

BOARD OF TRUSTEES Governance Committee

Tuesday, April 21, 2026
10:45 AM

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Notice: Some Board Members may participate by videoconference.

Mission

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

AGENDA

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|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------|
| I. Call to Order and Record of Attendance | Ms. Sima Ladjevardian | 2 min |
| II. Approval of the Minutes of Previous Meeting | Ms. Sima Ladjevardian | 2 min |
| • Governance Committee – February 24, 2026 | | |
| III. Discussion Regarding the Harris Health Board Videoconferencing Policy
– <i>Ms. Sara Thomas</i> | | 10 min |
| IV. Overview of the Harris Health Board Fiduciary Duties – <i>Ms. Sara Thomas</i> | | 10 min |
| V. Discussion Regarding the Texas Healthcare Trustees (THT) Healthcare Governance Conference and Certified Healthcare Trustee and Leader Certification | Ms. Sima Ladjevardian | 5 min |
| VI. Adjournment | Ms. Sima Ladjevardian | 1 min |

HARRIS HEALTH
MINUTES OF THE BOARD OF TRUSTEES
GOVERNANCE COMMITTEE MEETING
Tuesday, February 24, 2026
10:45 A.M.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Ms. Libby Viera - Bland, Presiding Officer, called the meeting to order at 10:48 A.M. It was noted there was a quorum present, and the attendance was recorded. The meeting may be viewed online through the Harris Health website: http://harrishealthtx.swagit.com/live .	
II. Approval of the Minutes of the Previous Meeting <ul style="list-style-type: none"> • Governance Committee Meeting – November 18, 2025 		Moved by Ms. Carol Paret, seconded by Ms. Libby Viera-Bland, and unanimously approved the minutes of the November 18, 2025 meeting. Motion carried.
III. Presentation Regarding the 2025 Board Self-Assessment	Ms. Ashley Schultz, Member Success Manager, The Governance Institute, delivered a presentation regarding the 2025 Board Self – Assessment. Ms. Schultz provided an overview of the assessment methodology and participation rate, noting that the results indicated overall strong board performance and alignment with national benchmarks across several governance responsibilities. The assessment also identified opportunities to strengthen board attendance, education, and onboarding for new members, particularly for members without prior healthcare governance experience. Committee members discussed the importance of ensuring new board members have access to resources that support understanding of healthcare governance, financial oversight, and system operations. Members also discussed refining the self-assessment tool to better reflect the structure and responsibilities of the board and to provide clearer guidance and instructions to participants in future assessments. A copy of the presentation is available in the permanent record.	As Presented.

IV. Discussion Regarding Matters of the Standard Operating Procedures	Ms. Maria Cowles, Executive Vice President, Chief Strategy Officer, led a discussion regarding Standard Operating Procedures (SOPs) and the current process for reviewing correspondence received through the Board Office. Ms. Cowles explained that the Board Office regularly receives communications related to employee concerns, patient complaints, compliance matters, and other operational issues that are typically addressed by Harris Health administration. The Committee discussed the importance of maintaining transparency while ensuring the board remains focused on its governance and oversight responsibilities. Ms. Cowles recommended refining the process so that routine correspondence continues to be routed to the appropriate Harris Health departments, while summaries of such communications are provided to the Board Chair and Board Officers during regular agenda preparation discussions for awareness and potential follow-up when appropriate.	As Discussed.
V. Discussion Regarding Board Member Attendance	Ms. Maria Cowles also led a discussion regarding board member attendance. The committee reviewed attendance trends and discussed the importance of consistent participation to ensure the board is able to maintain quorum and effectively conduct its business. Members discussed continuing to monitor attendance and evaluating the impact of recent scheduling adjustments, including moving meeting dates to improve availability. Committee members also discussed the potential value of providing periodic attendance summaries and reinforcing expectations through board orientation and peer engagement when attendance challenges arise. A copy of the board member attendance is available in the permanent record.	
VI. Discussion Regarding Texas Healthcare Trustees (THT) 2026 Healthcare Governance Conference	Ms. Cowles provided information regarding the 2026 Texas Healthcare Trustees (THT) Governance Conference, scheduled for June 4 – 6, 2026 in San Antonio, Texas. The committee discussed the educational benefits of the conference and encouraged board members to participate either in person or virtually when possible. Members also discussed opportunities for continuing governance education and the availability of voluntary Trustee Certification through the Texas Healthcare Trustees program, which includes completion of educational requirements and a certification exam. The committee expressed support for encouraging board members to pursue certification as part of ongoing board development and governance education.	

VII. Adjournment	There being no further business and without objection from the Members of the Committee, the meeting adjourned at 11:39 A.M.	
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I certify that the foregoing are the Minutes of the Meeting of the Governance Committee of the Board of Trustees of the Harris Health held on February 24, 2026.

Respectfully submitted,

Sima Ladjevardian, JD, Committee Chair

Recorded by Cherry A. Joseph, MBA

**Board of Trustees
Governance Committee Attendance
Tuesday, February 24, 2026**

COMMITTEE MEMBERS PRESENT	COMMITTEE MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Sima Ladjevardian (<i>Committee Chair</i>)		
Carol Paret		
Libby Viera-Bland		
Dr. Marlen Trujillo		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Alexander Barrie	Jerald Summers
Ashley Schultz (<i>The Governance Institute</i>)	John Matcek
Cherry Joseph	Lindsey “Katie” Rutherford
Daniel Smith	Maria Cowles
Ebon Swofford (<i>Harris County Attorney’s Office</i>)	Olga Rodriguez
Esmail Porsa (<i>CEO & President, Harris Health</i>)	Randy Manarang
Jennifer Zarate	Shawn DeCosta

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

BOARD OF TRUSTEES

Quality Committee

Tuesday, April 21, 2026
12:00 PM

(or immediately following the Governance Committee meeting)

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Notice: Some Board Members may participate by videoconference.

MISSION

Harris Health is a 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	1 min
II. <u>Approval of the Minutes of Previous Meeting</u>	Dr. Andrea Caracostis	2 min
<ul style="list-style-type: none"> • Quality Committee Meeting – March 24, 2026 		
III. <u>Harris Health Safety Message: Minute for Medicine Video – Dr. Thomas Cummins</u>		5 min
<ul style="list-style-type: none"> • Hand Hygiene 		
IV. <u>Consideration of a Recommendation for Approval of the 2026 Harris Health Quality Manual – Dr. Joseph Kunisch</u>		5 min
V. Executive Session	Dr. Andrea Caracostis	75 min
A. <u>Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032, to Receive Peer Review and/or Medical Committee Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils, and Possible Action Regarding this Matter Upon Return to Open Session – Dr. Thomas Cummins</u>		<i>(65 min)</i>
B. <u>Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session – Ms.Carolynn Jones, Ms. Arlen Garcia and Ms. Carol Chatman</u>		<i>(10 min)</i>

