**138,710**	**140,146**	**-1.0%**	**140,288**	**-1.1%**
Average Daily Census	668.2	647.7	3.2%	654.3	661.1	-1.0%	661.7	-1.1%
Average Operating Beds	704	704	0.0%	702	704	-0.2%	702	0.1%
Bed Occupancy %	95.0%	92.0%	3.2%	93.2%	93.9%	-0.8%	94.3%	-1.2%
Inpatient Average Length of Stay	6.61	6.55	0.8%	6.64	6.37	4.3%	6.61	0.4%
Inpatient Case Mix Index (CMI)	1.696	1.712	-1.0%	1.685	1.712	-1.6%	1.731	-2.7%
Payor Mix (% of Charges)								
Charity & Self Pay	47.2%	45.5%	3.8%	46.6%	45.5%	2.3%	41.8%	11.4%
Medicaid & Medicaid Managed	20.2%	18.8%	7.3%	19.8%	18.8%	5.4%	19.7%	0.5%
Medicare & Medicare Managed	11.3%	10.6%	6.1%	11.1%	10.6%	4.6%	11.4%	-2.1%
Commercial & Other	21.3%	25.1%	-15.0%	22.5%	25.1%	-10.2%	27.1%	-17.0%
Total Unduplicated Patients - Rolling 12				**237,079**			**245,260**	**-3.3%**
Total New Patient - Rolling 12				**81,368**			**88,417**	**-8.0%**

Harris Health

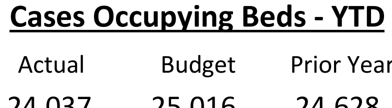
Statistical Highlights

April FY 2026



Cases Occupying Beds - CM

Actual	Budget	Prior Year
3,493	3,473	3,497

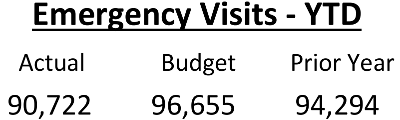


Cases Occupying Beds - YTD

Actual	Budget	Prior Year
24,037	25,016	24,628

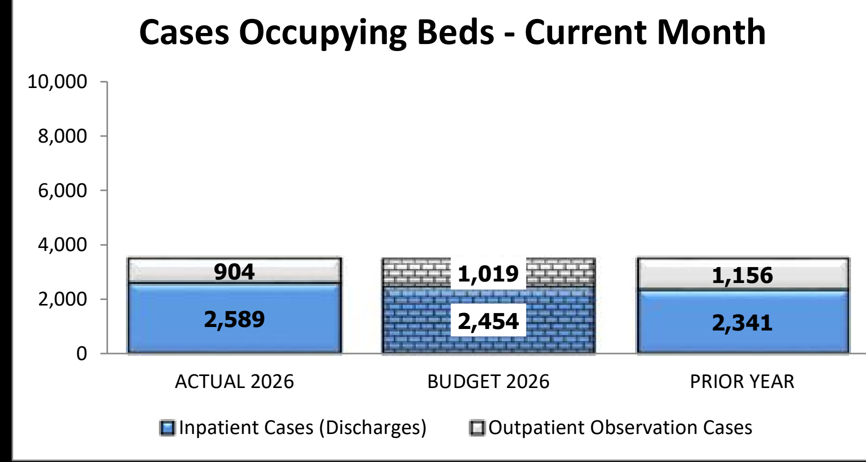
Emergency Visits - CM

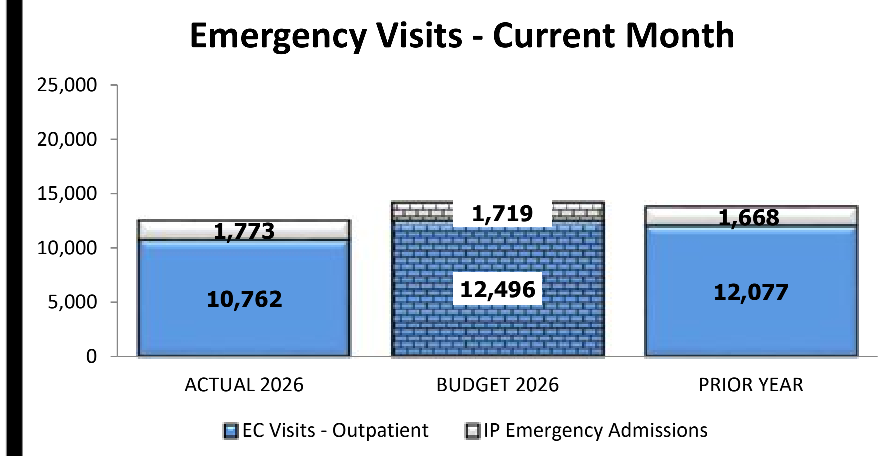
Actual	Budget	Prior Year
12,535	14,215	13,745

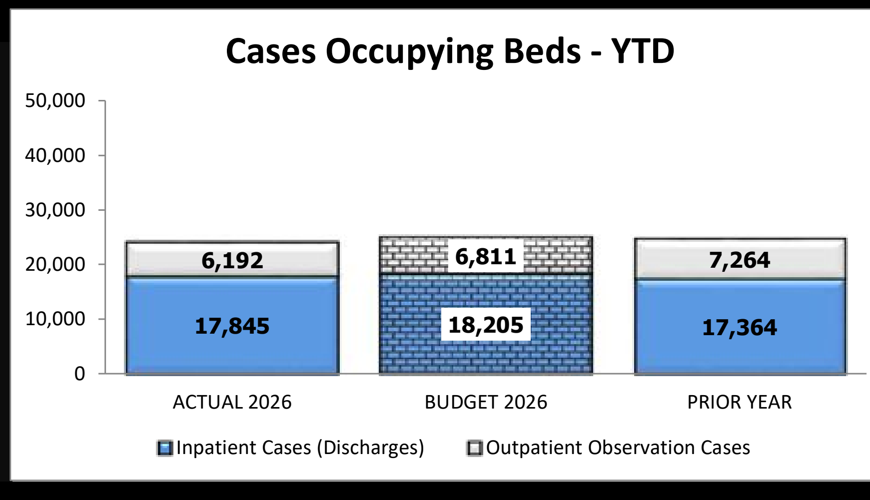


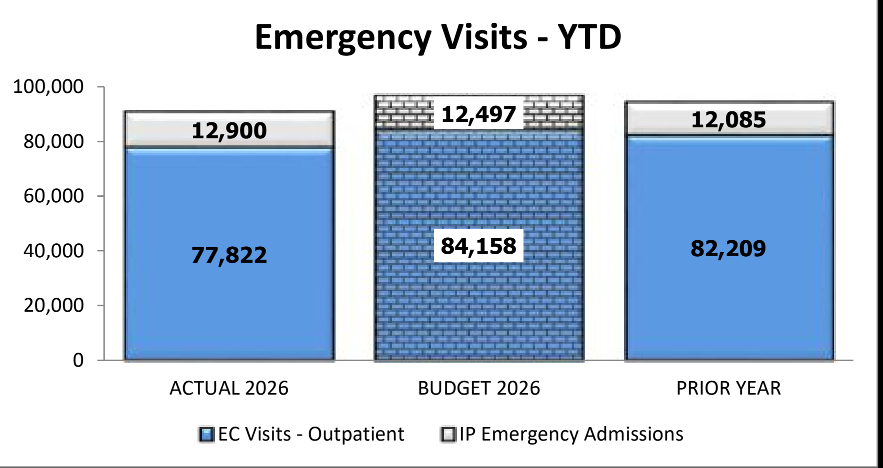
Emergency Visits - YTD

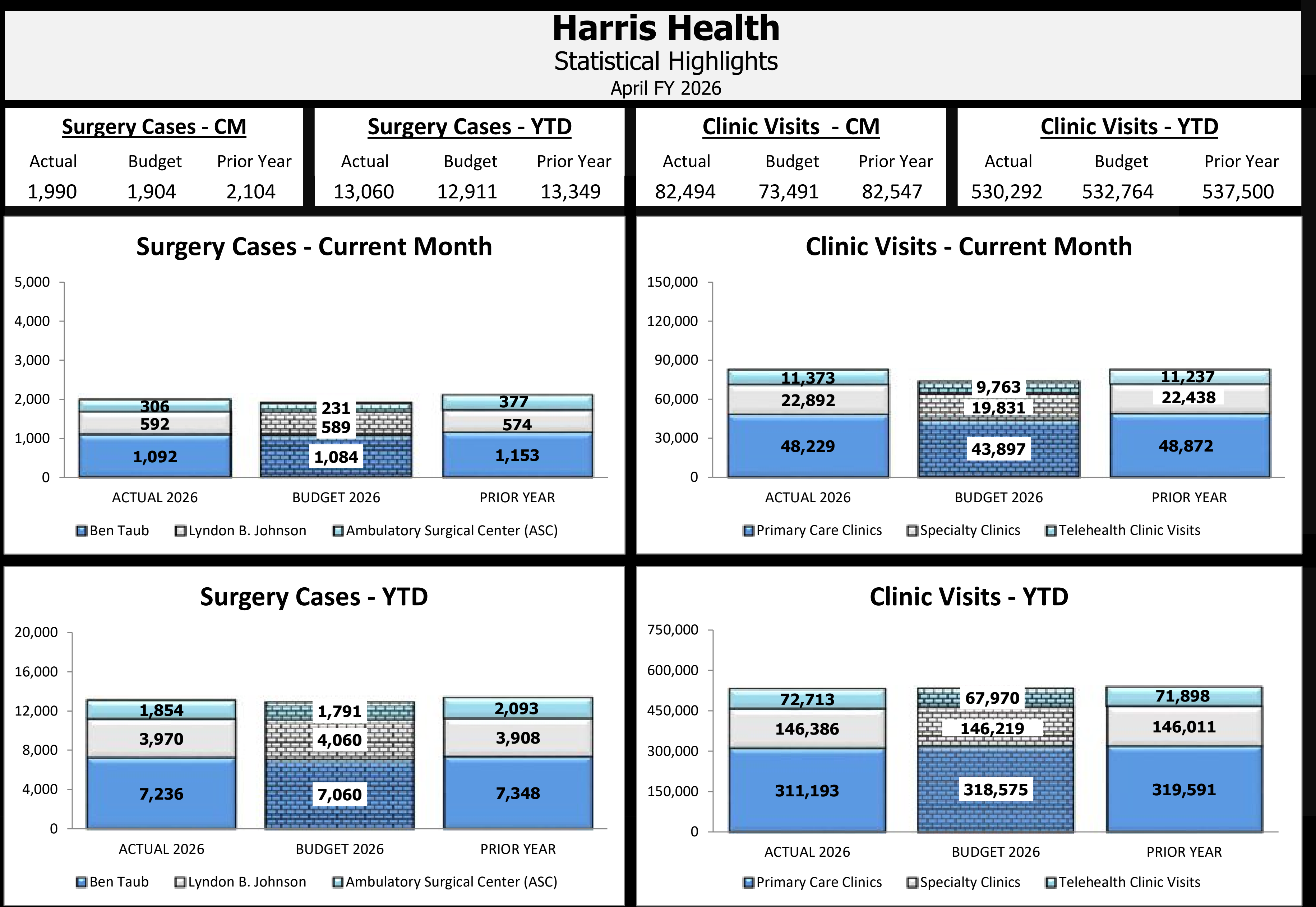
Actual	Budget	Prior Year
90,722	96,655	94,294

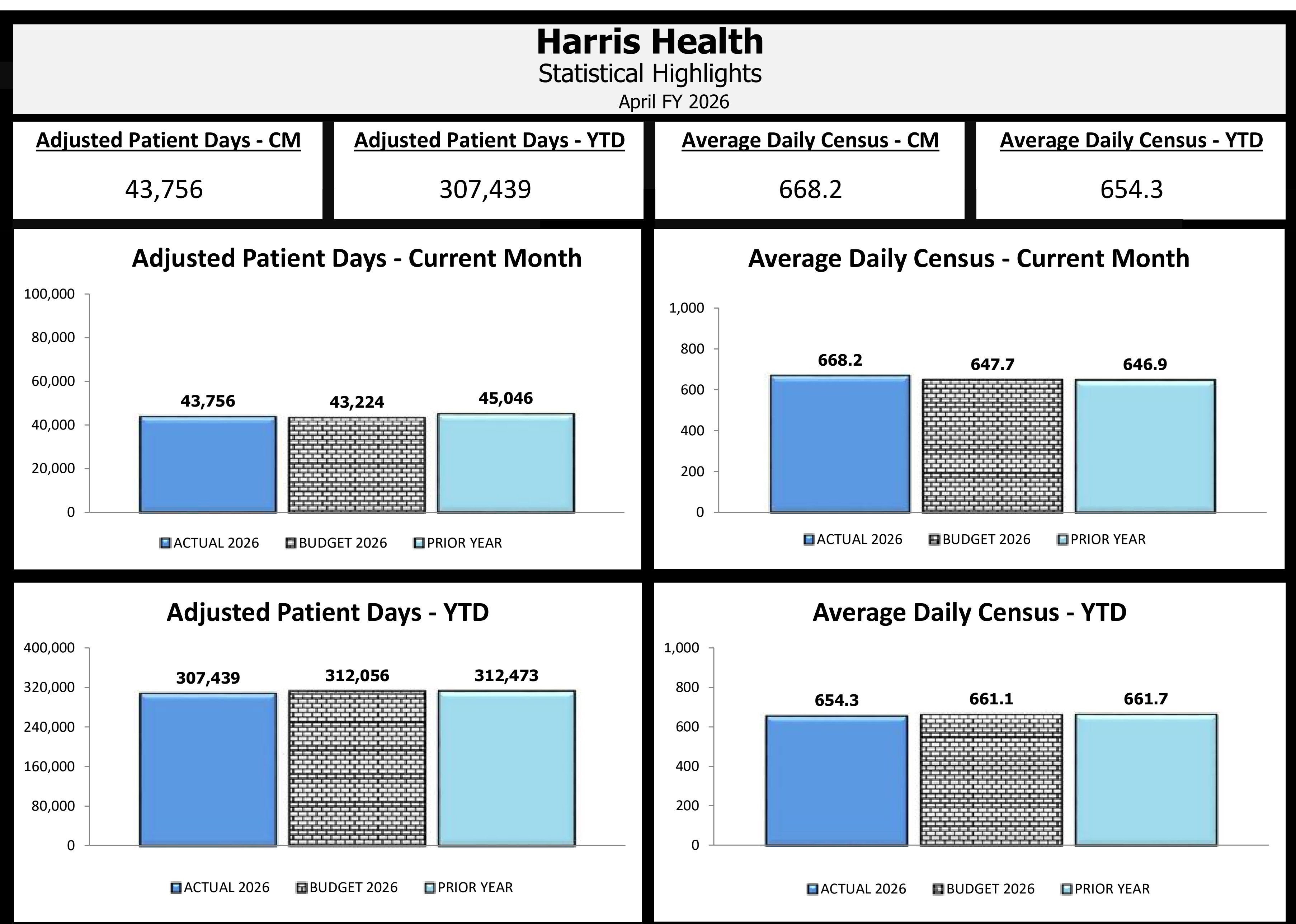


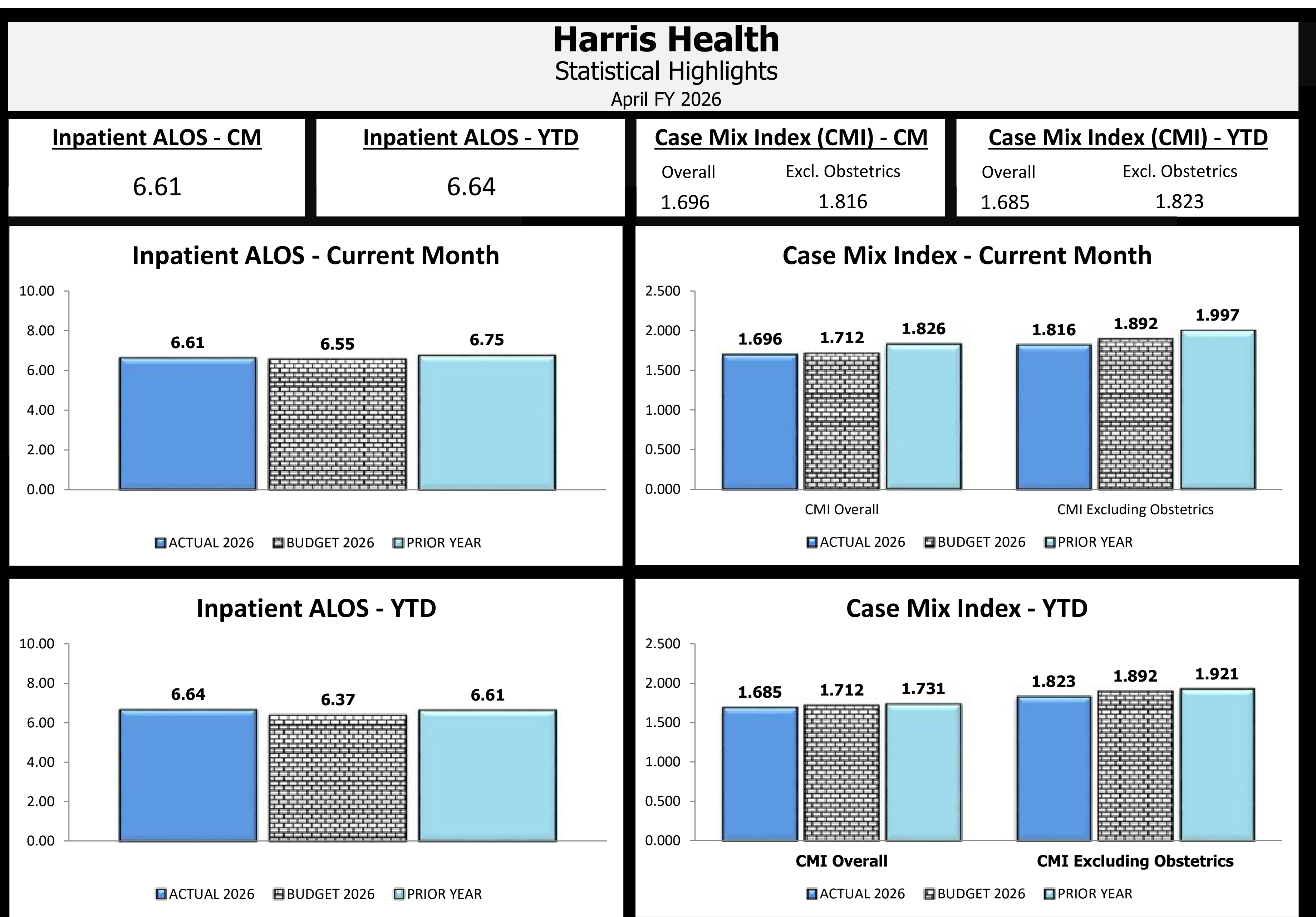







Harris Health
Statistical Highlights
April FY 2026
Surgery Cases - CM
Actual Budget Prior Year
1,990 1,904 2,104
Surgery Cases - YTD
Actual Budget Prior Year
13,060 12,911 13,349
Clinic Visits - CM
Actual Budget Prior Year
82,494 73,491 82,547
Clinic Visits - YTD
Actual Budget Prior Year
530,292 532,764 537,500
Surgery Cases - Current Month
5,000
4,000
3,000
2,000
1,000
0
306
592
1,092
231
589
1,084
377
574
1,153
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Ben Taub
Lyndon B. Johnson
Ambulatory Surgical Center (ASC)
Clinic Visits - Current Month
150,000
120,000
90,000
60,000
30,000
0
11,373
22,892
48,229
9,763
19,831
43,897
11,237
22,438
48,872
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Primary Care Clinics
Specialty Clinics
Telehealth Clinic Visits
Surgery Cases - YTD
20,000
16,000
12,000
8,000
4,000
0
1,854
3,970
7,236
1,791
4,060
7,060
2,093
3,908
7,348
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Ben Taub
Lyndon B. Johnson
Ambulatory Surgical Center (ASC)
Clinic Visits - YTD
750,000
600,000
450,000
300,000
150,000
0
72,713
146,386
311,193
67,970
146,219
318,575
71,898
146,011
319,591
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Primary Care Clinics
Specialty Clinics
Telehealth Clinic Visits