VI. Reconvene	Dr. Andrea Caracostis	1 min
VII. Adjournment	Dr. Andrea Caracostis	1 min

HARRIS HEALTH SYSTEM
MINUTES OF THE BOARD OF TRUSTEES
QUALITY COMMITTEE MEETING
Tuesday, March 24, 2026
12:00 PM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order and Record of Attendance	Dr. Andrea Caracostis, Committee Chair, called the meeting to order at 12:00 p.m. It was noted that a quorum was present, and the attendance was recorded. The meeting may be viewed online through the Harris Health website: http://harrishealthtx.swagit.com/live .	
II. Approval of the Minutes of Previous Meeting <ul style="list-style-type: none"> • Quality Committee Meeting – February 24, 2026 		Moved by Ms. Libby Viera – Bland, seconded by Dr. Andrea Caracostis, and unanimously approved the minutes of the February 24, 2026 meeting.
III. Harris Health Safety Message: Minute for Medicine Video <ul style="list-style-type: none"> • Time Out – Universal Protocol 	Dr. Thomas Cummins, Executive Vice President & Chief Medical Executive, presented a Minute for Medicine video series related to Time Out – Universal Protocol. A copy of the video series is available in the permanent record.	As Presented.
IV. Presentation Regarding Hospital at Home	Dr. Amy Smith, Senior Vice President, Chief Health Officer, and Dr. Shazia Sheikh, Physician Partner, presented a high-level overview of the Hospital at Home program, an innovative care model designed to deliver acute-level hospital services in the home setting, thereby expanding bed capacity and enhancing access to care. Dr. Sheikh stated that the program, which has been operational for approximately two years, has experienced significant growth in patient volume and service capacity, contributing to increased admissions and a reduction in inpatient bed utilization. She highlighted ongoing geographic expansion, enhancements in clinical capabilities including the addition of in-home therapies, active participation in national initiatives to advance Hospital at Home standards, and the recent extension of the federal waiver supporting the program, allowing for continued growth and sustainability.	As Presented.

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	<p>Dr. Sheikh addressed Board questions regarding patient eligibility and mentioned that patients may enter the program through the emergency department or transition from inpatient care in accordance with regulatory requirements, with a range of appropriate acute diagnoses treated within the program. She also discussed cost considerations and stated that while internal financial analyses are still in progress, national data indicates potential cost savings associated with the model. Dr. Sheikh further emphasized that current priorities include continued program expansion, operational efficiency, and increasing awareness and adoption among patients, families, and providers. A copy of the presentation is available in the permanent record.</p>	
<p>V. Executive Session</p>	<p>At 12:13 p.m., Dr. Caracostis stated that the Quality Committee of the Board of Trustees would go into Executive Session for items V. 'A and B' as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §§151.002 and 160.007.</p>	
<p>A. Report Regarding Quality of Medical and Healthcare, Pursuant to Tex. Occ. Code Ann. §§151.002, 160.007 and Tex. Health & Safety Code Ann. §161.032, to Receive Peer Review and/or Medical Committee Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils, and Possible Action Regarding this Matter Upon Return to Open Session</p>		<p>No action taken.</p>

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
<p>B. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Health Care Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, and Possible Action Regarding this Matter Upon Return to Open Session</p>		<p>No action taken.</p>
<p>VI. Reconvene</p>	<p>At 1:19 p.m., Dr. Andrea Caracostis reconvened the meeting in open session; she noted that a quorum was present and that no action was taken in Executive Session.</p>	
<p>VII. Adjournment</p>	<p>There being no further business and without objection from the Members of the Committee, the meeting adjourned at 1:19 p.m.</p>	

I certify that the foregoing are the Minutes of the Meeting of the Quality Committee of the Board of Trustees of the Harris Health System held on March 24, 2026.

Respectfully submitted,

Andrea Caracostis, MD, MPH, Committee Chair

Recorded by Cherry A. Joseph, MBA

**Board of Trustees
Quality Committee Attendance
Tuesday, March 24, 2026**

COMMITTEE MEMBERS PRESENT	COMMITTEE MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Andrea Caracostis (<i>Committee Chair</i>)	Libby Viera-Bland	
Dr. Shubhada Hooli	Dr. Marlen Trujillo	

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Alexander Barrie	Louis Smith
Dr. Amy Smith	Maria Cowles
Dr. Asim Shah	Dr. Matasha Russell
Berrlyn Nelson	Michael Nnadi
Carolynn Jones	Dr. O. Reggie Eging
Cherry Joseph	Olga Rodriguez
Daniel Smith	Randy Manarang
Derek Curtis	Dr. Sandeep Markan
Ebon Swofford (<i>Harris County Attorney's Office</i>)	Sara Thomas (<i>Harris County Attorney's Office</i>)
Esmail Porsa (<i>CEO & President, Harris Health</i>)	Shawn DeCosta
Dr. Glorimar Medina	Dr. Shazia Sheikh
Dr. Jackie Brock	Dr. Thomas Cummins
Dr. Jennifer Small	Dr. Tien Ko
Jennifer Zarate	Tiffani Dusang
Dr. Joseph Kunisch	Victoria Nikitin
John Matcek	Dr. Yashwant Chathampally
Kiki Teal	

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

Tuesday, April 21, 2026

Harris Health Safety Message: Minute for Medicine Video

High-reliability Organization (HRO) Safety Message Video:

- Hand Hygiene



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

High Reliability Organization (HRO) Safety Message

Hand Hygiene

**Thomas Cummins, MD, MMM
EVP & Chief Medical Executive**

**Board of Trustees Quality Committee
April 21, 2026**

HARRISHEALTH

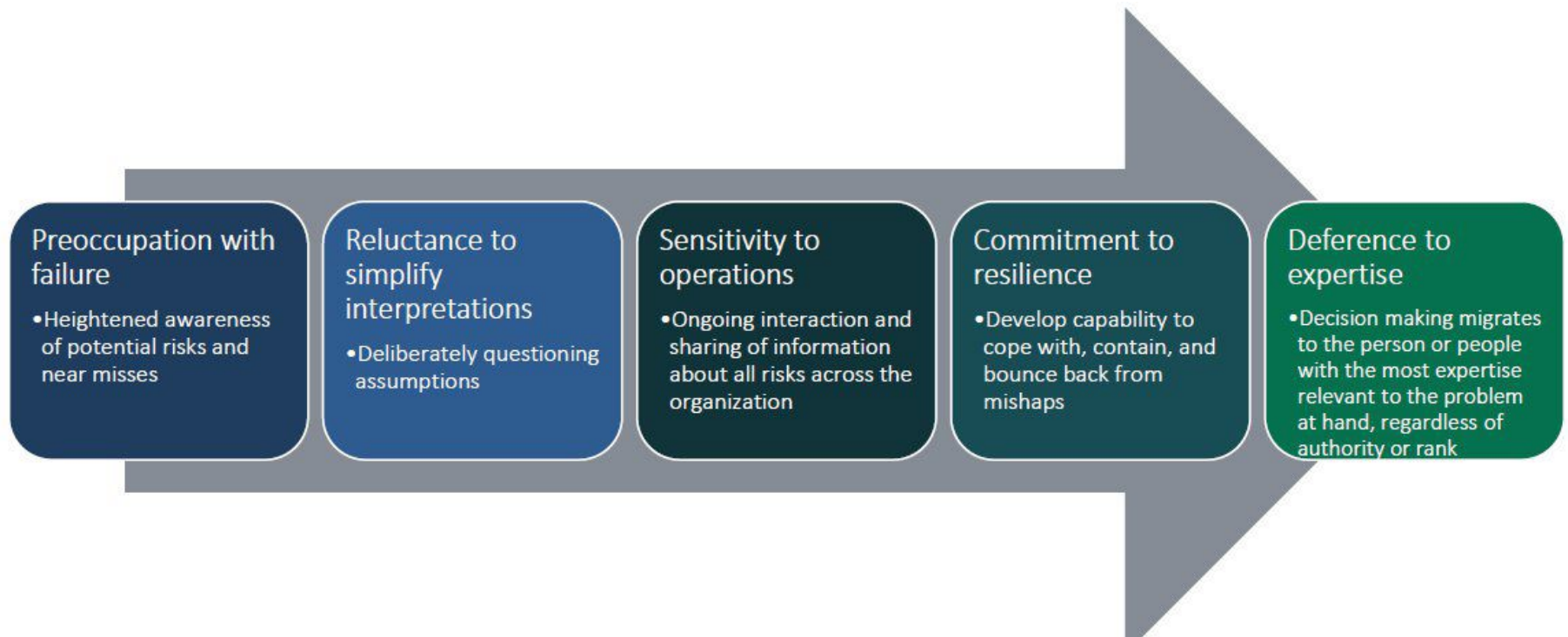
SAFETY MESSAGE

HARRIS | **ZERO**
HEALTH | **HARM**

SAFETY 1ST. ALWAYS.

HARRISHEALTH

Five Principles of a High Reliability Organization



HRO Video:

Harris Health Minute For Medicine: Hand Hygiene

- <https://youtu.be/jzeEGlekwlS>

Tuesday, April 21, 2026

Consideration of a Recommendation for Approval of the 2026 Harris Health
Quality Manual



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

2026 Harris Health Quality Manual Updates Executive Summary

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

**Board of Trustees Quality Committee
April 21, 2026**

HARRISHEALTH

2026 Quality Manual Update Summary

•Strategic Alignment

- Updated to align with the **Harris Health 2026–2030 Strategic Plan** and High Reliability Organization (HRO) priorities

•Mission, Vision & Values

- Revised to reflect current, system-approved language and standardized values

•Governance & Reporting

- Clarified quality oversight and reporting relationships across **BOT, BOT Quality Committee, QGC, and Pavilion QRCs**
- **Formally added Monthly Operations Review (MOR)** to the quality reporting structure to support executive-level performance oversight

• Scope & Readiness

- Updated scope to reflect current service areas and improved clarity to support regulatory and survey readiness.

HARRISHEALTH

Quality Manual 2026

Approved by:
Harris Health Quality
Governance Council
Approved: -

Board of Trustees Harris Health
Approved: -

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I. INTRODUCTION

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

II. PURPOSE

The Quality Manual outlines Harris Health's organizational approach to monitoring and improving quality of care, patient safety, and overall satisfaction. The manual supports our commitment to our patients in that it supports Harris Health's mission, vision, values, and strategic goals. The manual also establishes a systematic, organization-wide approach to quality that cultivates a culture of patient safety and continual performance improvement. The Quality Manual documents the Quality Assessment and Performance Improvement (QAPI) requirements of the CMS Conditions of Participation (COP). The Quality Manual is a counterpart to Harris Health's Patient Safety Plan, which, together, outline Harris Health's organizational approach to monitoring and improving quality, patient safety, and performance. Additionally, this manual is a component of Harris Health's Patient Safety Evaluation System under the federal Patient Safety and Quality Improvement Act of 2005 (PSQIA) and Patient Safety Rule.

III. GUIDING PRINCIPLES

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

- A. Safe: Avoiding harm to patients from care that is intended to help them.
- B. Timely: Reducing waits and sometimes-harmful delays for both those who receive and those who give care.
- C. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively.)
- D. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- E. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- F. Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

IV. JUST AND ACCOUNTABLE CULTURE

It is inevitable that people will make mistakes. Thus, a Just and Accountable Culture creates an open, fair, and learning culture by recognizing that individuals demonstrate certain behaviors,

which organizational leaders should identify and manage appropriately. Behavioral choices include Human Error, At-Risk Behavior, and Reckless Behavior.

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

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

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

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

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

Our 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.

Our Vision:

As One Harris Health, our vision is to enable healthier communities through innovative care delivery, collaboration and partnerships.

We Value:

C- Collaboration
A- Accountability
R- Respect
E-Excellence
I-Integrity
C-Compassion

VI. STRATEGIC GOALS AND QUALITY OBJECTIVES

Harris Health leadership, in collaboration with the Board of Trustees and affiliated Medical Staff, has cooperatively developed strategic pillars related to Quality and Patient Safety, People, Resiliency, Health Promotion and Disease Prevention, System Optimization, and Access.

Goals and Objectives have also been developed to support the shared commitment to Safety, Quality, and Performance Improvement. Refer to Harris Health Strategic Plan 2026 - 2030 for Quality Strategic Goals and Objectives. The Strategic Plans are aligned with the targets and goals of each pavilion and further cascaded to the department levels.

Please refer to the Executive Dashboard and the metrics as identified by the pavilions and service area Quality Improvement Workgroups.

Strategic Plan Overview:

- ~~Quality and patient safety: As a high reliability organization (HRO), Harris Health will achieve optimal health outcomes and provide safe, effective, person-centered care.~~
- ~~People: Harris Health will empower and engage our patients, workforce and communities by providing opportunities to learn, grow and thrive.~~
- ~~Resiliency: Harris Health will anticipate, adapt to and learn from internal and external risks without compromising our commitment to our mission, vision and values.~~
- ~~Health Promotion & Disease Prevention: Harris Health is committed to collaborating with others to improve health, reduce disparities, and increase the quality of life for the communities we serve.~~
- ~~System Optimization: Harris Health will leverage people, technology and other resources to improve our value to the community.~~
- ~~Access: Harris Health will provide care, education and opportunities for collaboration when, where and how our communities need it.~~

The Pathway - A Transformative Model of Patient Care Delivery

As we build toward the future, our patient care priorities will be one that focuses on enhancing patient care, continuing our journey to becoming a High Reliability Organization (HRO), expanding access, fostering innovation in healthcare delivery and working collaboratively to improve the health of Harris County residents. Despite all our challenges, the future of Harris Health is extremely bright. Together, building on our strong foundation, we will fulfill our mission to improve the health of our communities.