Harris Health
Statistical Highlights
April FY 2026
Adjusted Patient Days - CM
43,756
Adjusted Patient Days - YTD
307,439
Average Daily Census - CM
668.2
Average Daily Census - YTD
654.3
Adjusted Patient Days - Current Month
100,000
80,000
60,000
40,000
20,000
0
43,756
43,224
45,046
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Average Daily Census - Current Month
1,000
800
600
400
200
0
668.2
647.7
646.9
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Adjusted Patient Days - YTD
400,000
320,000
240,000
160,000
80,000
0
307,439
312,056
312,473
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Average Daily Census - YTD
1,000
800
600
400
200
0
654.3
661.1
661.7
ACTUAL 2026
BUDGET 2026
PRIOR YEAR



Harris Health
Statistical Highlights
April FY 2026
Inpatient ALOS - CM
6.61
Inpatient ALOS - YTD
6.64
Case Mix Index (CMI) - CM
Overall
Excl. Obstetrics
1.696
1.816
Case Mix Index (CMI) - YTD
Overall
Excl. Obstetrics
1.685
1.823
Inpatient ALOS - Current Month
10.00
8.00
6.00
4.00
2.00
0.00
6.61
6.55
6.75
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Case Mix Index - Current Month
2.500
2.000
1.500
1.000
0.500
0.000
1.696
1.712
1.826
1.816
1.892
1.997
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Inpatient ALOS - YTD
10.00
8.00
6.00
4.00
2.00
0.00
6.64
6.37
6.61
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Case Mix Index - YTD
2.500
2.000
1.500
1.000
0.500
0.000
1.685
1.712
1.731
1.823
1.892
1.921
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR

Harris Health

Statistical Highlights - Cases Occupying Beds

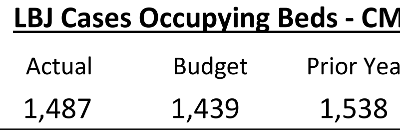
April FY 2026

BT Cases Occupying Beds - CM

Actual	Budget	Prior Year
1,974	1,995	1,937

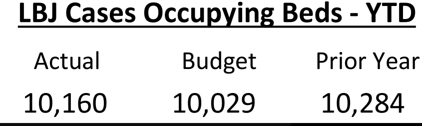
BT Cases Occupying Beds - YTD

Actual	Budget	Prior Year
13,724	14,708	14,233



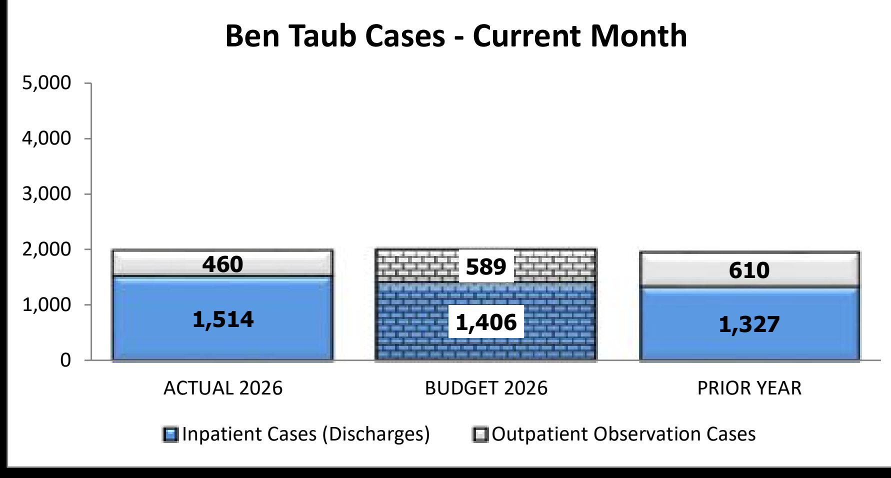
LBJ Cases Occupying Beds - CM

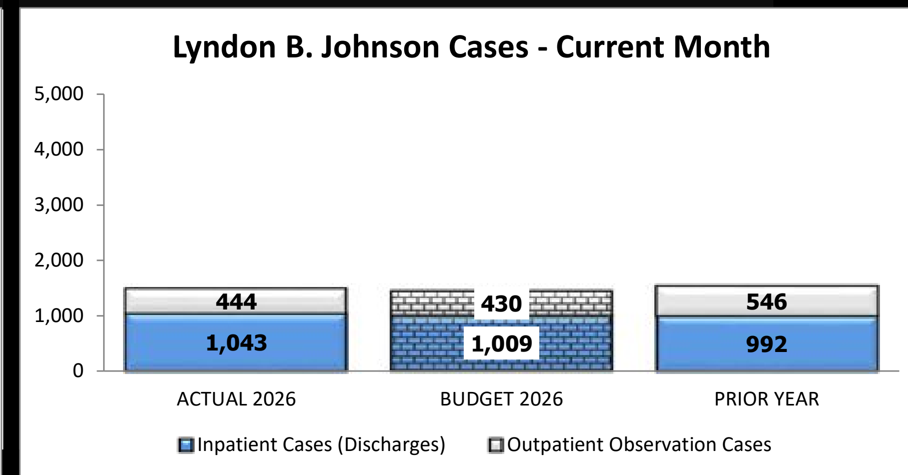
Actual	Budget	Prior Year
1,487	1,439	1,538

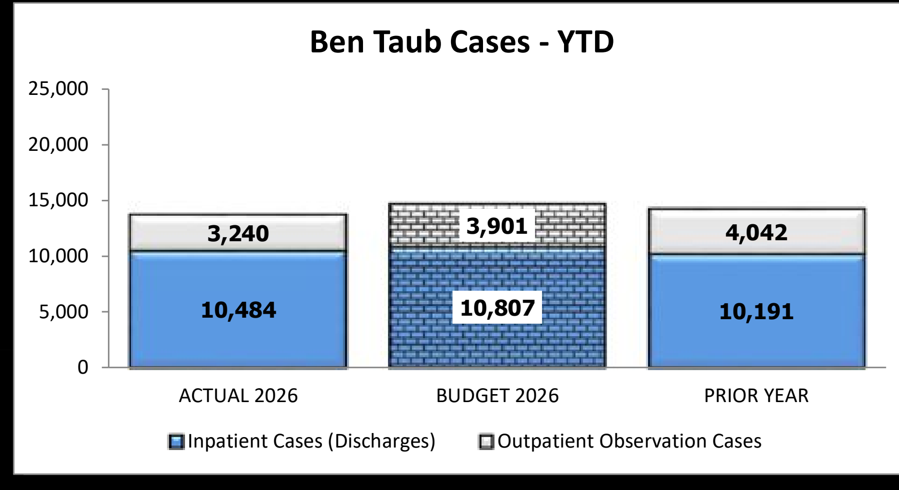


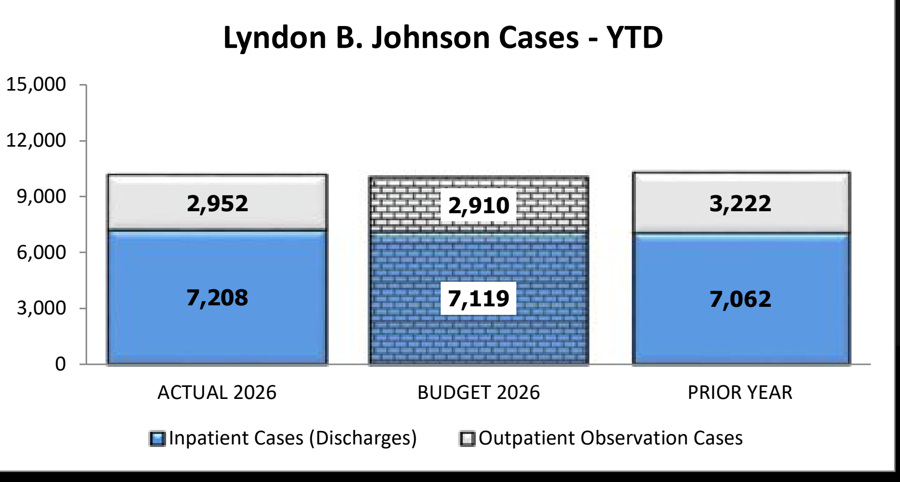
LBJ Cases Occupying Beds - YTD

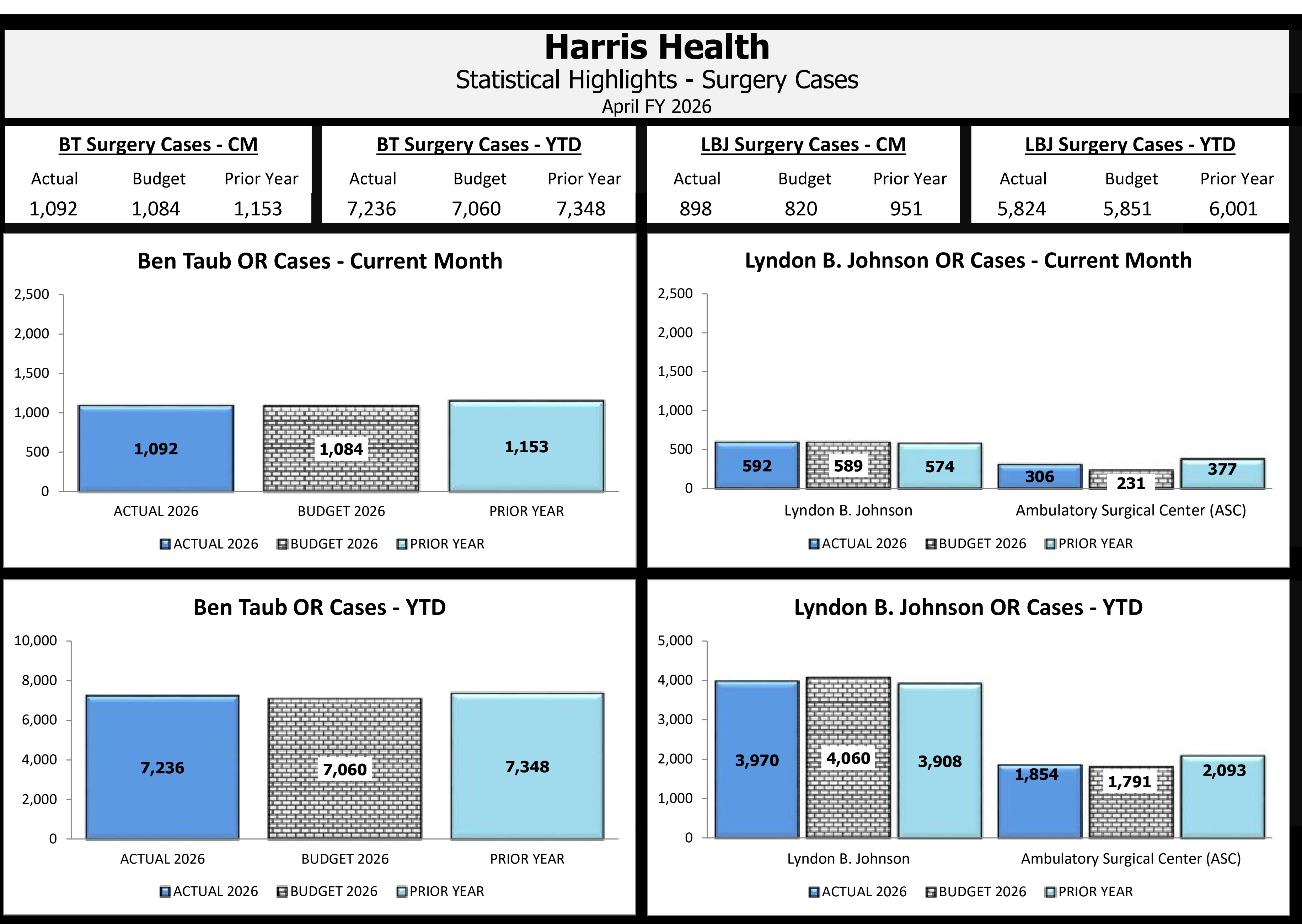
Actual	Budget	Prior Year
10,160	10,029	10,284










Harris Health
Statistical Highlights - Surgery Cases
April FY 2026
BT Surgery Cases - CM
Actual Budget Prior Year
1,092 1,084 1,153
BT Surgery Cases - YTD
Actual Budget Prior Year
7,236 7,060 7,348
LBJ Surgery Cases - CM
Actual Budget Prior Year
898 820 951
LBJ Surgery Cases - YTD
Actual Budget Prior Year
5,824 5,851 6,001
Ben Taub OR Cases - Current Month
ACTUAL 2026 1,092
BUDGET 2026 1,084
PRIOR YEAR 1,153
Lyndon B. Johnson OR Cases - Current Month
Lyndon B. Johnson 592 589 574
Ambulatory Surgical Center (ASC) 306 231 377
Ben Taub OR Cases - YTD
ACTUAL 2026 7,236
BUDGET 2026 7,060
PRIOR YEAR 7,348
Lyndon B. Johnson OR Cases - YTD
Lyndon B. Johnson 3,970 4,060 3,908
Ambulatory Surgical Center (ASC) 1,854 1,791 2,093
ACTUAL 2026 BUDGET 2026 PRIOR YEAR

Harris Health

Statistical Highlights - Emergency Room Visits

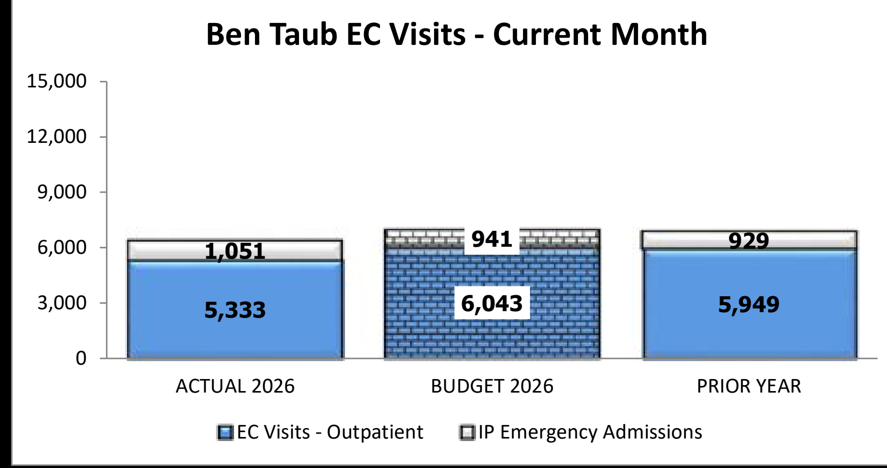
April FY 2026

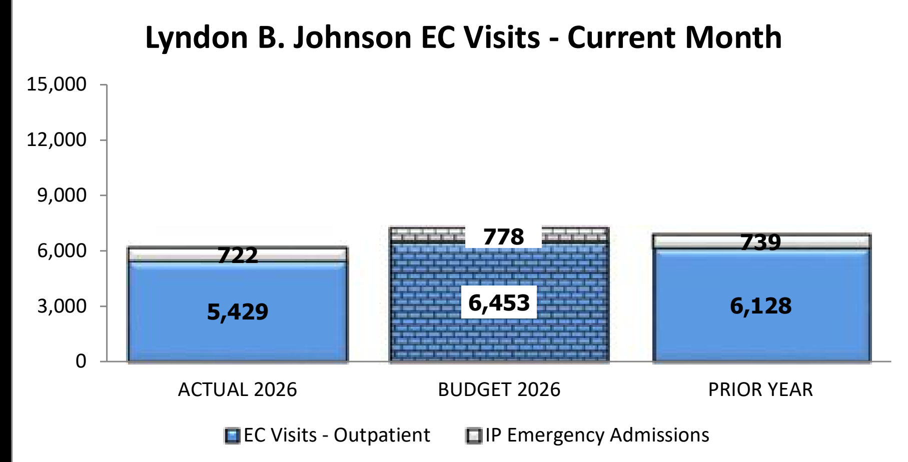
BT Emergency Visits - CM		
Actual	Budget	Prior Year
6,384	6,984	6,878

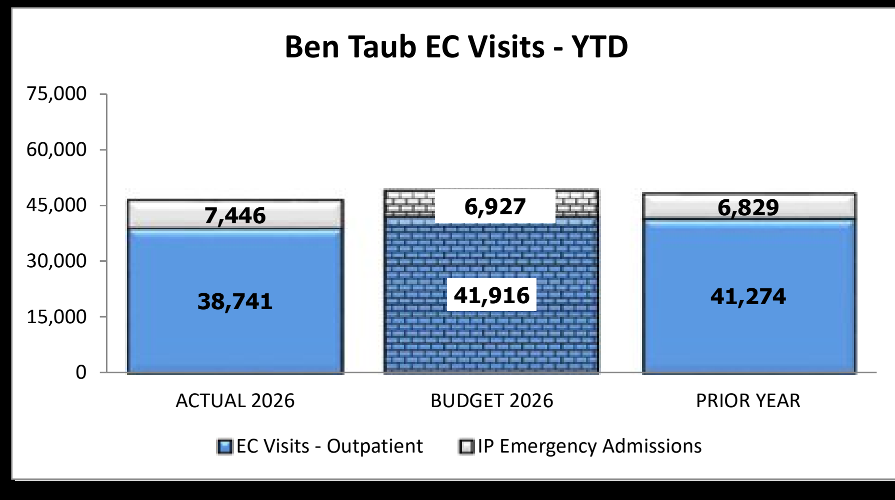
BT Emergency Visits - YTD		
Actual	Budget	Prior Year
46,187	48,843	48,103

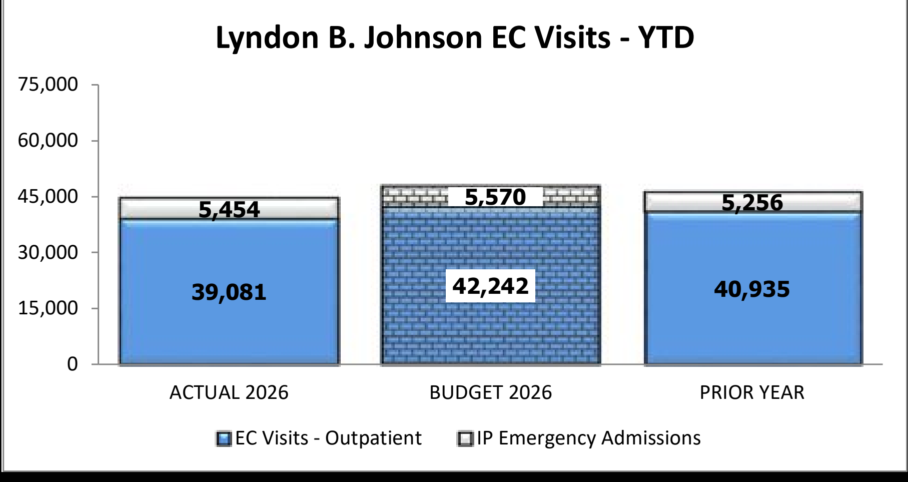
LBJ Emergency Visits - CM		
Actual	Budget	Prior Year
6,151	7,231	6,867

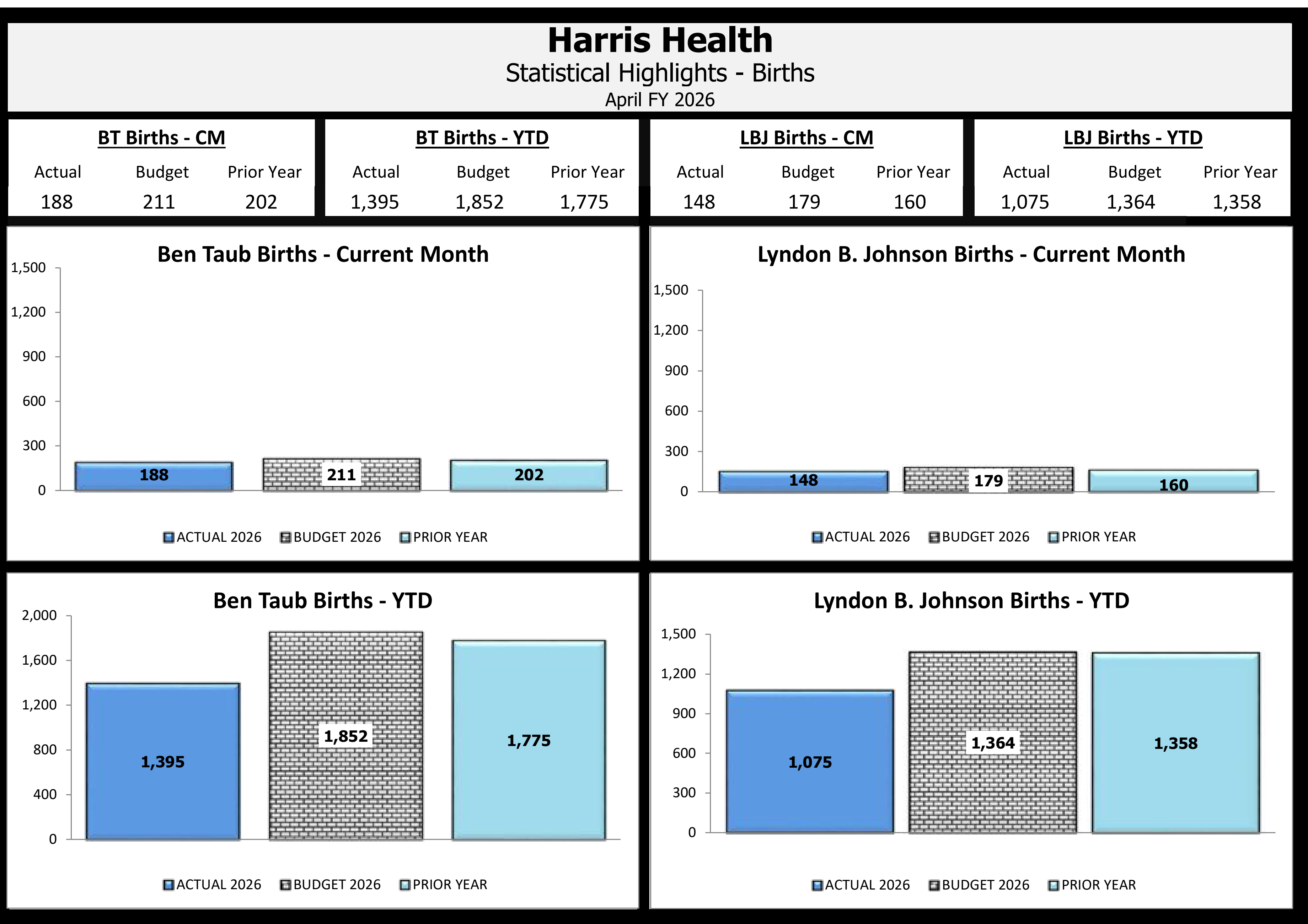
LBJ Emergency Visits - YTD		
Actual	Budget	Prior Year
44,535	47,812	46,191

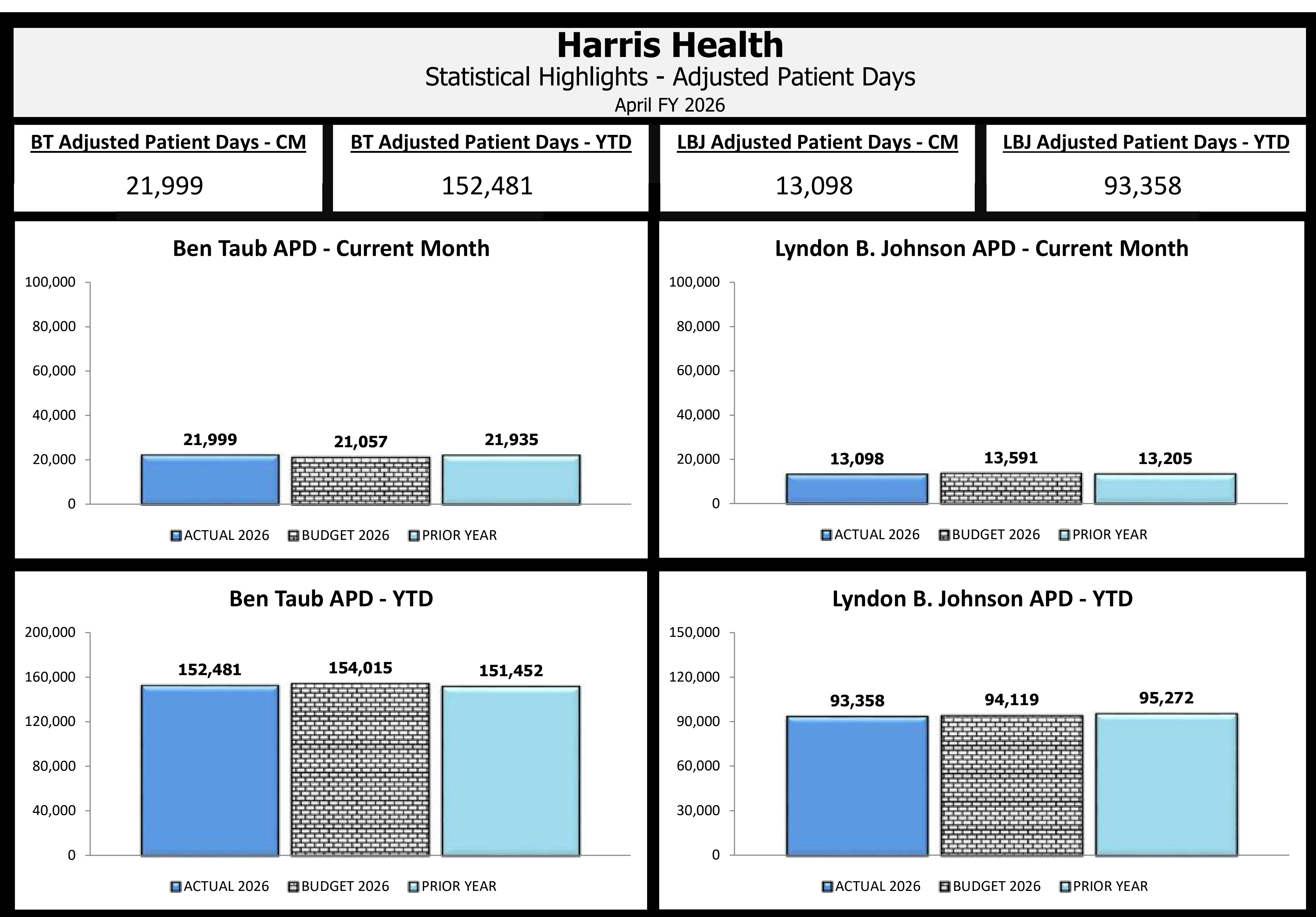


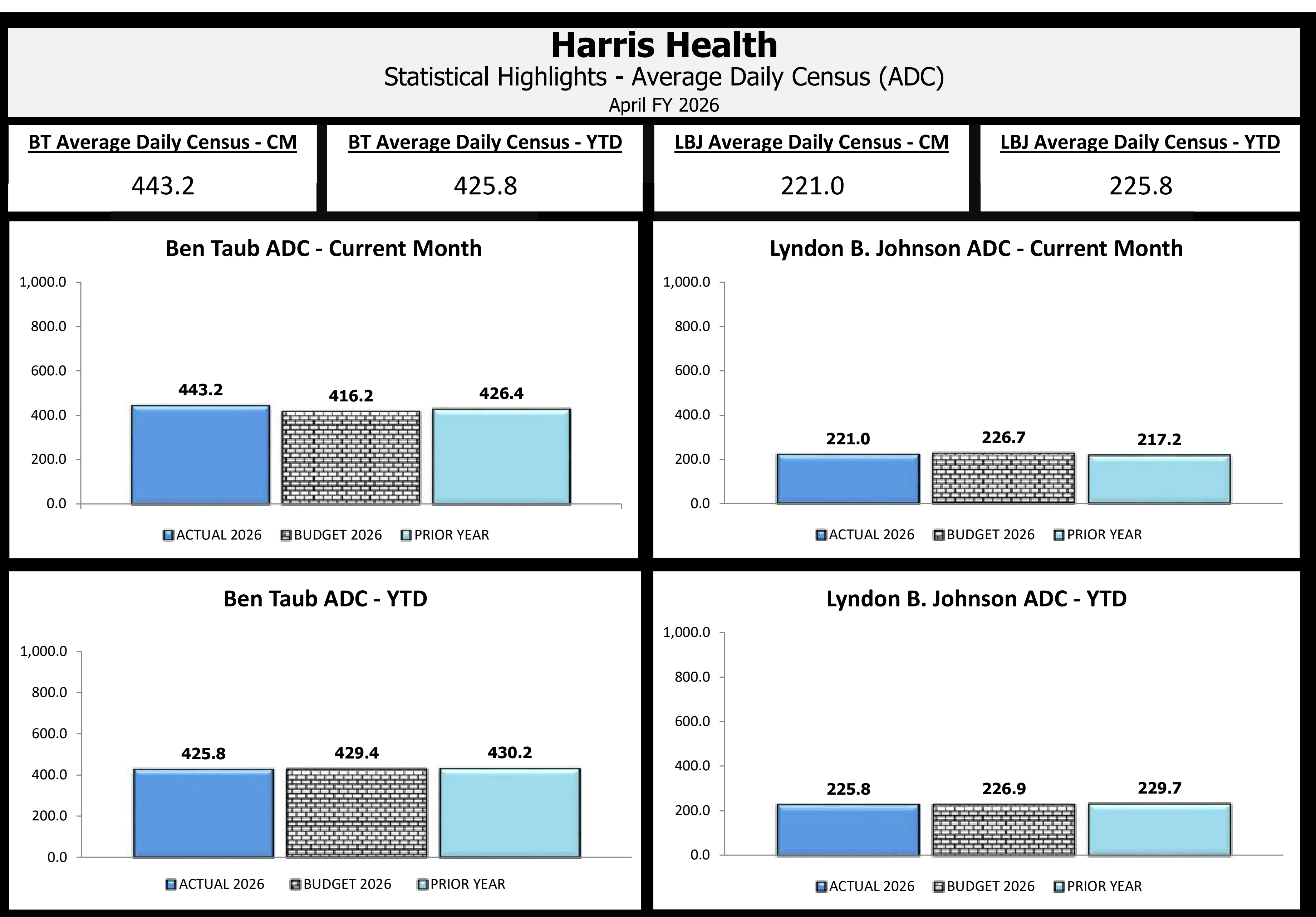




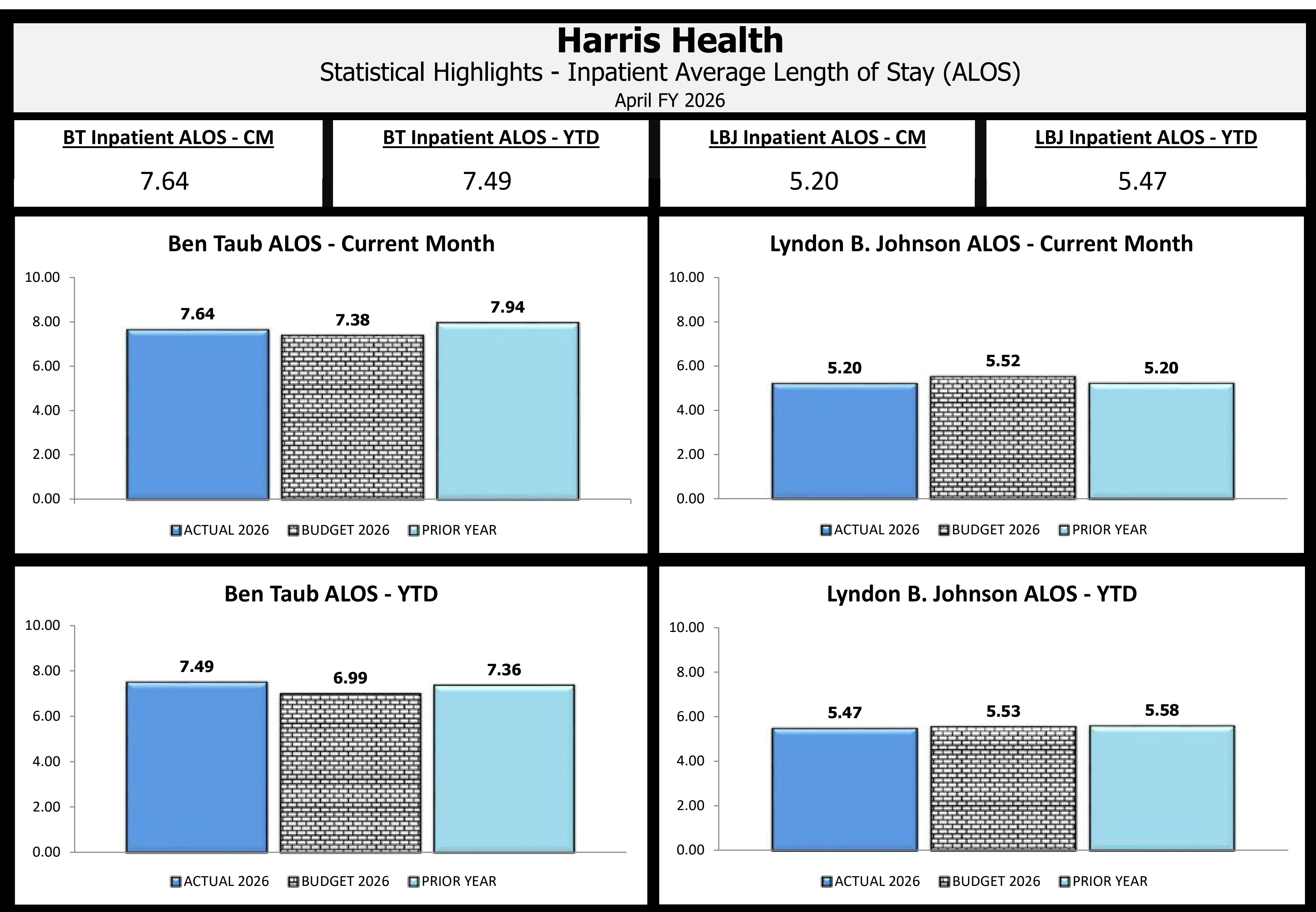



Harris Health
Statistical Highlights - Births
April FY 2026
BT Births - CM
Actual Budget Prior Year
188 211 202
BT Births - YTD
Actual Budget Prior Year
1,395 1,852 1,775
LBJ Births - CM
Actual Budget Prior Year
148 179 160
LBJ Births - YTD
Actual Budget Prior Year
1,075 1,364 1,358
Ben Taub Births - Current Month
1,500
1,200
900
600
300
0
188
211
202
ACTUAL 2026 BUDGET 2026 PRIOR YEAR
Lyndon B. Johnson Births - Current Month
1,500
1,200
900
600
300
0
148
179
160
ACTUAL 2026 BUDGET 2026 PRIOR YEAR
Ben Taub Births - YTD
2,000
1,600
1,200
800
400
0
1,395
1,852
1,775
ACTUAL 2026 BUDGET 2026 PRIOR YEAR
Lyndon B. Johnson Births - YTD
1,500
1,200
900
600
300
0
1,075
1,364
1,358
ACTUAL 2026 BUDGET 2026 PRIOR YEAR