VII. SCOPE

The Quality Manual encompasses all Harris Health services that impact patient care, safety, and health outcomes, unless those services are governed by a separate quality manual

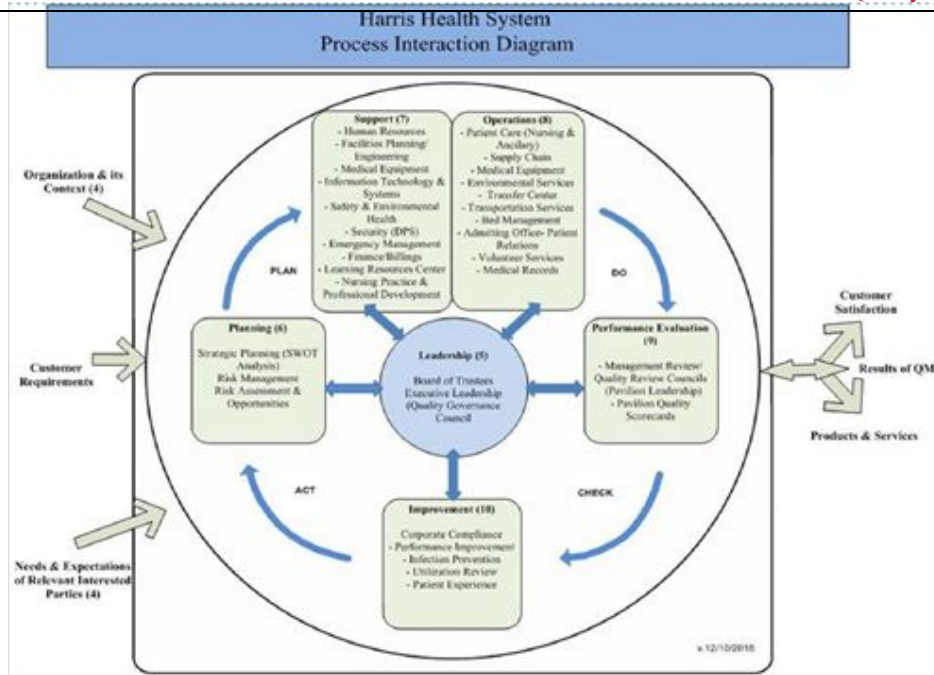
A. Overview:

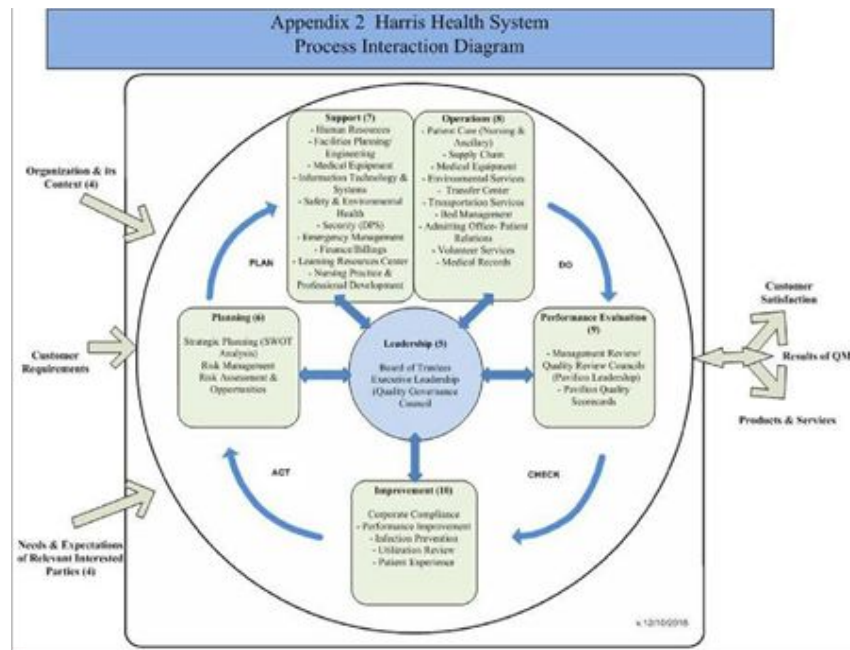
~~Harris Health is a community owned, comprehensive, integrated, healthcare system dedicated to providing high quality, cost effective, compassionate health care to all residents of Harris County regardless of their ability to pay.~~ To fulfill its service mission, Harris Health operates:

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

B. Process Interaction:

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





C. Key Processes and Support Processes

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

1. Patient identification and assessment – includes patient intake, triage, registration, and health assessment leading to admission or discharge.
2. Development of treatment plan – includes care and treatment planning, provided either for inpatient or outpatient.
3. Delivery of care – includes delivery and coordination of care (treatment and services such as diagnostic, therapeutic, and custodial).
4. Transition of care – includes assessment of treatment plan effectiveness, analysis of patient outcomes, patient status determination to either continue treatment, change treatment or discharge, and patient feedback.

VIII. GOVERNANCE, STRUCTURE, AND LEADERSHIP RESPONSIBILITIES

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

1. Governance:

Board of Trustees

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

2. BOT Quality Committee

This is a committee of the Board of Trustees that oversees the Quality, Patient Safety, and Performance Improvement (PI) Programs of Harris Health to maintain a high reliability environment supporting quality, patient and staff safety, and overall satisfaction within Harris Health. The BOT Quality Committee establishes the Quality Governance Council and other medical committees for the purpose of improvement of quality health care.

3. Quality Governance Council (QGC)

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

The review includes information on:

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

The review also includes the decisions and actions related to:

- a) Opportunities for performance and quality improvement;
- b) Any need for changes to the quality management system;
- c) Resource needs.

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

4. Patient Safety Collaborative (PSC)

The Patient Safety Collaborative Committee is an interdisciplinary Committee that aims to

promote a culture of transparency to provide a multidisciplinary objective review and analysis of patient safety events and functions as a medical committee/medical peer review committee. All functions of the Patient Safety Collaborative Committee are confidential, privileged and protected from disclosure pursuant to Federal and State laws, including but not limited to Chapter 161 of the Texas Health & Safety Code and Chapters 151 and 160 of the Texas Occupations Code. The Patient Safety Collaborative consists of system and pavilion leaders that collaborate to review events related to patient safety. The goal of the Collaborative is to partner together to achieve zero harm at Harris Health System.

5. Pavilion Quality Review Council (QRC)

The QRC provides oversight for the Quality Management System/QAPI Plan at the Pavilion level. Each Pavilion has its own QRC. The QRC has the responsibility and authority to determine that the Quality Management System has been effectively implemented and maintained at the Pavilion level. The QRC acts at the direction of the QGC and reports to the QGC. The QRC is responsible for measurement, monitoring, and analysis of the National Integrated Accreditation for Healthcare Organizations (NIAHO) QM.7 Standard Requirements (SR 4).4a-SR.4s quality of care metrics and other regulatory survey findings. The QRCs develop performance goals that are in alignment with the Harris Health strategic objectives. In addition, all accredited and certified programs are required to routinely report (minimum of once per year) outcomes and performance metrics to QRC. The different service area Committees are to report up to the QRCs. The QRCs may also initiate performance improvement teams for issues that are unique to the departments within the pavilion. Refer to Ben Taub Hospital QRC Bylaws, Lyndon B. Johnson Hospital QRC Bylaws, and Ambulatory Care Services QRC Bylaws for their respective membership composition and oversight responsibility.

6. Medical Executive Board and Pavilion Medical Executive Committees

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

7. System Level Committees

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

A. Service Area Committees

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

B. Evidence Based Practice Committee (EBPC)

This committee supports the development of clinical practice guidelines, standing delegated orders and care protocols for Harris Health. It ensures that the care provided to patients is current and based on evidenced based practices.

~~and based on evidenced based practices.~~

C. Management Operation Reviews:

The Monthly Operation Review (MOR) is a cross functional meeting for management to analyze key performance indicators (KPSs) regarding quality, financial performance, volumes, staff engagement, operational effectiveness, and strategy among other items. It identifies bottlenecks, tracks progress against goals, ensures quality care, and boosts efficiency by reviewing data on an ongoing basis. The MORs may direct a group or task force to work on improvement efforts. Information from the improvement project will be shared or reported to the quality oversight committees as appropriate.

D. Structure and Organizational Standards (SOS) Committee

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

E. Physical Environment

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

F. Executive Corporate Compliance Survey Readiness Subcommittee (ECCSR)

This is a subcommittee of the Harris Health Executive Corporate Compliance. The subcommittee serves as an oversight body to ensure a state of survey readiness and to maintain compliance with federal, state, local, accreditation and other certification standards that govern the quality and safe care to Harris Health patients. This committee meets six (6) times annually. The provision of maintaining regulatory compliance is an interdisciplinary, collaborative effort and therefore, a system-wide management approach is implemented across the health system.

G. Workplace Safety and Violence Prevention (WPS-VP) Committee. The WPS-VP Committee is accountable for supporting the interdisciplinary team with the development and implementation of the practices, policies, and resources needed to ensure early identification and safe management of employee/staff, patients and visitors with history of, at risk for, or exhibiting violent behavior. The committee supports patient safety and quality at the system and pavilion levels.

8. The Survey Readiness Subcommittee is designed to fulfill the following objectives:

- Continuously evaluating for compliance to federal, state or local laws and regulations to maintain licensure/accreditation/certification status and fiduciary responsibilities;
- Taking a proactive stance to developing & implementing policy or procedure to meet the intent of regulatory requirements;
- Standardizing the process for management of survey activity including

staff involvement, awareness, and delineating roles & responsibilities;

- Identifying opportunities, improve processes and provide resources, as appropriate, to deliver quality and safe care and maintain regulatory compliance; and
- Developing an approach for achieving an integrated health system

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

Refer to ECCSR Plan and Charter for additional information.

8. Department/Service Committees/Councils

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

9. Clinical Care Committees (CCC)

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

~~Specifically, the CCC:~~

- ~~— Identifies and implements specific initiatives and projects that:

 - ~~· Are consistent with the overall goals and purposes of the entire Harris Health in advancing the delivery of care to the patient population;~~
 - ~~· Articulate, clearly, the requisite resources required and the associated work plan;~~
 - ~~· Have a clear, demonstrable end point that results in readily measurable improvements in patient outcomes and/or readily measurable reductions in patient mortality and length of stay; and~~
 - ~~· Articulate, clearly, the requisite resources required and the associated work plan including an explicitly stated time frame for their completion and implementation.~~~~
- ~~A. Identifies patient care best practices as supported by scientific evidence and facilitate their usage throughout the system.~~
- ~~A. Works to eliminate unnecessary variations in patient care processes to achieve the highest outcomes in efficiency and safety.~~
- ~~A. Develops and reviews clinical outcomes performance reports and shares them with the providers and pavilions to improve patient care.~~
- ~~A. Provides meaningful communication of its initiatives to Harris Health Executives by leveraging the Quality Reporting Council/Committee framework.~~
- ~~A. The CCC is composed of a Multidisciplinary group representing all clinical and ancillary departments with significant influence on the delivery of care to a septic patient. The CCC is supported by a dedicated Harris Health Quality Performance Improvement Program Manager who will assist the CCC Chairs with setting the agenda and coordinating the meeting logistics including meeting minutes and maintaining documents. Each CCC will maintain a Charter approved by the QGC. The CCC recommendations and performance improvement reports will be submitted quarterly in writing to the Quality Reporting Committees which may consists of Pavilion level QRCs, QGC and Quality Board Subcommittee when appropriate. Within this Quality Assurance and Performance Improvement (QAPI) framework, any additional resources will be requested and assistance with any barriers to performance improvement will be presented.~~

10. Medical Staff Committees

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

17. Structure

- A. ~~The~~ Appendix B Quality Reporting Procedure describes and illustrates the structure

and flow of quality information within Harris Health.

18. Leadership Responsibilities

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

IX. MEASUREMENT, ANALYSIS AND IMPROVEMENT

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

A. Quality Measures

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

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

B. Internal Quality Audits

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

C. Reporting Communication

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

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

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

1. Quality information request, design and approval

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

E. Data Management

1. Data Acquisition/Collection

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

2. Data Sampling

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

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

3. Validation

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

4. **Data Analysis Display and Report Development**
Harris Health shall determine, collect and analyze appropriate data to demonstrate suitability and effectiveness of its quality management system. The organization will also evaluate where continual improvement of the effectiveness of the quality management system can be made. This process shall include data generated as a result of monitoring and measurement and from other relevant sources.
5. **Data Analysis Tools and Methodology**
Several methods are used to analyze performance data to identify trends against established goals. For example, trend charts, fish bone diagrams, value mapping, bubble charts, statistical process control charts (SPCC's), Failure Mode and Effects Analysis (FMEA) and Root Cause Analysis (RCA) are being used. Several risk adjusted methodologies are available for patient outcome-based information [such as Vizient and National Surgical Quality Improvement Project (NSQIP)]. These electronic tools will be utilized to support the translation of the data analysis to action plans.
6. **Benchmarking**
Harris Health's performance is compared to other national organizations via participating in a variety of comparative databases. For example, but not limited to: Vizient, NSQIP, National Healthcare Safety Network (NHSN), CMS Core Measures, Value Based Purchasing, Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS), Healthcare Effectiveness Data and Information Set (HEDIS). When regional or national benchmarks are not available, Harris Health will determine a one-year baseline performance period than set internal improvement goals to assure the performance goal is tracking towards reducing variation and/or patient harm.

X. QUALITY GOALS

Harris Health Balanced Scorecard (BSC)

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

XI. CONTINUAL IMPROVEMENT (PERFORMANCE IMPROVEMENT)

A. Overview

Harris Health utilizes improvement cycles to include but not limited to Define- Measure-Analyze-Improve-Control (DMAIC) supported by LEAN Six Sigma methodologies for performance improvement. Harris Health shall continually improve its quality management system, using the quality policy, quality objectives, audit results, analysis of data, corrective and preventative actions and management review. System level improvement projects will be initiated and chartered via an effective planning and approval process at QGC. Pavilion level improvement projects will be initiated and chartered via an effective planning and approval process at the pavilion QRC and reported to QGC. A database of ongoing and completed performance improvement and quality improvement initiatives is available in the System PI Project Database (Repository).

B. Models for Improvement

1. DMAIC (Define, Measure, Analyze, Improve, and Control) these five steps represent an improvement cycle that is data driven and meant to improve processes by identifying best practices and standardizing work.
2. LEAN Six Sigma experts use the steps of the DMAIC (define, measure, analyze, improve, control) model, in a specific order, to develop, design and redesign a process so that there's effectively a minimal chance that an error will occur with the goal of zero harm. To attain their goal, the experts work to achieve six sigma, a measurement for standard deviation originating from statistics, to perfect their processes. This supports the Harris Health philosophy of doing no harm to patients. These experts will also use methodologies to eliminate waste and optimize processes that supports the delivery of quality driven low-cost healthcare.
3. **Project Management**
The project management approach will be utilized in conducting performance and quality improvement initiatives. The process starts with identification of the gap or need from key performance indicators and other metrics, selection and prioritization of projects are determined by multidisciplinary teams to determine the impact of care and resources available. Identification of the project team includes the executive sponsor, process owner as team lead, and project facilitator. The project facilitator shall ensure the project management process is carried out from planning, implementing, monitoring and reporting, closure and project handoff.