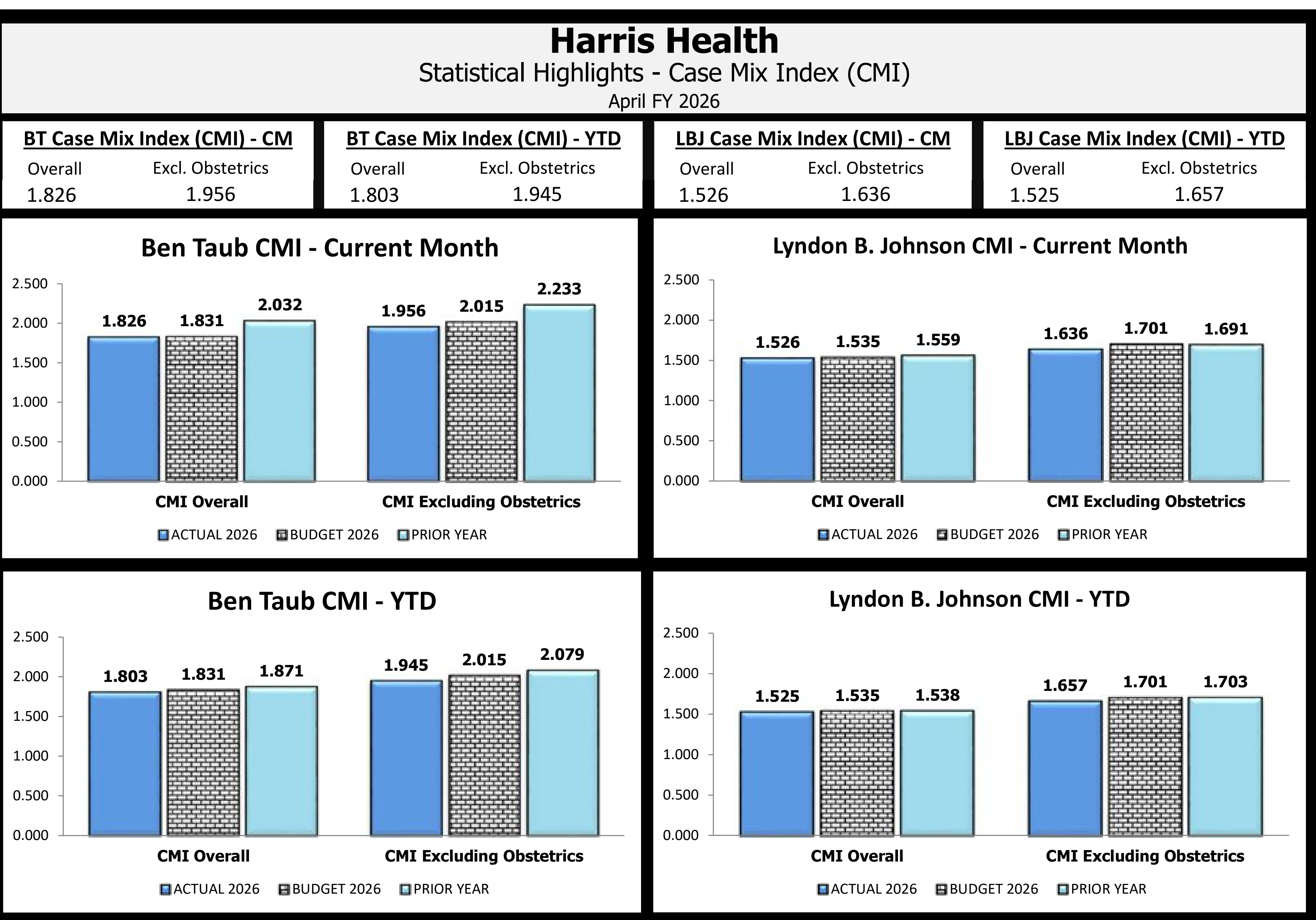

Harris Health
Statistical Highlights - Adjusted Patient Days
April FY 2026
BT Adjusted Patient Days - CM
21,999
BT Adjusted Patient Days - YTD
152,481
LBJ Adjusted Patient Days - CM
13,098
LBJ Adjusted Patient Days - YTD
93,358
Ben Taub APD - Current Month
100,000
80,000
60,000
40,000
20,000
0
21,999
21,057
21,935
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson APD - Current Month
100,000
80,000
60,000
40,000
20,000
0
13,098
13,591
13,205
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Ben Taub APD - YTD
200,000
160,000
120,000
80,000
40,000
0
152,481
154,015
151,452
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson APD - YTD
150,000
120,000
90,000
60,000
30,000
0
93,358
94,119
95,272
ACTUAL 2026
BUDGET 2026
PRIOR YEAR



Harris Health
Statistical Highlights - Average Daily Census (ADC)
April FY 2026
BT Average Daily Census - CM
443.2
BT Average Daily Census - YTD
425.8
LBJ Average Daily Census - CM
221.0
LBJ Average Daily Census - YTD
225.8
Ben Taub ADC - Current Month
1,000.0
800.0
600.0
400.0
200.0
0.0
443.2
416.2
426.4
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson ADC - Current Month
221.0
226.7
217.2
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Ben Taub ADC - YTD
425.8
429.4
430.2
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson ADC - YTD
225.8
226.9
229.7
ACTUAL 2026
BUDGET 2026
PRIOR YEAR



Harris Health
Statistical Highlights - Inpatient Average Length of Stay (ALOS)
April FY 2026
BT Inpatient ALOS - CM
7.64
BT Inpatient ALOS - YTD
7.49
LBJ Inpatient ALOS - CM
5.20
LBJ Inpatient ALOS - YTD
5.47
Ben Taub ALOS - Current Month
7.64
7.38
7.94
Lyndon B. Johnson ALOS - Current Month
5.20
5.52
5.20
Ben Taub ALOS - YTD
7.49
6.99
7.36
Lyndon B. Johnson ALOS - YTD
5.47
5.53
5.58
ACTUAL 2026
BUDGET 2026
PRIOR YEAR



Harris Health
Statistical Highlights - Case Mix Index (CMI)
April FY 2026
BT Case Mix Index (CMI) - CM
Overall
Excl. Obstetrics
1.826
1.956
BT Case Mix Index (CMI) - YTD
Overall
Excl. Obstetrics
1.803
1.945
LBJ Case Mix Index (CMI) - CM
Overall
Excl. Obstetrics
1.526
1.636
LBJ Case Mix Index (CMI) - YTD
Overall
Excl. Obstetrics
1.525
1.657
Ben Taub CMI - Current Month
2.500
2.000
1.500
1.000
0.500
0.000
1.826
1.831
2.032
1.956
2.015
2.233
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson CMI - Current Month
1.526
1.535
1.559
1.636
1.701
1.691
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Ben Taub CMI - YTD
1.803
1.831
1.871
1.945
2.015
2.079
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR
Lyndon B. Johnson CMI - YTD
1.525
1.535
1.538
1.657
1.701
1.703
CMI Overall
CMI Excluding Obstetrics
ACTUAL 2026
BUDGET 2026
PRIOR YEAR

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Approval to Utilize the Construction Manager at Risk (CMAR) delivery method for the construction of the Ben Taub Hospital Expansion

---

Administration requests Board of Trustees approval to utilize the Construction Manager at Risk (CMAR) delivery method for Ben Taub Hospital Expansion and that the Purchasing Agent be authorized to issue a Request for Qualification (RFQ) for the selection of the Construction Manager. This is required by Texas Government Code, Title 10, General Government, Subtitle F, State and Local contracts and Fund Management, Chapter 2269, Contracting Delivery Procedures for Construction Projects, Subchapter B, General Powers and Duties, Section 2269.056 (a) The governing body of a governmental entity (Harris Health) that considers a construction contract using a method authorized by this chapter other than competitive bidding must, before advertising, determine which method provides the best value for the governmental entity.

The CMAR project delivery method is recommended because of the complexity, duration of the project, and the best value method of selection may be utilized. Best value considers many factors including:

- The ability of the General Contractor (GC) to be engaged early in the design, ensuring constructability concerns are addressed during design.
- Cost evaluation and materials trade-offs are determined during design, reducing cost overruns and unnecessary delays/change orders throughout the project.
- A guaranteed maximum price can be established prior to the start of the project reducing owner's risk.
- An experienced CMAR contractor can help position the project so it meets or exceeds diversity goals established by Harris Health prior to the bidding of the project work by the CMAR.

Patrick Casey
SVP, Facilities Construction & Systems Engineering

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

BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, June 10, 2026

Consideration and approval of Harris Health Policy 3.43 Board of Trustees Member Conflict of Interest and Nepotism

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Harris Health Policy 3.43 governs the Board of Trustees Member Conflicts of Interest and Nepotism. This Policy is designed to set forth detailed standards and procedures for identifying, disclosing, and managing conflicts of interest among Board members and their families. The Policy outlines a Board member's legal obligations under Chapters 171 and 176 of the Texas Local Government Code and nepotism under Chapter 573 of the Texas Local Government Code.

The recommended Policy revisions include:

- Additional description to the Policy Statement;
- The definition of "Abstention"; and
- Clean up and clarifying revisions.

The proposed revisions are attached behind.

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

TITLE: **BOARD OF TRUSTEES MEMBER CONFLICT OF INTEREST AND NEPOTISM**

PURPOSE: To provide guidelines to Board of Trustees members for conducting Harris Health System (Harris Health) business free from the influence of personal or private interests and to prevent favoritism, or the appearance of favoritism for relatives and household members.

POLICY STATEMENT:

Each member of the Board of Trustees has a duty of loyalty to Harris Health and may not use their position for personal, family, or professional gain. Board members have a duty to give undivided allegiance to Harris Health when making decisions affecting Harris Health and must avoid the appearance of a conflict of interest in Harris Health's relationships. All Board members shall comply with state and federal laws, rules, and regulations governing their ethical conduct, including the disclosure of conflicts of interest in accordance with Chapters 171 and 176 of the Texas Local Government Code and nepotism in accordance with Chapter 573 of the Texas Local Government Code. In furtherance of these obligations and to protect the integrity and impartiality of the Board members, Harris Health has adopted this policy.

This Policy is designed to set forth detailed standards and procedures for identifying, disclosing, and managing conflicts of interest among Board members and their families. Its aims are to safeguard the integrity and reputation of Harris Health, promote undivided loyalty, and reinforce ethical conduct in all Board matters. This policy applies to all Board members and, where required by law, their immediate family members. It covers any situation in which personal, financial, organizational, or familial interests may conflict with the Board member's duty to act solely in the best interests of Harris Health–. Further, all Board members shall endeavor to disclose any individual interest or that of a family member which may influence or appear to influence an official act or decision.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ABSTENTION:** The act of refraining from participation in Board discussions, decisions, or votes relating to a disclosed conflict.

~~A.~~B. **APPEARANCE OF CONFLICT**: the impression that a reasonable person may form, after full disclosure of the facts, that a conflict of interest exists.

~~B.~~C. **BOARD OF TRUSTEES MEMBER (BOT MEMBER)**: A member of the Harris Health governing body who has been appointed by the Harris County Commissioner's Court to serve on the Harris Health Board of Trustees.

~~C.~~D. **BUSINESS ENTITY**: For purposes of this policy, includes a sole proprietorship, partnership, firm, corporation, holding company, joint-stock company, receivership, trust, governmental entity, non-profit entity, institutions of higher education or any other entity recognized by law.

~~D.~~E. **BUSINESS RELATIONSHIP**: A connection between two or more parties based on commercial activity of one of the parties.

~~E.~~F. **DECISION:** A determination by the BOT made only through a formal vote.

~~F.~~G. **FAMILY RELATIONSHIP**: An individual's spouse, parent, child, brother, sister, grandparent, grandchild, great-grandparent, great-grandchild, aunt who is a sister of a parent of the individual, uncle who is a brother of a parent of the individual, nephew who is a child of a brother or sister of the individual, niece who is a child of a brother or sister of the individual, mother-in-law, father-in-law, son-in-law, daughter-in-law, stepson, stepdaughter, stepmother, stepfather, brother-in-law, sister-in-law, spouse's grandparent, spouse's grandchild, grandchild's spouse, or spouse of a grandparent.

~~G.~~H. **FIRST-DEGREE RELATIVE**: An individual's child, parent, spouse, mother-in-law, father-in-law, son-in-law, daughter-in-law, stepson, stepdaughter, stepmother or stepfather.

~~H.~~I. **HOUSEHOLD MEMBER**: A person or persons with whom a BOT Member shares a common abode, including other employees, partners, and others who live together.

~~I.~~J. **INVESTMENT INCOME**: means dividends, capital gains, or interest income generated from:

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1. A personal or business:

   a. Checking or savings account;
   b. Share draft or share accounts; or
   c. Other similar account; or

2. A personal or business investment; or
3. A personal or business loan.

~~J.~~K. **PARTICIPAT~~(ION)~~E**: for the purposes of this policy, participate or participation means to take part in any discussion, comment, action, decision, deliberation or vote.

~~K.~~L. **SPECIAL ECONOMIC EFFECT**: With respect to any matter, a reasonably foreseeable economic effect that is distinguishable from the effect that the matter would have on the public. For example, if the Harris Health Board of Trustees were to discuss purchasing goods or services from a Business Entity in which a BOT Member has a Substantial Interest, that discussion would have a Special Economic Effect on the Business Entity.

II. INTERESTS IN BUSINESS ENTITIES OR REAL PROPERTY THAT REQUIRE AFFIDAVITS OR ABSTENTION:

A. Overview:

Texas law requires BOT Members to file affidavits disclosing certain Substantial Interests in business entities or real property. In most cases, BOT Members must abstain from Participation relating to those interests.

B. Substantial Interest:

1. A BOT Member or his/her First-Degree Relative has a Substantial Interest in a Business Entity if such person:

   a. Owns ten percent (10%) or more of the voting stock or shares of the Business Entity; **OR**

b. Owns either ten percent (10%) or more or fifteen thousand dollars ($15,000.00) or more of the fair market value of the Business Entity; **OR**

c. Receives funds from the Business Entity that exceed ten percent (10%) of the person's gross income for the previous year.

2. A person has a Substantial Interest in real property if the interest is an equitable or legal ownership with a fair market value of twenty-five hundred dollars ($2,500.00) or more.

C. Required Affidavit and Abstention from Participation:

1. If a BOT Member has a Substantial Interest in a Business Entity, the BOT Member must file, before any vote, decision, or discussion on any matter that will have a Special Economic Effect on the Business Entity, an affidavit stating the nature and extent of the Substantial Interest **AND** shall abstain from further Participation in the matter.

2. If a BOT Member has a Substantial Interest in real property, the BOT Member must file, before any vote, decision, or discussion on any matter that will have a Special Economic Effect on the value of the property, an affidavit stating the nature and extent of the Substantial Interest **AND** shall abstain from further Participation in the matter.

D. Exception to Abstention Requirement:

~~1.~~ If BOT Member files ~~an affidavit~~a Disclosure Affidavit pursuant to this Policy, that BOT Member is not required to abstain from Participation

~~2.~~1. regarding the matter requiring the affidavit if a majority of the Harris Health Board of Trustees are ~~likewise~~also required to file affidavits ~~pursuant to this Policy of similar interests~~ on the same ~~official action~~matter.

~~3.~~2. 2. For a vote on a Harris Health final budget, if a BOT Member with a substantial interest in a business entity files ~~an~~a Disclosure affidavit pursuant to this Policy, the BOT member may vote for the budget but only after the Board concluded the separate vote on the budget item involving the business entity in which the BOT Member has a substantial interest~~; even though the BOT member may vote, such member is not authorized to Participate in the discussion of any portion of the budget~~.

E. Community Health Choice (CHC) Membership:

If a BOT Member is also a member of the CHC Board of Directors, such BOT Member is not required to abstain from Participation regarding a matter involving CHC because he or she does not have a personal financial interest in the CHC.

F. Harris Health Employee Benefits:

A BOT Member is required to abstain from Participation on matters related to Harris Health employee benefits if health benefit payments to a health care provider or reimbursement to the BOT Member exceeded ten percent (10%) of the Member's gross income for the previous year. ~~However,~~A BOT Member is not required to abstain if retirement investment income payments ~~exceeding that level or exceeding~~exceed a ten percent (10%) of the ~~fair market value level in an investment would not require abstention~~Member's gross income because Harris Health provides a 401(a) plan, which is not a "business entity," and the plan administrator is not providing the payments.

G. Client of BOT ~~Member~~Member's Employer:

A BOT Member ~~is~~employed by a third-party would be required to abstain from Participation only if the third-party employer had involvement in the client's matter ~~that is~~pending before Harris Health for a vote. If there is no employer involvement in the agenda matter involving the client, then Disclosure is required but abstention ~~from Participation~~ is not required.

~~H.~~ Appearance of Conflict:

H.

~~1.~~ A BOT Member is required to abstain from Participation if the BOT member has a relationship to a matter that is before Harris Health that creates an Appearance of Conflict. An appearance of conflict of interest should be handled through the conflicts management plan procedures outlined below. This may include an employment, economic, personal or any other relationship that has the potential to compromise the BOT Member's

impartiality or duty of loyalty to Harris Health.`

I. Procedures:

1. The Harris Health Board Office (Board Office) shall request information from all BOT Members and in consultation with the Harris County Attorney's Office (County Attorney's Office) evaluate them for a Substantial Interest in a Business Entity and real property upon appointment to the Harris Health Board of Trustees.
2. Any affidavits required to be filed under this Section II must be filed with the Board Office.
3. Prior to each regular Board meeting, the Board Office shall identify the business entities involved in agenda item votes proposed for such meeting and inquire of each BOT member whether he or she has a Substantial Interest in the identified Business Entities. If a Substantial Interest is identified, then the BOT Member shall sign and file an affidavit disclosing the Substantial Interest if he or she has not already filed one with the Board Office. At the meeting, when the presiding officer of the Board announces the agenda item involving the Substantial Interest as ready for consideration by the Board but before a motion is made or discussion commences, the BOT Member or Members having the Substantial Interest shall announce that he or she has a conflict of interest affidavit on file and will not Participate and/or vote (as the case may be), unless an exception to abstention applies.
4. A BOT Member who has a Substantial Interest in a Business Entity and Real Property under this section, shall also refrain from Participation with Administration (outside of the board meeting) related to a contemplated transaction to avoid an Appearance of Conflict. BOT Members are required, instead, to interact with the CEO and Administration in their capacity as a BOT Member only. The BOT Member has a fiduciary duty of loyalty to Harris Health and shall not represent another entity in potential or actual transactions with Harris Health.
5. A BOT Member is encouraged to discuss all conflicts of interest, including ~~or~~ potential conflicts of interest and appearance of conflict of interest, he or she identifies with the County Attorney's Office, and Harris Health Administration should do the same for any for any BOT Member conflicts or potential conflicts of which it becomes aware. The County Attorney's Office

may provide its legal ~~analysis, formally~~analysis, formally or informally, in its discretion.

6. At least once per year, or more often at the time of knowing that ~~an actual or potential~~a conflict of interest, including potential conflict of interest or appearance of conflict of interest exists, each BOT Member shall confer with the County Attorney's Office and execute a conflicts management plan when applicable.
7. Regardless of the involvement of the Board Office and the County Attorney's Office, each BOT Member is personally responsible for ensuring his or her Substantial Interests are properly disclosed and that he or she abstains from Participation when required. All BOT Members are advised that in certain cases, failure to comply with this policy could constitute a Class A Misdemeanor.