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

C. Education/Training

For continual quality improvement and patient safety efforts to succeed, it is essential that all leadership, staff, and physicians participate in education/ training regarding process improvement and patient safety issues identification and reporting. A system-wide training plan on quality and patient safety shall be established, implemented and reviewed for effectiveness. Education on quality and patient safety will be provided to the members of the Board of Trustees, system and pavilion executive leaders, service area and department leaders, staff and physicians at orientation and on ongoing basis. Basic and

advanced education modules that will include topics in PI, measurement and monitoring techniques, and the use of the DMAIC methodology as well as risk-based thinking are also provided on a recurring basis. The Quality Programs Performance Improvement Team provides on-line and face-to-face education sessions regarding performance improvement to the leadership and staff.

D. Coordination and Support

In order to coordinate and support Performance Improvement activities, Harris Health shall:

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

E. Point of Service Performance Improvement

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

XII. PATIENT SAFETY/RISK MANAGEMENT

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

XIII. CONFIDENTIALITY & PRIVILEGE

BOT Quality Committee

The BOT Quality Committee is a medical peer review committee and/or medical committee when it is evaluating the competence of a Medical Staff member or the quality of medical and healthcare services provided by Harris Health, and to the extent that the evaluation involves discussion or records that specifically or necessarily identify an individual patient or Medical Staff member. This committee meets in "executive session" to conduct medical peer review and/or medical committee activities, and when the committee is conducting such activities, the

committee's proceedings and records, as well as any communication made to the committee are confidential, legally privileged, and protected from disclosure pursuant to state and federal law. See Texas Health & Safety Code §161.0315; Tex. Occ. Code §151.002 and §160.007 PSQIA, and 42 CFR Part 3.

Privilege/Confidentiality of Quality Manual Activities

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

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

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

XIV. ANNUAL EVALUATION

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

of Trustee Committee.

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

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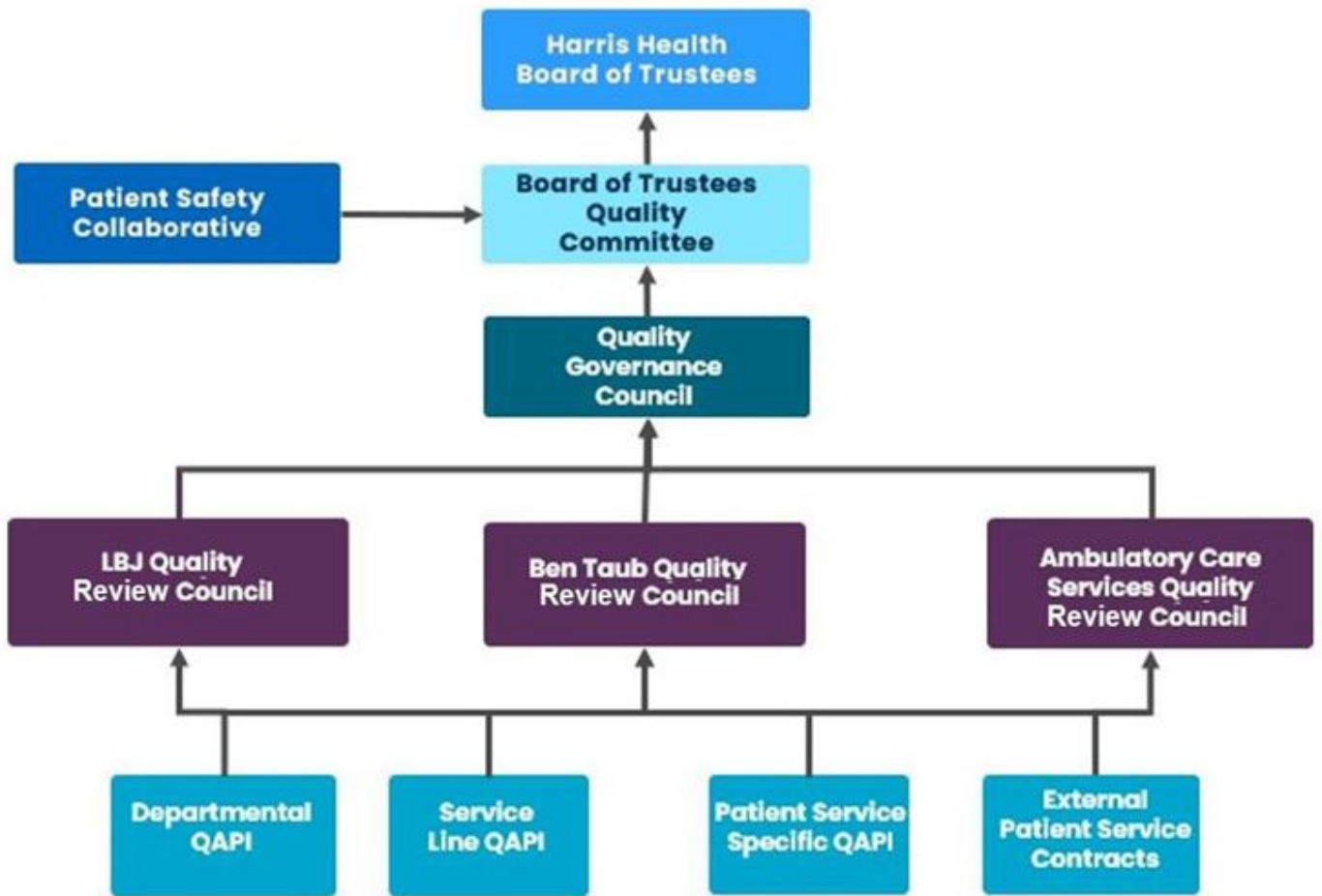
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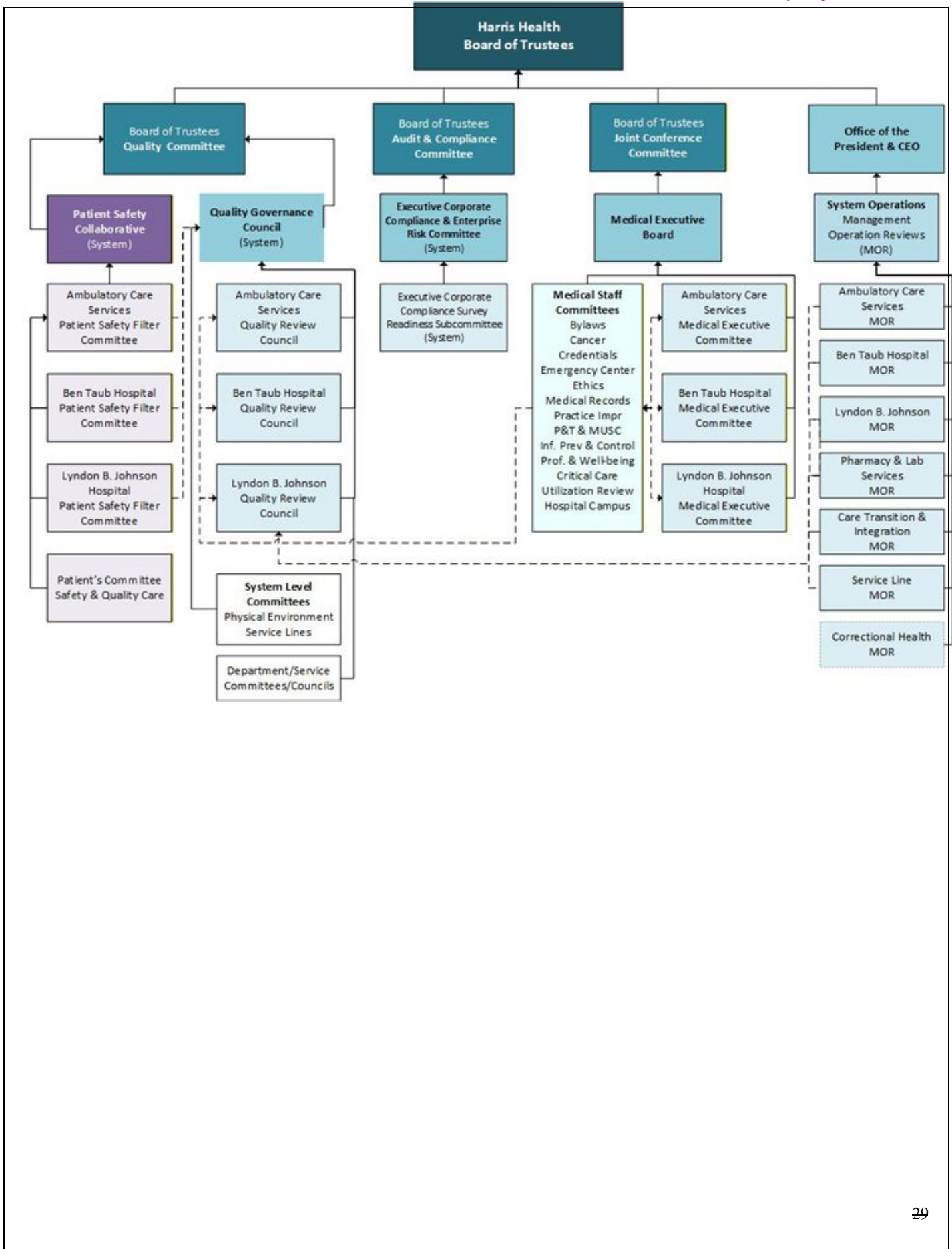
Appendix A

Quality and Patient Safety Organizational Structure

Note from VHN: please use the updated flow for Quality information flow to the BOT.

Harris Health Quality Assurance & Performance Improvement (QAPI) Governance



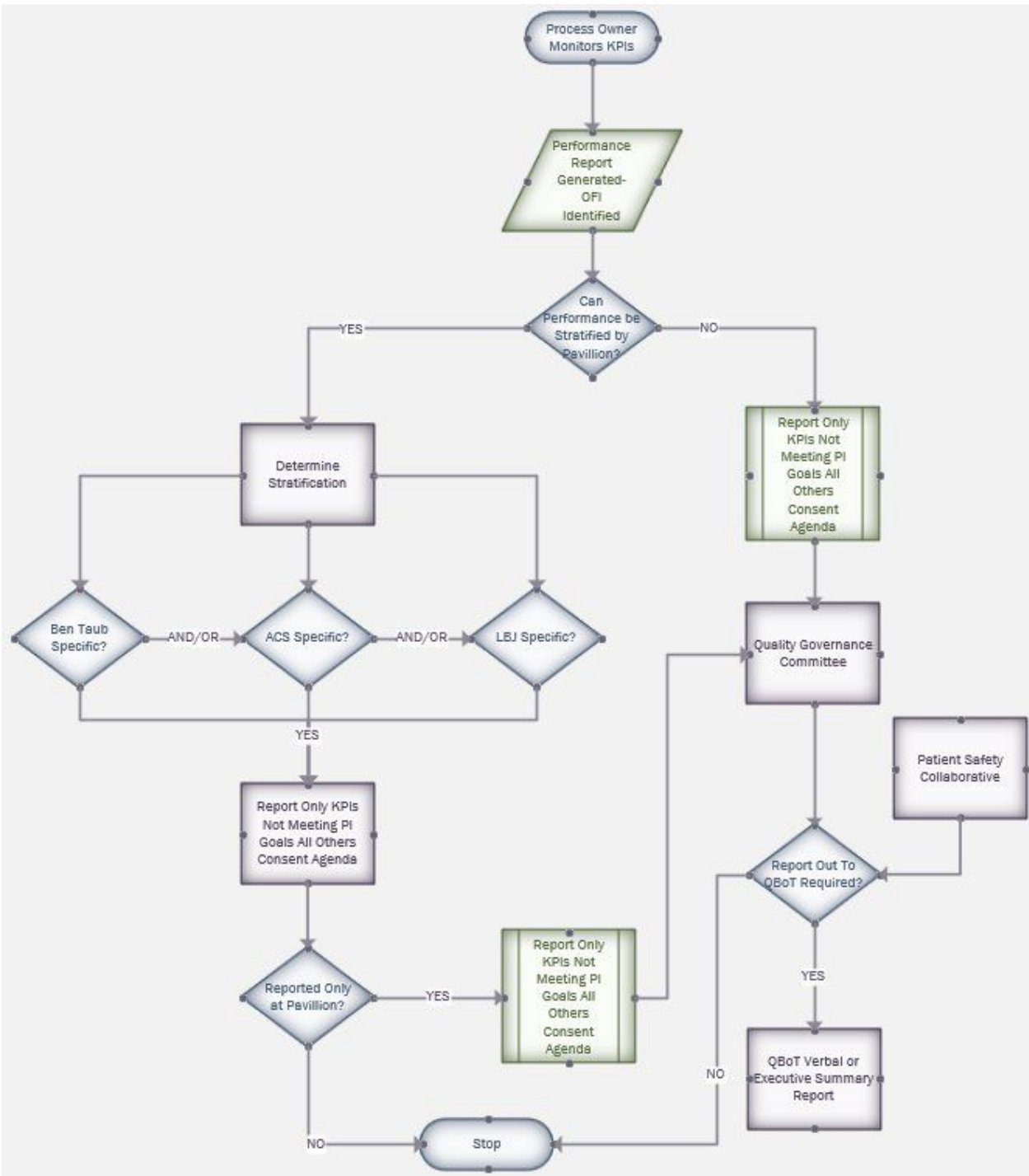


Appendix B

Quality Reporting Procedure

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

Quality Report Process-flow Diagram



Process owner:

Consent Agenda Guidance:

1. Purpose

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

2. Description

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

3. Content of Consent Agenda

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

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

5. Approval of Consent Agenda

The consent agenda will be approved by the committee at the beginning of each meeting.

- Committee members may request that matters be added, deleted or that the order of items be moved and the committee chair shall make a decision on each request. Any decision may be subject to challenge and reversed by the committee.
- Any item may be moved out of the consent agenda section at the request of any committee member, before approval of the agenda. A member may request to move an item to further discuss it, inquire about it, or vote against it. No motion or vote of the committee is required to a request to move an item out of the consent agenda.
- When a committee member requests that an item be moved out of the consent agenda section, the committee chair shall decide where to place that item on the agenda.
- When only one item on the consent agenda list does not qualify as a consent agenda item or is requested to be moved, that item shall be moved out of the consent agenda and the rest of the items shall remain on the consent agenda.