III. DISCLOSURE OF CERTAIN BUSINESS RELATIONSHIPS WITH VENDORS:

A. Overview:

Texas law requires BOT Members to disclose certain business relationships that they have with actual or potential vendors of Harris Health.

B. Conflicts Disclosure:

1. A BOT Member must file a conflicts disclosure statement with respect to a vendor if:

   a. The vendor enters into a contract with Harris Health or Harris Health is considering entering into a contract with the vendor; **AND**
   b. The vendor:

      Has an employment or other Business Relationship with the BOT Member or a First-Degree Relative of the BOT Member that results in the BOT Member or First-Degree Relative receiving taxable income, other than Investment Income, that exceeds twenty-five hundred dollars ($2,500) during the twelve (12) month period preceding the date that the BOT Member becomes aware that:

1) A contract between Harris Health and vendor has been executed; **OR**

2) Harris Health is considering entering into a contract with the vendor; **OR**

3) Has given to the BOT Member or a First-Degree Relative of the BOT Member one or more gifts that have an aggregate value of more than one hundred dollars ($100) in the twelve (12) month period preceding the date the BOT Member becomes aware that:

   a) A contract between Harris Health and vendor has been executed; or
   b) Harris Health is considering entering into a contract with the vendor;

   OR

   c) Has a Family Relationship with the BOT Member.

2. A BOT Member must file a Local Government Officer Conflicts Disclosure Statement Form published by the Texas Ethics Commission.

C. Exceptions:

1. A BOT Member is not required to file a conflicts disclosure statement for the following gifts received by the BOT Member or their First-Degree Relatives:

   a. A political contribution; or
   b. Food accepted as a guest.

2. A BOT is not required to file a conflicts disclosure statement if his/her Business Relationship with a vendor is based on any of the following:

   a. A transaction that is subject to rate or fee regulation by a federal, state, or local governmental entity or an agency of a federal, state, or local governmental entity; or
   b. A transaction conducted at a price and subject to terms available to the

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public; or

c. A purchase or lease of goods or services from a person that is chartered by a state or federal agency and that is subject to regular examination by, and reporting to, that agency.

D. Applicable Procedures:

1. A BOT Member shall file the conflicts disclosure statement with the Board Office no later than 5 p.m. on the seventh (7th) business day after the date which the BOT Member becomes aware of the facts that require the filing of the conflicts disclosure statement. For transparency purposes, Harris Health encourages BOT Members to review information from Harris Health Administration regarding disclosure conflicts as soon as vendors are disclosed and to promptly determine if a conflicts disclosure statement should be filed. Harris Health encourages BOT Members and Harris Health Administration to consult with the County Attorney's Office regarding any questions or uncertainty with the filing of a conflicts disclosure statement. The County Attorney's Office may give advice formally, or informally, at its discretion. Conflicts under this Section III. may also be subject to a conflicts management plan.
2. If the BOT Member misses the deadline to file the conflicts disclosure statement and the Board Office is or becomes aware of the BOT Member's obligation to file the conflicts disclosure statement with regard to a vendor, the Board Office shall give notice to the BOT Member of the failure to file the conflicts disclosure statement, and the BOT Member shall file the required conflicts disclosure statement not later than the seventh (7th) business date after the date the BOT Member receives this notice from the Board Office.
3. Because the filing of a conflicts disclosure statement does not require abstention of any sort, a BOT Member need not announce or publicly disclose before, during, or after a Board meeting the existence of a relationship identified in the statement apart from having filed the statement. BOT Members should be aware that, because Harris Health maintains an internet website, it is required by law to provide access to conflicts disclosure statements on this website.
4. The Board Office will maintain the conflicts disclosure statements in accordance with Harris Health's records retention schedule.
5. Upon adoption of this Policy, the Board Office will maintain and publish a list

to all BOT Members of vendors who contracted with Harris Health or were considered for a contract, and all BOT Members are obligated to file a Texas Ethics Commission Form CIS for vendors required to be disclosed under Chapter 176 of the Texas Local Government Code.

6. Regardless of the involvement of the Board Office and the County Attorney's Office, each BOT Member is personally responsible for ensuring that his or her relationships with vendors are properly disclosed. All BOT Members are advised that in certain cases, failure to comply with this policy could constitute a Class A Misdemeanor.

IV. NEPOTISM:

A. Overview:

Texas law prohibits public officials from appointing, confirming the appointment of, or voting for the appointment or confirmation of the appointment of a close relative of public officials to a paid public position or employment.

B. Nepotism:

1. A BOT Member may vote, discuss, or make a decision on employment, promotions, transfers, assignments or supervise an individual that the BOT Member has a Family Relationship with or is a Household Member.
2. A BOT Member may not directly or indirectly use his or her position to secure the employment, promotion, transfer, or assignment of an individual that the BOT Member has a Family Relationship with or is a Household Member.

C. Exceptions:

1. If an individual is appointed as a BOT Member and such BOT Member has a Family Relationship with a Harris Health employee or a Household Member employed with Harris Health, the BOT Member must immediately notify the Board Office.
2. Such Family Relationship individual or Household Member may continue being employed by Harris Health if the Family Relationship individual or Household Member has been continuously employed with Harris Health for 30 days prior to the appointment of the BOT Member ("Continuous Employment").

3. If the Family Relationship individual or Household Member falls under the Continuous Employment exception, the BOT Member shall not participate in any discussion, decision, or vote regarding the Family Relationship individual or Household Member's employment, compensation, promotion, transfer, assignment or dismissal if these actions only apply to the individual and is not taken regarding a bona fide class or category of employees.

REFERENCES/BIBLIOGRAPHY:

Chapters 171 and 176 of the Texas Local Government Code Chapter
573 of the Texas Local Government Code.

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Office of Corporate Compliance

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (If Board of Managers Approved, include Board Motion #)
	1.0	Approved 2/27/2020	Board of Trustees Board Motion No. 20.02-20

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration and approval of Harris Health Policy 3.06 Delegation of Duties of the President and Chief Executive Officer

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Harris Health Policy 3.06 governs the delegation of duties of the President and Chief Executive Officer ("CEO") in the event that he is absent, incapacitated, or unable to perform his duties.

The Chief Operating Officer ("COO") and Chief Financial Officer ("CFO") have been appointed as Assistant Administrators. The COO is specifically authorized to perform the CEO's powers and duties in the event the CEO is absent, incapacitated, or unable to perform his duties. Further, the CFO is authorized to perform the CEO's powers and duties in the event the CEO and the COO are absent, incapacitated, or unable to perform the duties.

We recommended deleting section II. C. of the Policy regarding the order of delegation by seniority and instead referring to the Board Resolution in Appendix A. The proposed revision is attached behind.

Carolynn Jones
EVP, Chief Compliance and Risk Officer

Status Pending PolicyStat ID 20162108

HARRISHEALTH

Origination	3/31/2002	Owner	Carolynn Jones: Executive Owner
Last Approved	N/A	Area	Administration
Effective	Upon Approval	References	Porsa, Esmaeil
Last Revised	5/13/2026		
Next Review	3 years after approval		

Delegation of the Duties of the President and Chief Executive Officer_3.06

COPY

PURPOSE:

To outline the requirements for the designation of an individual or individuals (Assistant Administrator(s)) to perform the duties of the President and Chief Executive Officer of the Harris Health ~~System~~ when he or she is absent, incapacitated, or unable to perform his or her duties.

POLICY STATEMENT:

In accordance with the Texas Health and Safety Code, Harris Health ~~System~~'s ~~(Harris Health)~~ Board of Trustees will appoint an individual or individuals (Assistant Administrator(s)) to perform the duties of the Harris Health President and Chief Executive Officer, when he or she is absent, incapacitated, or unable to perform his or her duties.

POLICY ELABORATION:

I. **DEFINITIONS:**

PRESIDENT AND CHIEF EXECUTIVE OFFICER (CEO): The individual appointed by Harris Health's Board of Trustees to fulfill duties as Harris Health's Administrator, as defined by Chapter 281 of the Texas Health and Safety Code.

II. **PROCEDURE:**

A. Harris Health's Board of Trustees has appointed Assistant Administrator(s) to perform any of the powers or duties of the CEO when the CEO is incapacitated, absent, or unable to perform his or her duties, subject to limitations prescribed by the Board Order. See Appendix A for the Board Order.

B. If the CEO plans to be absent and unavailable to fulfill his or her duties, prior to the absence the CEO will designate an Assistant Administrator to perform his or her powers

and duties during the absence. The CEO will send notice of the designation to appropriate individuals at Harris Health, including the Harris Health Board of Trustees Board Chair, Executive Vice Presidents and the Chief Legal Officer (CLO). In the event that both the CEO and the individual designated by the CEO become incapacitated, absent, or unable to perform his or her duties, the powers and duties of the CEO will be assigned to the other Assistant Administrator.

C. ~~In the event that the CEO becomes incapacitated or is unable to perform his or her duties, or is absent and did not designate an Assistant Administrator to perform his or her duties during the absence, the Assistant Administrator with the greatest seniority will perform the powers and duties of the CEO.~~

D. In the event that the CEO and Assistant Administrator(s) become incapacitated or unable to perform his or her duties, the Harris Health Board of Trustees will timely appoint an additional Assistant Administrator.

E. Before assuming the duties of Administrator, the CEO must execute a bond payable to Harris Health in the amount of not less than $10,000, conditioned on the faithful performance of the Administrator's duties and any other requirements required by the Board of Trustees.

REFERENCES/BIBLIOGRAPHY:

Texas Health and Safety Code Sections §§281.026 and 281.027
Appendix A – Board Order Appointing Assistant Administrators

COPY

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health ~~System~~ President and Chief Executive Officer

APPENDIX A

BOARD ORDER APPOINTING ASSISTANT ADMINISTRATORS

STATE OF TEXAS

COUNTY OF HARRIS

MOTION NO. **20.10-136**

On **December 29, 2020**, the Harris County Hospital District d/b/a Harris Health System Board of Trustees convened in a regular session at its regular meeting place. The following members of the Board were present:

		Present	Absent
Dr. Kimberly Monday	Chair	☑	☐
Linda Morales	Vice Chair	☑	☐
Elena Marks	Secretary	☑	☐
Dr. Arthur Bracey	Board Member	☑	☐

Dr. Andrea Caracostis	Board Member	☑	☐
Anne Clutterbuck	Board Member	☑	☐
Lawrence D. Finder	Board Member	☑	☐
Dr. Ewan D. Johnson	Board Member	☑	☐
Alicia Reyes	Board Member	☑	☐

The Board determined that a quorum was present. Among other business, a resolution on the following matter was considered:

Appointment of Assistant Administrators

Ms. Alicia ~~Reyesintroduced~~Reyes introduced the resolution and made a motion that it be adopted.

Ms. Anne ~~Clutterbuckseconded~~Clutterbuck seconded the motion for adoption. The motion, carrying with it the adoption of the resolution, prevailed by the following vote:

		Yes	No	Abstain
Dr. Kimberly Monday	Chair	☑	☐	☐
Linda Morales	Vice Chair	☑	☐	☐
Elena Marks	Secretary	☑	☐	☐
Dr. Arthur Bracey	Board Member	☑	☐	☐
Dr. Andrea Caracostis	Board Member	☑	☐	☐
Anne Clutterbuck	Board Member	☑	☐	☐
Lawrence D. Finder	Board Member	☑	☐	☐
Dr. Ewan D. Johnson	Board Member	☑	☐	☐
Alicia Reyes	Board Member	☑	☐	☐

COPY

The adopted resolution reads as follows:

Harris Health, by and through its Board of Trustees, approves and hereby authorizes the Appointment of the Chief Operating Officer (COO) and Chief Financial Officer (CFO) as Assistant Administrators as authorized by Texas Health & Safety Code Section 281.027.

The COO is specifically authorized to perform any of the Administrator ("CEO")'s powers or duties if the CEO is incapacitated, absent, or unable to perform the CEO's duties. Further, the CFO is specifically authorized to perform any of the Administrator ("CEO")'s powers or duties if both the CEO and COO are incapacitated, absent, or unable to perform their duties.

The designation as an Assistant Administrator and this authorization to act is with the express limitation that no material change in strategic direction, policy or practice of the District occurs, without prior consultation with the Board of Trustees, during the period of the CEO's incapacitation, absence, or inability to perform his or her duties.

Harris Health System
P.O. Box 66769, Houston, Texas 77266-6769

October 20, 2021

Louis Smith
Senior Executive Vice President/Chief Operating Officer
4800 Fournace
Sixth Floor, East Wing
Bellaire, Texas 77401

Re: Delegation of Signature Authority

Dear Louis Smith:

The Board of Trustees of the Harris County Hospital District d/b/a Harris Health System ("Harris Health") has authorized me to sign certain agreements on behalf of Harris Health as described in Harris Health Policy 3.03.

As the administrator of Harris Health appointed under Texas Health and Safety Code § 281.026, I hereby delegate to you, on a non-exclusive basis, the authority to sign any contract that I am authorized to sign under Harris Health Policy 3.03 on my behalf by permission.

If I later find it appropriate or necessary to rescind this delegation of authority, I will rescind it in writing.

Sincerely,

Esmaeil Porsa, M.D.

Approved as to legal form:

L. Sara Thomas
Vice President Legal Affairs/Division Director
Harris County Attorney's Office
Harris Health System

harrishealth.org

Approval Signatures

Step Description	Approver	Date
Workflow Start Notification	Lauren Banks: Executive Owner	Pending

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Approval of the Renewal of Dr. Tien Kos Term of Appointment as Chief of Staff for LBJ Hospital

---

1. The renewal request is pursuant to Section 5.4.1 (b) of the Administration Service Agreement between the University of Texas Health Science Center and Harris Health.
2. The term is for July 1, 2025 through June 30, 2027.

____
Glorimar Medina, MD, MBA, FACHE
CEO – Hospital Campuses

McGovern Medical School
Office of the Dean

LaTanya J. Love, MD
Dean
H. Wayne Hightower Distinguished Professor in the Medical Sciences
Executive Vice President, University Affairs, UTHealth Houston

DATE: May 20, 2026

TO: Esmaeil Porsa, MD. MBA, MPH, CCHP
President and CEO, Harris Health System

FROM: LaTanya Love, MD
Dean, McGovern Medical School at UTHealth Houston

Per the executed agreement between Harris Health System and UTHealth Houston, Section 5.4.l(b), I recommend reappointment of Dr. Tien Ko as the Chief of Staff of LBJ Hospital.

We recognize the efforts and success of Dr. Ko's current tenure and look forward to his continued leadership.

Sincerely,

LaTanya Love, MD
Dean
H. Wayne Hightower Distinguished Professor in the Medical Sciences
McGovern Medical School at UTHealth Houston
Executive Vice President for University Affairs
UTHealth Houston

713.500.5231 phone 713.500.0602
LaTanya.D.Jones@uth.tmc.edu
6431 Fannin Street, Suite G.150
Houston, TX 77030

 HARRISHEALTH

Wednesday, June 10, 2026

Consideration of Approval of the Renewal of Dr. Sandeep Markans Term of Appointment as Chief of Staff for Ben Taub Hospital

---

1. The term is for July 1, 2025 through June 30, 2027.

Glorimar Medina, MD, MBA, FACHE
CEO – Hospital Campuses

BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Bi-monthly 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

Harris Health 4800 Fournace Place, Bellaire, Texas 77401 | harrishealth.org

June 2026

Board of Trustees Bi-monthly Legislative Report

FEDERAL UPDATE

CONGRESSIONAL PRIMARY ELECTION: Texas primary turnout exceeded the 2022 records with 2.3 million voting in the Democratic primary and 2.2 million in the Republican primary out of 18.7 million registered voters. The Houston delegation lost a senior member of the Energy & Commerce Committee to a primary defeat in Rep. Crenshaw, and the Texas delegation lost two senior members of the Ways & Means Committee to retirement in Reps. Arrington and Doggett, which represents a major setback for the State on committees with direct health care jurisdiction.

The runoff election results for Texas are attached. Senator Cornyn was defeated handily by Ken Paxton, Alex Muellar bested Briscoe Cain for the newly redrawn 9th District, and Christian Menefee beat Congressman Al Green in the 18th.

Letecia Plumber, DDS (D) will face off against Orlando Sanchez (R) for Harris County Judge which could shift the current 4:1 Democratic majority to a 3:2 majority, with major implications for tax rate votes at the county level.

CMS PROPOSED RULE AND MEDICAID SUPPLEMENTAL PAYMENTS: On May 22, the Centers for Medicare & Medicaid Services (CMS) published a highly anticipated proposed rule (CMS-2449-P) to implement provisions in Sec. 71116 of H.R. 1 that will impose new limits on Medicaid state-directed payments (SDPs). The proposed rule also contains new restrictions on targeted practitioner payments in fee-for-service Medicaid that were not contemplated in H.R. 1. The 60-day comment period ends July 21, 2026. Asa a reminder over a third of Harris Health's budget is derived from SDPs and DSH. Some of the proposed changes are highlighted here.

The proposed rule does not consider provisions in Sec. 71115 of H.R. 1 that limit new and existing provider taxes. CMS is likely to address these in separate rulemaking. These rulemakings are significantly concerning to Texas as the SDPs state portion is funded by both IGTs from governmental entities and Local Provider Participation Funds (LPPF) assessed on non-governmental hospitals.

In the proposed rule, CMS lays the groundwork for a potentially precipitous reduction in Texas hospitals' Medicaid reimbursement on a compressed timeline. The rule leaves many questions unanswered about the future stability of Texas's directed payment programs. Key takeaways include:

- CMS won't view the Medicare upper payment limit (UPL) as an acceptable Medicare rate equivalent. Consistent with prior agency communications, CMS reiterated that the Medicare equivalent payment limit will be calculated on a per-service, per-provider basis in SDPs, rather than an aggregate payment limit approach like UPL.
- CMS relies on the existing definition of "total published Medicare payment rate" as the prospective payments in the web pricer or fee schedule. For prospectively paid hospitals, these are "inclusive of all components included in the rate developed by CMS for Medicare payment." This does include applicable Medicare payment adjustments. For Medicare cost-reimbursed hospitals, such as children's, critical access and cancer hospitals, CMS proposes to use the most recent complete Medicare cost report and cost-based methodology payment approach as the Medicare rate for purposes of the limit. CMS invites comments, particularly with respect to the proposal for PPS-exempt hospitals.

Uncertainty in this part of the rule makes it difficult to assess the value of Texas' 110% floor based on the total published Medicare payment rate. In anticipation of a similar requirement, Texas HHSC has been developing a Medicare-equivalent price for individual Medicaid claims.

- Texas' CHIRP program will be eligible for grandfathering at the SFY 2026 dollar value of $9.15 billion. Texas submitted its complete CHIRP preprint to CMS before July 4, 2025 for the rating period beginning September 1, 2025. This falls within the time range CMS considers eligible for grandfathering.
- CMS defines "grandfathered total dollar amount" and specifies that grandfathered SDPs will be phased down by removing 10% of the total grandfathered dollar amount annually. Grandfathered SDPs are subject to a 10-percentage point annual phase-down beginning with the first rating period on or after January 1, 2028, until the new statutory Medicare payment limit is reached -- for non-expansion states like Texas, that's of 110% of the total published Medicare payment rate. In Texas, $915 million per year would be removed from CHIRP beginning in SFY 2029, which corresponds to 10% of the grandfathered total dollar amount of $9.15 billion. Each subsequent year, an additional $915 million would be removed from the program until the as-yet unknown "floor" value of 110% of Medicare is reached.

This proposed phase-down would be especially severe for Texas. Because the program is so large, CHIRP could face a steep reduction over a short period. CMS offers no alternative methods or flexibility for states in calculating the phase-down and rejected other approaches that would have reduced CHIRP funding more gradually.

- CMS proposes to eliminate uniform increase SDPs. Beginning with rating periods on or after January 1, 2028, CMS proposes to eliminate new uniform increase SDPs. CMS would allow grandfathered SDPs to continue operating as uniform increase programs until they fully phase down to the statutory Medicare payment limit, at which point they'd be required to transition to either a minimum or maximum fee schedule program (not to exceed the applicable Medicare payment limit) or a value-based incentive program. In Texas, CHIRP has two uniform rate increase components paid per-claim (UHRIP and ACIA) with a third value-based component (APHRIQA). The uniform increase components of CHIRP would be required to transition at the end of the grandfathering period under this proposal.
- CMS proposes new limits on targeted practitioner payments in fee-for-service Medicaid. States have been allowed to make fee-for-service supplemental payments to selected practitioners up to the average commercial rate. Currently, no federal UPL regulation governs these payments. These new proposed limits are not applicable to current UPL payments made on a class-wide basis to hospitals providing the same Medicaid-covered services. Therefore, HARP for private and non-state-government owned Texas hospitals is not likely to be affected.
- The regulation also clarifies that DSH payments to hospitals are not subject to these proposed limits.

We will continue to monitor and share feedback on these rules as they are finalized. In the meantime, we are working closely with HHSC, Front Line Hospital Alliance, AEH, THA and THOT to assess the financial impact on Harris Health and Texas.

FRONT LINE HOSPITAL ALLIANCE UPDATE (FLHA): Dr. Porsa and the Government Relations team continue to advocate for federal designation initiatives and 340B drug pricing policy in Washington, D.C. with our congressional delegation, House and Senate leadership, the Paragon Health Institute, the White House, CMS and the Health Resources Services Administration. On May 20 and 21 Dr. Porsa and the government relations team along with other CEOs from the FLHA attended meetings with 13 congressional offices, the President's Domestic Policy Council, CMS, and the Paragon Institute.

Progress is being made on formal designation and protections related to policy and legislative proposals affecting SDPs, finance, facility fees/site-neutral payment, and 340B.

Key follow-up items from this fly-in include:

- Follow up with retiring Chairman Jodey Arrington on federal designation proposals that would exempt FLHA-designated facilities from site-neutral and facility fee legislation he is considering, as well as on potential Medicaid DSH reforms for designated hospitals. Arrington is expected to pursue a Reconciliation 3.0 package later this year that may include health care provisions.
- Follow up with the Paragon Institute on FLHA's proposed reforms related to designation and 340B, and reiterate our request that the Institute formally recognize the FLHA class of hospitals as the hospitals for which SDPs, DSH, and 340B were created.
- Follow up with Theo Markel, Special Assistant to the President on the Domestic Policy Council, regarding 340B, designation, and FLHA's proposals to reduce costs and reform payment. Harris Health and Metro Health will co-chair a committee of FLHA CFOs and finance staff to develop proposed payment and cost reforms for submission.

Attached are FLHA policy documents that were used in the meetings.

U.S. Health & Human Services Regional Director Meeting: Government relations staff attended an intimate meeting hosted by the Texas Hospital Association with HHS Regional Director Erin Tawney. We discussed the goals of HHS and how they intersect with the work and goals of Harris Health and other similarly situated Texas hospital districts.

She has a significant focus on prevention, wellness, and food as medicine, within the context of which, she showed significant interest in our Food Farmacy program.

She expressed an interest in visiting our system and learning more about the good work Harris Health does in the community and for our patients.

STATE UPDATE

Elected Official Meeting: As interim activity ramps up ahead of the 90th Texas Legislature, Dr. Porsa and government relations staff met with Rep. Lauren Ashley Simmons to convey the critical work of Harris Health in caring for Harris County residents and the challenges we face in doing so.

Rep. Simmons sits on key committees of jurisdiction, including Appropriations, Public Health, and the Select Committee on Health Care Affordability.

She currently represents Texas State House District 146, contained within the southwest portion of the City of Houston, and she will be a critical member with which to maintain positive contact with.

Texas Senate Committee Advocacy: The Senate Committee on Health & Human Services met to discuss its interim charge on *Rising Health Care and Insurance Costs*.

In doing so, it examined the drivers of rising health care costs in Texas and specifically considered issues such as facility fees, health savings accounts, flexible benefit plans and the role providers, third party payors, and pharmacy benefit managers in health care delivery.

Working with our associations and meeting with Harris County delegation committee member offices, Harris Health government relations staff ensured our perspective and concerns were documented and considered by the committee, chief among these being our obligation and incentives to care for vulnerable patients in the most efficient manner possible.

These discussions will be ongoing, and we will continue to engage.

340B Lunch & Learn: Harris Health government relations attended and helped garner legislative staff attendance for a Lunch & Learn opportunity at the Texas Capitol regarding the importance of the 340B drug program to our mission.

Multiple provider-based associations participated in this event representing both hospital systems and FQHCs. Presenters emphasized the critical role 340B upfront discounts play in ensuring patient access to vital medications, as well as its particular importance to the vulnerable patient populations Harris Health cares for.

Texas Hospital Association Behavioral Health Crisis Response Roundtable

Harris Health government relations, behavioral health, and service lines staff attended a day-long roundtable hosted by THA to discuss the state of behavioral health policy in Texas and formulate recommendations ahead of the 90th Texas Legislature.

Throughout the day hospital representatives of all kinds from all over Texas discussed emergency detention orders, behavioral health provider training, the differences in the behavioral health landscape from county to county, general best practices, and placements for patients with intellectual development disabilities.

We also heard from representatives in the law enforcement community as well as from the Judicial Committee on Mental Health.

Based on the roundtable discussions, THA is formulating legislative recommendations ahead of the 90th Regular Legislative Session.

Texas Legislative Interim Hearings: Interim hearings by state legislative committees have been ongoing.

Harris Health 4800 Fournace Place, Bellaire, Texas 77401 | harrishealth.org

The Senate Committee on Health & Human Services has held hearings on combatting fraud, waste, and abuse as well as on health care affordability.

The House Select Committee on Health Care Affordability generally examined affordability as it relates to statutory and regulatory burdens as well as the impact of fraud, waste, and abuse.

Common themes emerging across committees are growth in health care spending, value and price in health care services, provider and payor consolidation, and price transparency.

Harris Health personnel individually and through our associations have been successful in stressing our essential role as the region's safety net provider, and key members have echoed this sentiment in their on-the-record remarks.

Hearings will be ongoing, and Harris Health will continue to monitor, engage, and tell our story.

Texas 2026 Primary Runoff Election Summary
Yesterday evening the Texas Republican and Democratic primary runoffs concluded, setting the stage for what is expected to be one of the most competitive and expensive general election cycles in state history.

Key Outcomes:

- Attorney General **Ken Paxton** defeated U.S. Senator **John Cornyn** by a 28-point margin in the Republican Senate primary runoff. Paxton will face Democratic Rep. **James Talarico** in the November general election.

- Sen. **Mayes Middelton** defeated Congressman Chip Roy to secure the Republican nomination for Attorney General. Middelton will face Democratic nominee Sen. **Nathan Johnson** in the fall.

- **Bo French** won the Republican nomination for Texas Railroad Commissioner, defeating incumbent Jim Wright in a closely contested runoff by a margin of **50.56% to 49.44%**. This was the closest statewide runoff race of the 2026 primary cycle. Despite strong endorsements from Governor Greg Abbott, Lieutenant Governor Dan Patrick, and House Speaker Dustin Burrows, Wright was unable to secure re-nomination. French will face Democratic State Representative **Jon Rosenthal** in the November general election.

- Several Texas State House races went into a runoff yesterday. Incumbent **Rep. Venton Jones** (D) - Dallas, was able to hold off his challenger and maintain his seat. **Rep. Hubert Vo** (D) - Houston, was not able to hold on to his seat and lost to challenger Darlene Breaux. Several open seats went to runoffs and the winners head to the general election this fall (see attached list of House races winners)

Notable Context:

- Talarico has emerged as a formidable fundraiser, raising $27 million in the most recent quarter alone, for a total of $40.3 million raised and approximately $9.9 million cash on hand.

- Democrats view Texas as a critical battleground state, citing near-misses in recent cycles, including Beto O'Rourke's 2018 Senate race. No Democrat has won statewide since 1994. The 32-year drought is the longest for any Democrat Party in any state in the country.

- On the Republican side, Governor Greg Abbott maintains a significant financial advantage with over $106 million cash on hand.

Turnout:

- Early projections indicate total runoff turnout exceeded 1.35 million votes, making this the highest-turnout Republican primary runoff in Texas history. While still well below the massive 2.16 million-vote turnout seen in the initial March Republican primary, the unusually high runoff participation underscores both the national attention and high political stakes surrounding this year's races, particularly the high-profile showdown between Attorney General Ken Paxton and Senator John Cornyn.

The general election is anticipated to attract substantial national attention and hundreds of millions of dollars in campaign spending

Please note only 2 incumbents faced runoffs challengers. Rep. Venton Jones won and long-term member Rep. Hubert Vo lost.

May 26 Runoff Results

District + Area	Party	Nominee	Defeated Candidate	Current Incumbent
D 37, Rio Grande Valley	Democrat	Ozzie Ochoa, Jr., 61.5%	Esmi Cantu-Castle, 38.5%	Janie Lopez (R)
HD 40, Rio Grande Valley	Republican	Celeste Cabrera-Huff, 68.9%	Nehemias Gomez, 31.1%	Terry Canales (D)
HD 40, Rio Grande Valley	Republican	Gary Groves, 62.7%	Sergio Sanchez, 37.3%	Bobby Guerra (D) (retired)
HD 41, Rio Grande Valley	Democrat	Julio Salinas, 55.5%	Seby Haddad, 44.5%	Bobby Guerra (D) (retired)
HD 49, Austin	Democrat	Montserrat Garibay, 61.3%	Kathie Tovo, 38.7%	Gina Hinojosa (D) (running for Governor)
HB 97, Tarrant County	Democrat	Beth Llewellyn McLaughlin, 56.4%	Diane Symons, 43.6%	John McQueeney (R)

HB 100, Dallas	Democrat	Venton Jones, 84%	Amanda Richardson, 16%	Venton Jones (D)
HD 125, San Antonio	Democrat	Adrian Reyna, 80.1%	Michelle Barrientes Vela, 19.9%	Ray Lopez (D) (retired)
HD 126, Northwest Harris County	Republican	Stan Stanart, 68%	Kelly Peterson, 32%	Sam Harless (R) (retired)
D 131, Houston	Democrat	Staci Childs, 60.9%	Lawrence Allen Jr., 39.1%	Alma Allen (D) (retired)
HD 149, Houston	Democrat	Darlene Breaux, 59.8%	Hubert Vo, 40.2%	Hubert Vo (D)

Republicans currently hold an 88:62 majority in the Texas House. There were 21 incumbents who retired and did not file for reelection in 2026. There were 3 incumbents who lost in the March Primary and 1 additional loss in the Primary Runoff. Therefore, there will be at least 25 new House members in 2027 with many competitive races in the fall.

Texas House November Races

(I) Incumbent

District	Republican	Democrat	Competitive
1	Chris Spencer	Sean Huffman	
2	Brent Money (I)	Fatima Muse	
3	Kristen Plaisance	Nicole King	
4	Keith Bell (I)	Mark Moseley	
5	Cole Hefner (I)	Hector Garze	
6	Daniel Alders (I)	Lorenzo Johnson	
7	Jay Dean (I)	Fantasha Allen	
8	Cody Harris (I)	Jeff Chavez	
9	Rocky Thigpen	Shelley Tatum	
10	Brian Harrison (I)	Michael Myers	
11	Joanne Shofner (I)	Roxanne Lathan	
12	Trey Wharton (I)	Andie Ho	
13	Angelia Orr (I)	Albert Hunter	

14	Paul Dyson (I)	Janet Dudding	
15	Brad Bailey	Moniqua' Scott	
16	Will Metcalf (I)	Bobbie Clayton	
17	Stan Gerdes (I)	Mary Klenz	
18	Janis Holt (I)	Valorie Barton	
19	Ellen Troxclair (I)	Kelly Hall	
20	Terry Wilson (I)	Matthias-Jonah Early	
21	Ray Callas	Jacqueline Hernandez	
22	None	Christian Manuel (I)	
23	Terri Leo-Wilson (I)	Cheryl Clark	
24	Greg Bonnen (I)	Frank Carr	
25	Cody Vasut (I)	Mike Meadors	
26	Matt Morgan (I)	Eliz Markowitz	
27	Max Alaibo	Ron Reynolds (I)	
28	Gary Gates (I)	Sandy Ibanez	
29	Jeff Barry (I)	Karen Reeder	
30	AJ Louderback (I)	Crystal Sedillo	
31	Ryan Guillen (I)	Jennifer Dominguez	
32	Todd Hunter (I)	Gabriel Marroquin	
33	Katrina Pierson (I)	Orlando Lopez	
34	Denise Villalobos (I)	Stephanie Guerrero Saenz	X
35	Oscar Rosa	Oscar Longoria (I)	X
36	None	Serio Munoz Jr, (I)	
37	Janie Lopez (I)	Oziel Ochoa	X
38	Laura Cisneros	Erin Gamez (I)	
39	None	Armando Martinez (I)	
40	Celeste Cabrera-Huff	Terry Canales (I)	
41	Gary Groves	Julio Salinas	X
42	Teresa Johnson – Hernandez	Richard Raymond (I)	
43	J.M. Lozano (I)	Jeffery Jackson	
44	Alan Schoolcraft (I)	Eric Norman	
45	Tennyson Moreno	Erin Zwiener (I)	
46	None	Sherly Cole (I)	
47	Jennifer Mushtaler	Pooja Seth	
48	Anthony Gupta	Donna Howard (I)	
49	None	Monsterrat Garibay	
50	Howard Olsen	Samantha Lopez-Resendez	
51	Jessica Martinez	Lulu Flores (I)	
52	Caroline Harris Davila (I)	Chris Jimenez	X`
53	Wes Virdell (I)	Kathryn Hartsmann	

54	Brad Buckley (I)	Dawn Richardson	X
55	Hilary Hickland (I)	Amelia Rabroker	
56	Pat Curry (I)	Ashley Thorton	
57	Richard Hayes (I)	Raymond Stith	
58	Helen Kerwin (I)	Chris Oldham	
59	Shelby Slawson (I)	Andrew Turner	
60	Mike Olcott (I)	Krissy Guess	
61	Keresa Richardson (I)	Brittany Black	X
62	Shelly Luther (I)	Catherine Thorne	
63	Ben Bumgarner (I)	Denise Wooten	X
64	Andy Hopper (I)	Julie Evans	
65	Mitch Little (I)	Detrick Deburr	X
66	Matt Shaheen (I)	Sandeep Srivastava	X
67	Jeff Leach (I)	Jordan Wheatley	X
68	David Spiller (I)	Jasmine Henderson	
69	James Frank (I)	Leilani Barnett	
70	George Flint	Mihaela Plesa (I)	
71	Jay Hardaway	Diana Luna	
72	Drew Darby (I)	Shiloh Salazar	
73	Carrie Issac (I)	Merrie Fox	
74	Robert Garza	Eddie Morales Jr. (I)	X
75	None	Mary Gonzalez (I)	
76	Linda Howell	Suleman Lalani (I)	
77	Humberto Perez	Vince Perez (I)	
78	None	Joe Moody (I)	
79	Jesus Romero	Claudia Oradaz (I)	
80	Don McLaughlin (I)	Cecilia Castellano	X
81	Brooks Langraf (I)	Ceasar Sanchez	
82	Tom Craddick (I)	Cathy Broaderick	
83	Dustin Burrows (I)	Malik Williams	
84	Carl Tepper (I)	Margaret Durham	
85	Dennis Geesaman	Lawerence Brandyburg	
86	Holly Jeffreys	Cullin Knuston	
87	Caroline Fairly (I)	Diana Loya	
88	Ken King (I)	Heather Wallace	
89	Candy Noble (I)	Angie Carraway	X
90	None	Ramon Romero Jr. (I)	
91	David Lowe (I)	Yisak Worku	
92	James Woodruff	Salman Bhojani (I)	
93	Alan Blaylock	Ericka Lomick	X
94	Cheryl Bean (I)	Katie Duzan	X
95	None	Nicole Collier (I)	
96	Ellen Fleishmann	Ebony Turner	X
97	John McQueeney (I)	Beth McLaughlin	X
98	Armin Mizani	Cate Brennan	

99	Charlie Geren (I)	Michelle Winder	
100	Jordan Hoffnagle	Venton Jones (I)	
101	None	Junior Ezeonu	
102	Bonnie Abadie	Ana-Maria Ramos (I)	
103	Melanie Medley-Thomas	Rafael Anchia (I)	
104	None	Jessica Gonzalez (I)	
105	None	Terry Meza (I)	
106	Jared Patterson (I)	Joe Mayes	
107	None	Linda Garcia (I)	
108	Morgan Meyer (I)	Allison Mitchell	X
109	Will Campbell	Aicha Davis (I)	
110	None	Toni Rose (I)	
111	None	Yvonne Davis (I)	
112	Angie Chen Button (I)	Zach Herbert	X
113	Stephan Stanley	Rhetta Bowers (I)	
114	Timothy McDonough	John Bryant (I)	
115	Danny Rosellini	Cassandra Hernandez (I)	
116	Rhett Smith	Trey Martinez Fischer (I)	
117	Ben Mostyn	Philip Cortez (I)	
118	Jorge Borrego	Kristian Carranza	X
119	Melva Rivera Perez	Elizabeth Campos (I)	
120	None	Barbara Gervin-Hawkins (I)	
121	Marc LaHood (I)	Zack Dunn	X
122	Mark Dorazio (I)	Shelly Nickels	X
123	None	Diego Bernal (I)	
124	Sylvia Soto	Josey Garcia (I)	
125	Rick Martinez	Adrian Reyna	
126	Stan Stanart	Stefanie Bord	X
127	Charles Cunningham (I)	Michelle Williams	
128	Tom Butler	Desiree Klaus	
129	Scott Bowen	Albert Wittliff	X
130	Tom Oliverson (I)	Brett Robinson	
131	Scott Whitmarsh	Staci Childs	
132	Mike Scofield (I)	Sara McGee	
133	Mano DeAyala (I)	Joshh Wallenstein	X
134	Mike Michna	Ann Johnson (I)	
135	Liz Ramos	Odus Evbagharu	
136	Theodore Schramm	John Bucy III (I)	
137	Helen Zhou	Gene Wu (I)	`
138	Lacey Hull (I)	Tyler Smith	X

139	Kyle Harding	Charlene War Johnson (I)	
140	Laura Garcia DeLeon	Armando Walle (I)	
141	Julie Hunt	Senfronia Thomspsom (I)	
142	Heidi Hall	Harold Dutton (I)	
143	Frank Salazar	Ana Hernandez (I)	
144	David Flores	Mary An Perez (I)	
145	Inocensia Moreno	Christina Morales (I)	
146	Alexandria Butler	Lauren Simmons (I)	
147	Theodis Daniel	Jolanda Jones (I)	
148	Amanda LaBrie	Penny Morales Shaw (I)	
149	Dave Bennett	Darlene Breaux	
150	Valoree Swanson (I)	A'Yonna Kellum	

The Texas Senate has seen 2 new members join through special elections since the 89th Legislative Session ended. We expect District 9 to be a competitive rematch in the fall with Democrat Senator Rehmet flipping a longtime Republican seat.