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

6. **Motion to Approve Consent Agenda**

When the requested changes have been made to the consent agenda:

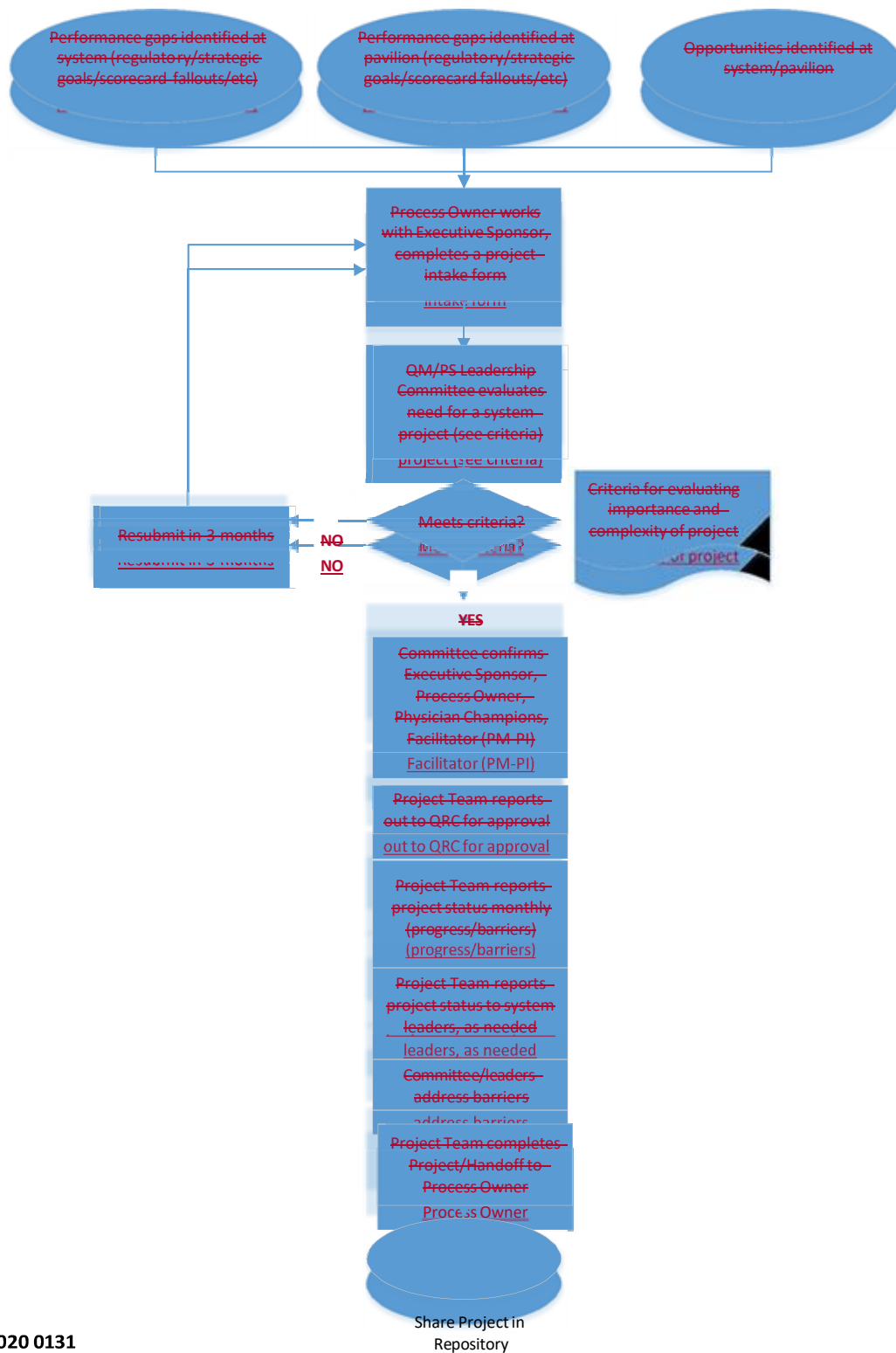
- Chairperson reads items listed under consent agenda.
- Chairperson asks “would any committee member like to remove any of the items from the consent agenda”, if no requests are made, then states: “If there is no objection, these items will be adopted”.
- The chairperson calls for a motion to accept the consent agenda and a vote is taken and recorded.

7. **Minutes**

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

Appendix C

System Performance Improvement Process



RS 2020 0131

Appendix D

Service Area Committee Charter

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

I. Purpose:

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

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

II. Duties and Responsibilities:

The Committee’s responsibilities include:

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

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

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

III. Membership

The Committee will be composed of:

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

IV. Meetings, Minutes and Committee Action

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

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

All Committee members are expected to attend each meeting. A quorum representing a majority of the Committee members must be present to transact business.

V. Amendments

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

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers and Stakeholders, etc.)
06/14/2016	Original 1.0	Reviewed 06/14/16	Approved by Harris Health Quality Governance Council
07/14/2016		Reviewed 07/04/16	Approved by Harris Health Board of Managers
11/08/2016	2.0	Revised 11/08/16	Approved by Harris Health Quality Governance Council
01/25/2017		Reviewed 01/25/2017	Approved by Harris Health Board of Managers
02/22/2018		Reviewed 02/22/2018	Approved by Harris Health Board of Trustees
3/13/2019		Reviewed 3/13/2019	Approved by Harris Health Quality Governance Council
3/13/2019		Reviewed 04/11/2019	Approved by Harris Health Board of Trustees
3/10/2020		Reviewed 3/12/2020	Approved by Harris Health Quality Governance Council
3/10/2020		Reviewed 3/14/2020	Approved by Harris Health Board of Trustees
5/17/2022		Reviewed 5/17/2022	Approved by Harris Health Board of Trustees
4/28/2023	3.0	Updated with minor changes in scope and added ECCSR structure	
6/20/2023		Reviewed 6/20/2023	Approved by Harris Health Quality Governance Council
9/28/2023		Reviewed 9/28/2023	Approved by Harris Health Board of Trustees
3/19/2024		Reviewed 3/19/2024	Approved by Harris Health Quality Governance Council
4/9/2024		Reviewed 4/25/2024	Approved by Harris Health Board of Trustees

2/18/2025		Reviewed 2/18/2025	Approved by Harris Health Quality Governance Council
3/27/2025		Reviewed 3/27/2025	Approved by Harris Health Board of Trustees
TBD		TBD	Approved by Harris Health Quality Governance Council
TBD		TBD	Approved by Harris Health Board of Trustees

Tuesday, April 21, 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 Reports in Connection with the Evaluation of the Quality of Medical and Healthcare Services, Including Report Regarding Harris Health Quality Review Councils, and Possible Action Regarding this Matter Upon Return to Open Session.




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

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Tuesday, April 21, 2026

Executive Session

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



Carolynn Jones, JD, CHC

Executive Vice President, Chief Compliance and Risk Officer

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