Texas Senate November Races

(I) Incumbent

District	Republican	Democrat	Competitive
1	Bryan Hughes (I)	Laticia Ambroz	
2	Bob Hall (I)	Keenan Colbert	
3	Trent Ashby	Bobby Tillman	
4	Brett Ligon (I)	Ron Angeletti	
5	Charles Schwertner (I)	Paul Thomasson	
9	Leigh Wambsganss	Taylor Rehmet (I)	X
11	Dennis Paul	Shannon Dicely	
13	None	Borris Miles (I)	
18	Lois Kolkhorst (I)	Erica Gillum	
19	Marcus Cardenas	Roland Gutierrez (I)	
21	Julie Dahlberg	Judith Zaffrini (I)	
22	David Cook	Amy Martinez-Salas	
24	Pete Flores (I)	Joe Herrera	
26	None	Jose Menendez	
28	Charles Perry (I)	Riley Rodriquez	
31	Kevin Sparks (I)	John Betamcourt	

Prepared by Buffy Crownover (Buffy@txlobby.com)

Establishing Designation of Front Line Hospitals Providing Vital Health Care Services to Underserved and Indigent Patients Act of 2026

I. Challenges Facing Front Line Hospitals:

Front Line hospitals are characterized by high disproportionate share and tertiary services provided to the sickest, poorest and costliest of patients in our communities. We are "super" safety-net hospitals, caring for a substantially higher volume of low-income patients. We also provide the full continuum of primary through tertiary services, including complex critical and trauma care, and specialized services to patient populations with comorbidities and other medical challenges. In addition, we train the next generation of physicians to care for these vulnerable patients. *While there are many worthy safety-net hospitals, what distinguishes the 135 "Front Line" hospitals is the triple mission of caring for an exceptionally high amount of low-income patients; providing high-cost, specialized treatment to medically complex and socially at-risk patients, and training the next generation of clinicians to serve those most in need, resulting in serious stresses on our financial viability.*

Front Line hospitals' commitment to providing complex care to those most in need with humanity and dignity results in *a perpetual financial struggle to make ends meet and deliver necessary services to these populations* that typically have relatively poor health status, multiple co-morbidities and challenges related to social risk factors. Collectively, these challenges contribute to substantial health risks for these patients who commonly suffer from multiple conditions, mental health, and substance abuse challenges. Many lack stable housing, employment, and proper nutrition – all of which contribute to poorer health. Most are insured by public programs such as Medicaid, Medicare, and CHIP, or have no insurance at all. And commercial populations are small, often well below 20 percent. Many have high populations of dually eligible Medicare and Medicaid beneficiaries.

The Medicaid changes in the 2025 Budget Reconciliation Law (Public Law 119–21) pose an existential threat to Front Line Hospitals due to our already precarious financial viability. It is imperative to ensure our survival and ability to continue shouldering the responsibility in caring for our nation's most medically and socially vulnerable patients.

As the cornerstone of the health safety-net in their respective communities, Front Line hospitals should be designated under federal Medicaid law as hospitals carrying the highest commitment of service to low-income patients. While federal law recognizes a variety of types of rural hospitals with special attributes, there is no similar federal recognition of Front Line hospitals.

The Congress has recognized, on a strong bipartisan basis over decades, the critical importance of federally qualified health centers (FQHCs) providing primary care in their communities through a designation process that holds them accountable for their commitment to underserved and indigent patients. Front Line hospitals provide the full spectrum of care - including specialty and tertiary care that FQHC's cannot provide - to the same low-income and high need, high cost patient populations.

Now is the critical moment to establish similar designation of Front Line hospitals.

Accordingly, the *Establishing Designation of Front Line Hospitals Providing Vital Health Care to Underserved and Indigent Patients Act of 2026* establishes a designation process, similar to FQHCs, recognizing the unique missions of Front Line hospitals, and holding them accountable for their continued commitment to high disproportionate share, teaching, and tertiary care.

II. *Establishing Designation of Front Line Hospitals Providing Vital Health Care Services to Underserved and Indigent Patients Act of 2026*, sponsored by Senator Michael Bennet.

This critical legislation will protect Front Line Hospitals as keystones of their communities' health safety-net in the following ways:

- Enables the Secretary of HHS to designate eligible Front Line hospitals, and secure their financial commitments to the provision of vital health care services to underserved and indigent patients, and hold them accountable through reporting and transparency.

- Requires State Medicaid plans to reimburse Front Line hospitals at a minimum payment floor, including non-hospital costs they bear in subsidizing physicians, clinics and emergency medical services, notwithstanding the Medicaid limitations to directed payment programs and provider taxes in the 2025 Budget Reconciliation Law.

- Protects their ability to provide life-saving services, such as neonatal and trauma care, to underserved and indigent patients and communities.

- Codifies the regulatory definition of State or other government-owned or operated hospitals, including their ability to provide intergovernmental transfers and certified public expenditures, and provides States with the flexibility to establish designated Front Line hospitals as a separate class for Medicaid directed payment programs.

- Establishes a pool from unspent State Medicaid disproportionate share allotments on an annual basis from which States may draw to meet the minimum payment floor for Front Line hospitals without affecting other DSH hospitals in their states.

The Front Line Hospital Alliance strongly supports Senator Michael Bennet's legislation and urges other Members of Congress to join with him in sponsoring the legislation and moving it forward.

A Targeted Solution to Strengthen the 340B Prescription Discount Program For Hospitals Serving High-Cost, High-Need Patients and Underserved Communities

May, 2026

Background On the Front Line Hospital Alliance and the State of the 340B Program Today

Super safety-net hospitals – including those who are members of the Front Line Hospital Alliance (FLHA) – operate on the most slim of margins and face significant financial stresses. Our hospitals on the "Front Line" of treating patients–are characterized by high disproportionate share and tertiary services provided to the sickest, impoverished and costliest of patients in our communities. Front Line hospitals care for a substantially higher volume of low-income patients than most other hospitals. We also provide the full continuum of primary through tertiary services, including complex critical and trauma care, and specialized services to patients with multiple comorbidities and other medical and social challenges. In addition, we train the next generation of physicians to care for these vulnerable patients.

When the 340B Drug Discount Program was created in 1992, it was intended to lower the cost of pharmaceuticals at covered entities dedicated to serving low-income and underinsured beneficiaries. Our hospitals are committed to providing life-saving medications at affordable prices, so that our low-income patients directly benefit from the 340B Drug Discount Program, depending on their income level. The U.S. Congress anticipated that there would be approximately 90 public or publicly equivalent hospitals that would qualify when the program was first created. We believe that Front Line hospitals – only 135 by our definition – are exactly the public and publicly equivalent hospitals originally intended by the Congress to benefit from 340B.

Front Line Hospital Alliance Supports Efforts To Improve the 340B Program

As changes to the 340B Program are considered – either by Congress or by the Administration – we believe that it is our duty as stewards of caring for the most vulnerable patients to come to the table with solutions. This way, we can ensure the 340B Program may continue to meet its original intent and allow us to continue serving patients in our communities. That is why the FLHA believes that public and publicly-equivalent hospitals like ours are the hospitals and healthcare entities that should be prioritized and accounted for when any changes to the 340B program are considered. We support policy changes to ensure Congress' original intent for the 340B program is met, including by: ensuring benefits reach the patients and hospitals most in need, enhancing transparency, improving program integrity, reducing program complexity, and providing sufficient time for stakeholders to implement required changes.

We believe each of these goals can be met by advancing policies such as:

- Instituting verification of patient eligibility for purposes of discounting medications at the time a patient purchases drugs from the contract pharmacy.
- Requiring covered entities to apply its financial assistance policy (FAP) at contract pharmacy locations and internal pharmacies.
- Establishing a robust clearinghouse to enable real time data exchange on 340B patient eligibility, address duplicate discounts, enable immediate identification of a 340B drug to address manufacturer concerns about other discounts, and improve program integrity.
- Redefining who may be considered as a "patient" and realign "child site" definition to better reflect the presence of primary hospital and secondary clinical locations and enable reporting and transparency.

Administration's Proposed Rebate Pilot Model

The Administration's proposed 340B Rebate Model Pilot Program–currently paused due to ongoing litigation–would devastate our hospitals as we simply don't have the cash flow to pay the up-front discount per the rebate model and wait for a post-purchase discount. As evidenced in the following chart, the up-front costs would be significant and DSH hospitals are prohibited from utilizing a GPO to lower the cost even to some degree, leaving many hospitals without options:

Hospital	Cost of Drug Using 340B Discount	Cost of Drug Using Group Purchasing Organization	Cost of Drug at Wholesale Acquisition Cost
Hospital #1 drug spend (over six months)	$1,572,793	$17,056,134	$23,873,077
Hospital #2 (over 12 months)	$2,051,113	$48,469,716	$87,945,164
Hospital #3 (over 12 months)	$2,456,726	$29,604,770	$44,323,026

We hope to work with the Congress and Administration to develop and test a more workable pilot program, grounded in the reforms we have proposed. In addition, we urge the Congress to direct the Congressional Budget Office (CBO) to perform new, comprehensive analysis to address questions following their September 2025 report on the program including:

- How much is attributable to growth of outpatient services in general, which is cheaper than inpatient?
- To what extent have services expanded, as intended by the 340B program? How do 340B and non-340B hospitals compare?
- What is the total American drug spend during these years? How much impact did COVID have on anti-infective drugs in 2020 and 2021? Other grantees don't provide expensive and specialized cancer care: how many new cancer drugs have been introduced, and what has been the resulting impact on 340B growth? Do 340B DSH hospitals treating more patients because many can't afford non-340B hospital care? Has there been an improvement in cancer outcomes? How much sicker and poorer are 340B DSH hospital patients?
- How much is attributable to Medicaid expansion, qualifying more hospitals? Has the aging baby boomer population created a higher demand in cancer drugs? How does 340B lead to higher prices for the federal government? How much does Medicaid save from hospitals using 340B versus their state rebate? How important are the savings for some financially struggling hospitals versus more profitable ones?

High Need Hospitals Dedicated to Underserved Patients
5.15.26

	Front Line Multimission	**Vulnerable Community Hospitals**	**Endangered Small Rural**	**PPS Exempt High-Medicaid or Specialty Children's Hospital**
Definition	Public urban teaching hospital ≥100 beds with CMI ≥1.3; IRB ≥0.17 (or ≥100 residents) **and** Medicare DPP ≥35%; **or** a nonprofit teaching hospital that meets the IRB and CMI criteria and if 100-1000 beds has a DPP ≥45%, or if ≥1000 beds, a DPP ≥55%.	Independent, public or nonprofit ≤500 **with either** beds ≥65% DPP **or** Medicare + Medicaid days ≥85%	Public or nonprofit rural hospitals with SCH, CAH, Low-Volume or MDH status ≤100 beds; **and** a provider-based physician adjustment as % of net patient revenue **and** a net loss from service to patients as % of net revenue of greater -20% combined;	PPS Exempt public or nonprofit children's hospital under Medicare that has either at least 45% Medicaid inpatient utilization, or is a specialty children's hospital
Explanation of Definition	These hospitals have high disproportionate patient percentages (DPP), high teaching, and high tertiary care, the combination of which renders them financially distressed. The nonprofit hospitals have higher thresholds to meet than public hospitals which are by their governance structure accountable to the people of their state or community.	These are independent community hospitals that have no other designation and are very high in either DPP or both Medicare and Medicaid combined, which are poor payers, particularly for outpatient services, rendering them financially vulnerable.	These are small rural hospitals that are especially endangered due to their high net patient revenue loss and for many, high cost of subsidizing physicians to serve in rural areas.	These are high-Medicaid children's hospitals disproportionately serving Medicaid/CHIP beneficiaries, or specialty children's hospitals dedicated to unique vulnerable population, such as children with cancer or major orthopedic medical conditions or requiring long term care.
Number of qualifying hospitals	**135** of 3319 Urban Hospitals	**87** of 1619 Independent Community Hospitals (5129 Community Hospitals)	**598** of 1,810 Rural Community Hospitals	**67** PPS Exempt Children's Hospitals

BOARD OF TRUSTEES

Meeting of the Board of Trustees

Wednesday, June 10, 2026

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:

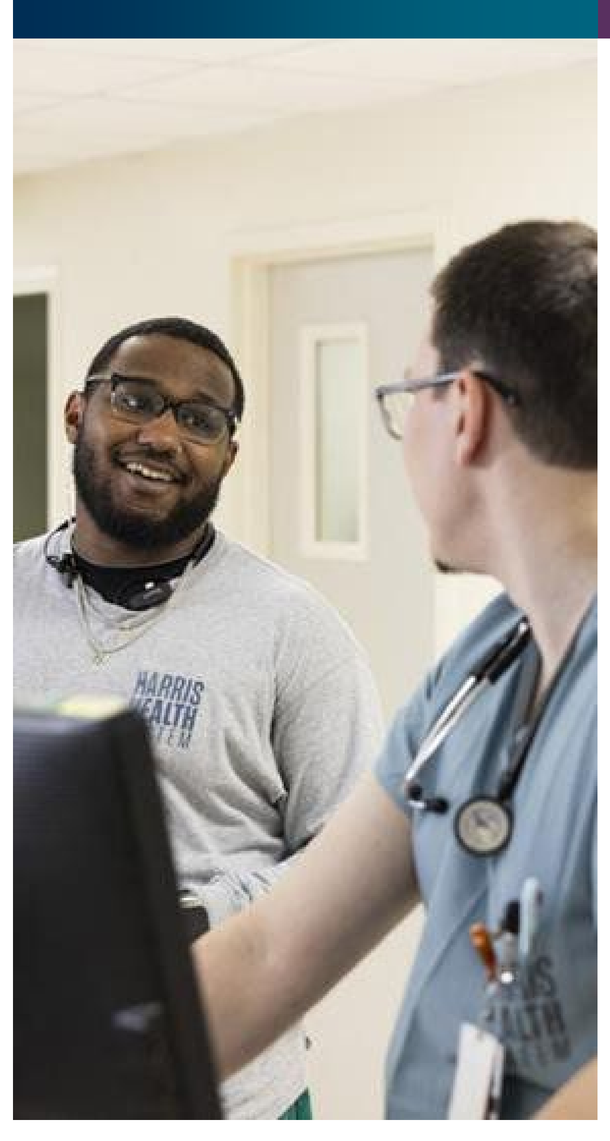
- **HCHP June Operational Updates**
- **National Board Appointment of HCHP Director**

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
CEO, Ambulatory Care Services

Health Care for the Homeless Monthly Update Report – June 2026

Jennifer Small AuD, MBA, CCC-A, Chief Executive Officer, Ambulatory Care Services
Tracey Burdine, Director, Health Care for the Homeless Program

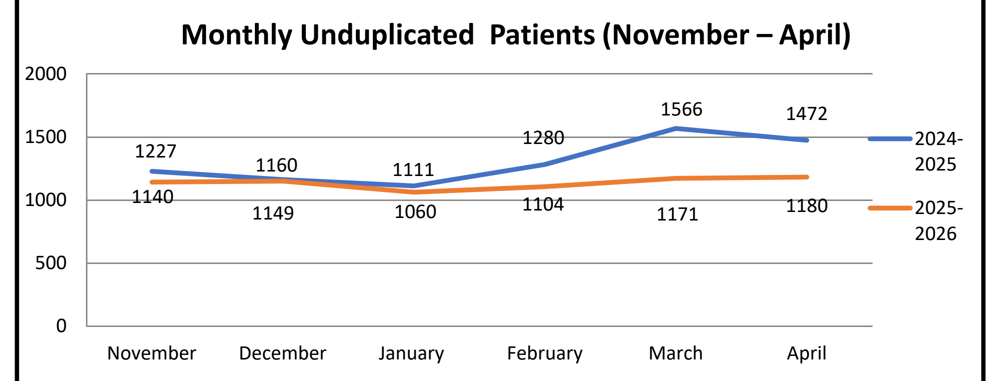


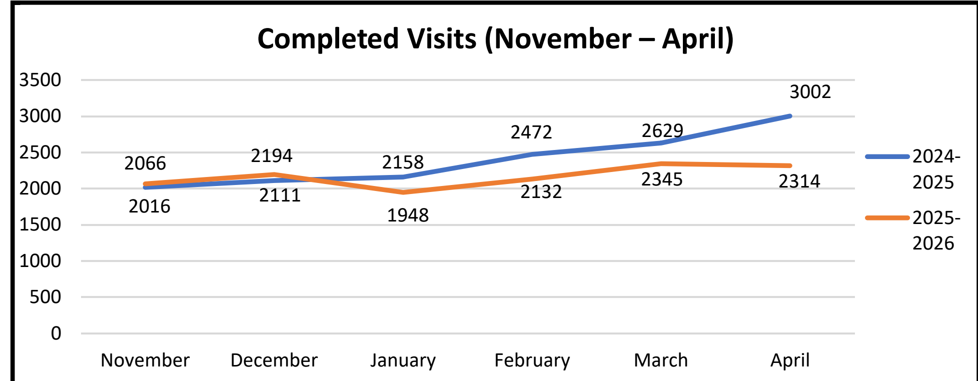
Agenda

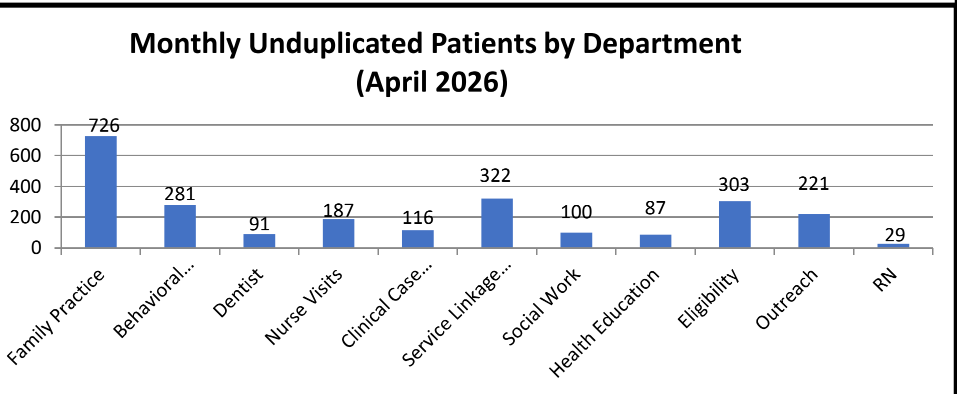
- Operational Update
  - ➢Productivity Report
  - ➢Board Authority
  - ➢HCHP Director National Board Appointment
  - ➢Patient Satisfaction Report

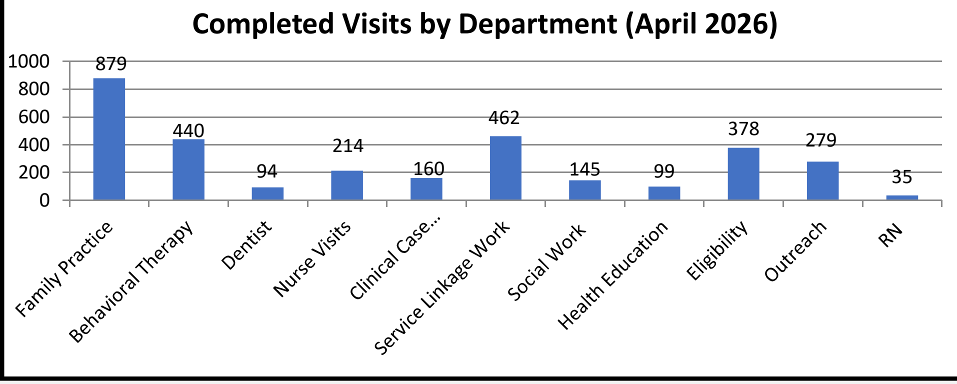
Patients Served – Operational Productivity Update (April 2026)

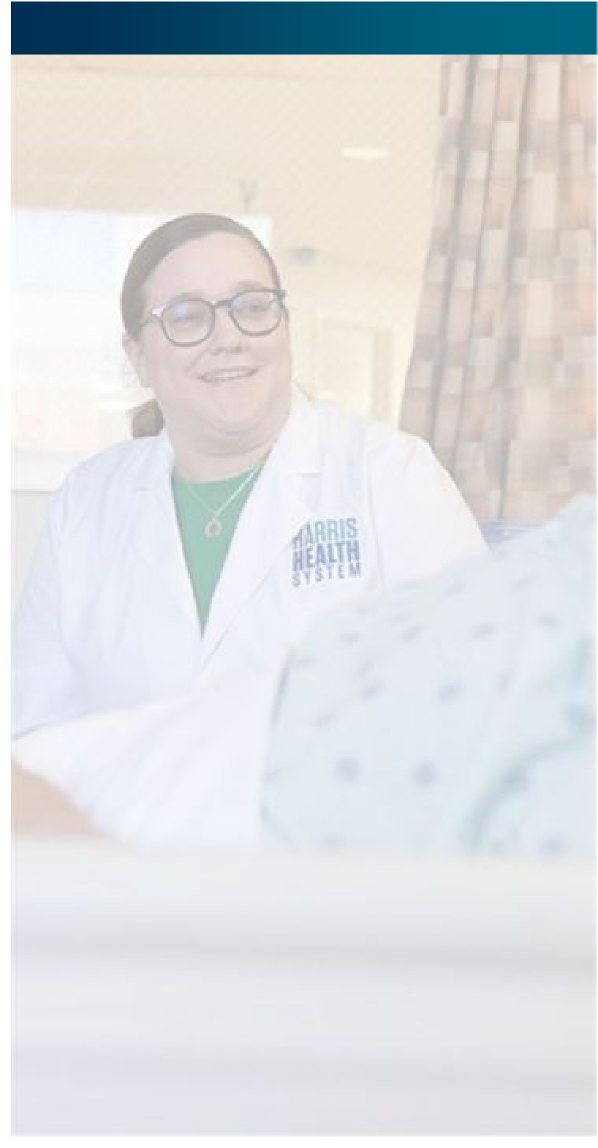
HRSA Unduplicated Patients Target: 7,250	HRSA Completed Visit Patients: 30,496
YTD Unduplicated Patients: 2,831	YTD Completed Visits: 8,883











Board Authority

Requirement:

- **Health center governing board must:**
  - Maintain appropriate authority to oversee the operations of the center
  - Assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations
  - Hold monthly meetings and record in meeting minutes the board's attendance, key actions, and decisions
  - Approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO)
  - Must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these policies
  - Must review and approve the annual Health Center Program project budget
  - Must assess the achievement of project objectives through evaluation of health center activities

HCHP Director National Board Appointment

Tracey Burdine, Director of Harris Health's Health Care for the Homeless Program, was selected to serve on the National Health Care for the Homeless Council Board of Directors.

Appointment Details

- Two-year appointment
- Term begins July 1, 2026
- New member Board Orientation scheduled for June 22, 2026

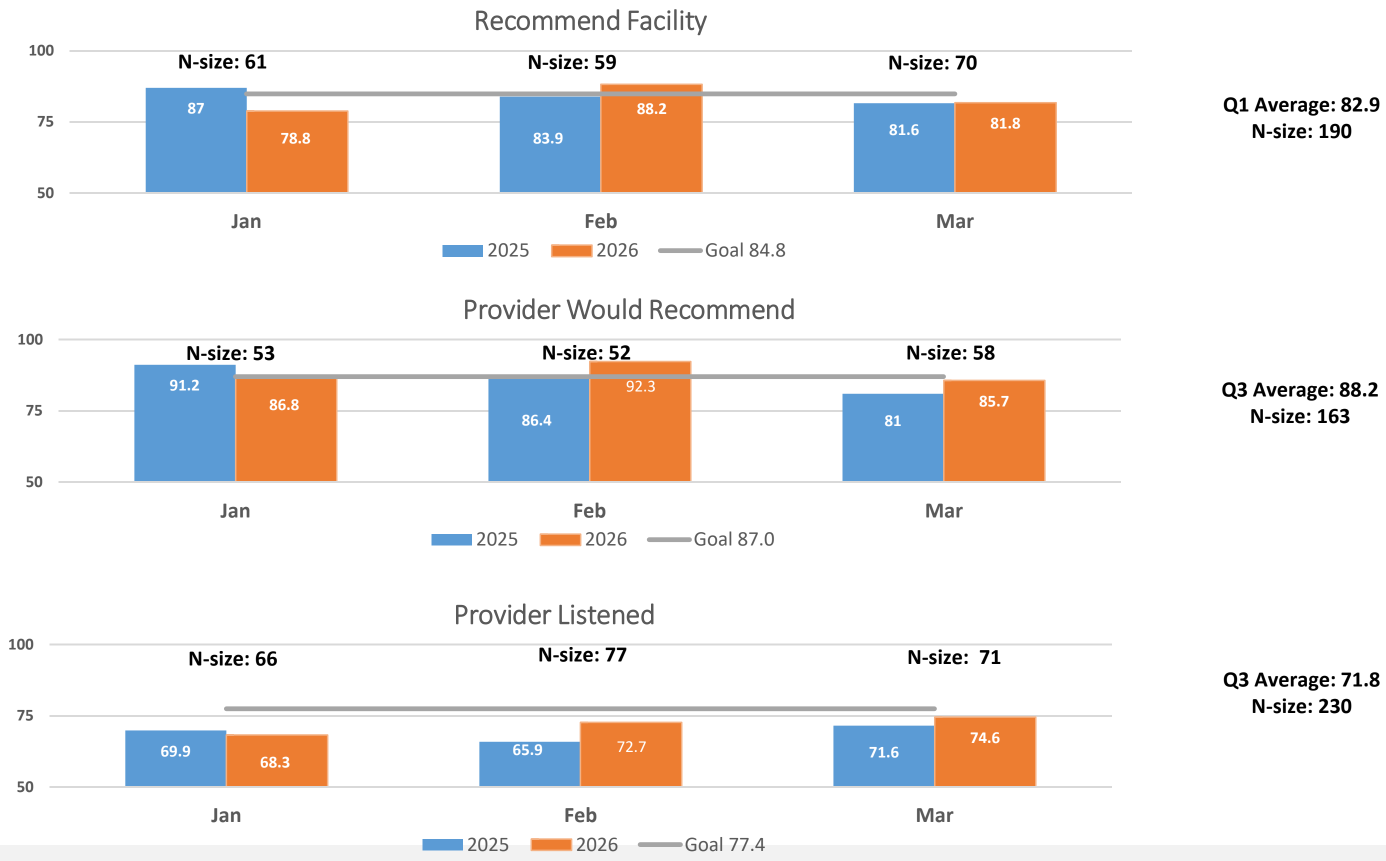
Board Significance

- Provides Harris Health an opportunity to impact homelessness at a national level
- Aligns with NHCHC's mission to build an equitable, high-quality health care system through training, research, and advocacy

Health Care for the Homeless Patient Satisfaction Report QTR 1 2026

HARRISHEALTH

HCHP Patient Satisfaction Trending Data Q1



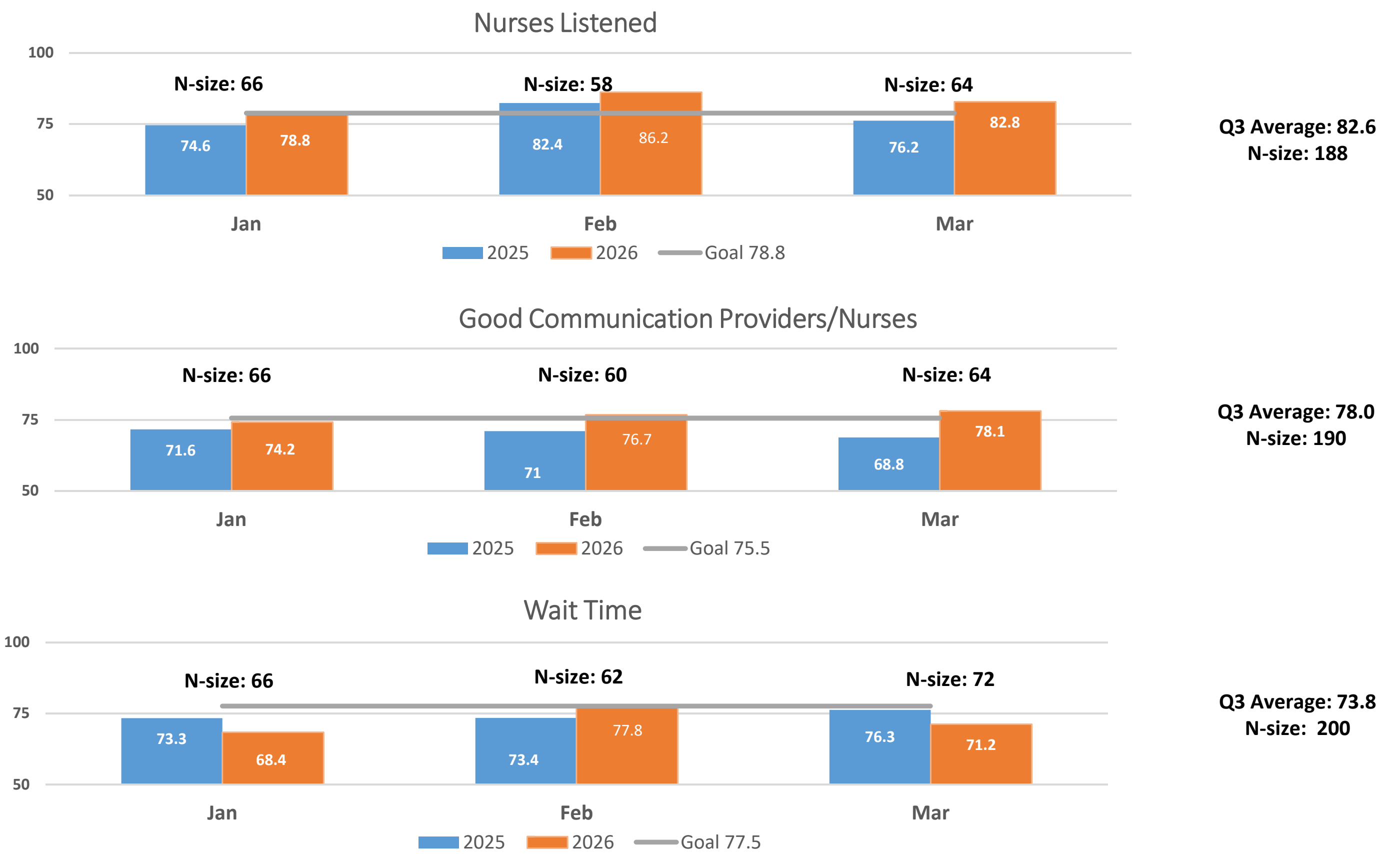
Q1 Average: 82.9
N-size: 190

Q3 Average: 88.2
N-size: 163

Q3 Average: 71.8
N-size: 230

HARRISHEALTH

HCHP Patient Satisfaction Trending Data Q1



Q3 Average: 82.6
N-size: 188

Q3 Average: 78.0
N-size: 190

Q3 Average: 73.8
N-size: 200

Health Care for the Homeless Program Data Trending Report and Action Plan

Problem Statement: Harris Health System's objective is to ensure compliance with internal goals for patient satisfaction. For the month of March 2026, the following metrics missed goal: Facility would Recommend, Provider Knew Medical History, Provider Listened and Waited More Than 15 Minutes.

Quality Measures FY 2026	GOALS FY25/26	January FY2025	February FY2025	March FY2025	April FY2025	May FY2025	June FY2025	July FY2025	August FY2025	September FY2025	October FY2026	November FY2026	December FY2026	January FY2026	February 2026	March 2026	YTD Total FY25/FY26
Good Communication Providers/Nurses	75.5	71.8	70.8	67.0	73.0	71.4	80.2	75.8	80.5	77.6	70.0	71.8	67.9	75.0	76.7	78.1	74.0 / 75.5
Provider Listened	77.4	71.6	64.0	68.2	68.3	67.8	74.5	72.5	81.9	72.4	68.9	64.3	68.7	68.3	72.7	74.6	73.5 / 77.4
Facility Would Recommend	84.8	87.3	82.8	83.1	82.9	90.6	86.8	80.0	86.4	83.7	80.6	81.3	87.5	78.8	88.2	81.8	84.8/ 84.8
Nurses Courteous and respectful	80.6	76.1	79.2	75.6	81.8	74.3	85.9	80.9	84.2	80.3	76.7	74.4	79.2	86.4	86.4	82.8	80.6 / 80.6
Nurses Listened Carefully	78.8	76.1	81.7	74.4	77.0	77.1	81.9	77.7	85.5	80.0	71.7	74.4	80.8	78.8	86.2	82.8	78.7/ 78.8
Provider would recommend	87.0	91.4	85.2	81.0	86.1	87.3	87.0	76.9	90.2	84.9	84.6	84.4	88.6	86.8	92.3	85.7	87.0 / 87.0
Waited more than 15 minutes	77.5	77.0	71.6	73.8	68.8	79.0	86.7	82.7	82.6	80.4	72.3	67.6	78.7	68.4	77.8	71.2	77.5 / 77.5

Plan (Root Cause-Based on analysis of the problem)-WHY?

The overall metrics were missed for the month of January due to following :

1. Provider Listened – Inconsistent confirmation of patient understanding and concerns during provider-patient interaction.
2.Facility Would Recommend – Lower facility scores reflect patient perceptions of the broader service environment rather than issues specific to clinic operations.
3.Provider Would Recommend: Inconsistencies between NRC patient feedback and automated system scores.
4.Waited more than 15 minutes - Extended wait times are associated with provider availability and internal clinic processes.

Check (How will you measure effectiveness?)

NRC Health Real-Time Monthly Survey Data

Do-(Action, Responsible Person, Implementation Date)

Responsible Persons: Sarath Roy (Operations Manager) , Lingasperi Govender (Nurse Manager), Matasha Russell (Interim Medical Director)

1. Hardwire usage of Harris Health Good Communication Scripting for nurses and providers during patient visits
2. Continue monthly patient satisfaction meetings and encourage active engagement during meetings
3. At discharge, nursing highlights provider communication on the AVS and Patient Satisfaction Card to support patient awareness of the care team during surveys.
4. Regularly review NRC feedback and follow up with patients who report feeling their concerns were not fully heard.

ACT (Effective/Ineffective): Adopt, Adapt, or Abandon

1. **Provider Listened: Ineffective/Adapt**
2. **Facility would recommend: Ineffective/Adapt**
3. **Provider would recommend: Ineffective/Adapt**
4. **Waited more than 15 minutes: Ineffective/Adapt**

BOARD OF TRUSTEES

HARRISHEALTH

Meeting of the Board of Trustees

Wednesday, June 10, 2026

Executive Session

Review of the Health Care for the Homeless Program (HCHP) Quality Management Report, Pursuant to Tex. Occ. Code Ann. §151.002 and Tex. Health & Safety Code §161.032, Including Consideration of Approval of the HCHP Quality Management Report Upon Return to Open Session.

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

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BOARD OF TRUSTEES

Meeting of the Board of Trustees

HARRISHEALTH

Wednesday, June 10, 2026

Executive Session

Discussion Regarding Committee Reviewed Reports, Pursuant to Tex. Gov't Code Ann. §551.085:

[Budget & Finance Committee]

- Review of the Community Health Choice, Inc. and Community Health Choice Texas, Inc. Financial Performance for the Four Months Ending April 30, 2026, Pursuant to Tex. Gov't Code Ann. §551.085.

[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, 2025, Pursuant to Tex. Gov't Code Ann. §551.085.

Anna Mateja
Chief Financial Officer
Community Health Choice, Inc.
Community Health Choice Texas, Inc.

Victoria Nikitin
EVP & Chief Financial Officer
Harris Health

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