HARRIS HEALTH SYSTEM

Quality Manual

2016

Approved: Harris Health Board of Managers on 7/14/2016

TABLE OF CONTENTS

I. INTRODUCTION

The Harris Health System is a community-owned, healthcare system dedicated to providing high quality, cost effective, compassionate health care to residents of Harris County regardless of their ability to pay. Harris Health System is a teaching system for Baylor College of Medicine and The University of Texas Health Science Center at Houston (UT Health). We train the next generation of healthcare providers, nurses and allied health professionals.

A nine (9)-member Board of Managers appointed by the Harris County Commissioners Court governs Harris Health System and approves this Manual. The Board of Managers appoints the Harris Health System President /Chief Executive Officer.

II. PURPOSE

The Quality Manual outlines Harris Health System's organizational approach to monitoring and improving quality, patient safety, and performance. The manual supports our commitment to our patients in that it supports Harris Health System's mission, vision, values, and strategic goals. The manual also establishes a systematic, organization – wide approach to quality, clinical and operational, that cultivates a culture of patient safety and continual performance improvement.

III. GUIDING PRINCIPLES

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

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

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

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

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

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

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

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

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

A. Our Mission**:**

We improve our community's health by delivering high-quality healthcare to Harris County residents and by training the next generation of health professionals.

B. Our Vision**:**

To create a healthier community and be recognized as one of America's best community-owned healthcare systems.

C. Our Values**:**

1. Our patients, staff, and partners;
2. Compassionate care;
3. Trust;
4. Integrity;
5. Mutual respect;
6. Communication; and
7. Education, research, and innovation.

D. Our Promise**:**

1. To provide high-quality health care by knowledgeable and highly trained staff;
2. To provide prompt, friendly and courteous service;
3. To be sensitive and responsive to our patients' needs and concerns as well as those of their families; and
4. To provide a clean, comfortable, and safe environment in all of our settings.

V. STRATEGIC GOALS AND QUALITY OBJECTIVES

Harris Health System leadership, in collaboration with the Board of Managers and affiliated Medical Staff, has cooperatively developed Strategic Initiatives related to People, Service, Quality and Financial domains.

Goals and Objectives have also been developed to support the shared commitment to Safety, Quality and Performance Improvement. Refer to Harris Health System Strategic Plan Quality Strategic Goals and Objectives.

Strategic Goals:

Our Patients – Enhancement of clinical quality, patient safety and patient satisfaction.

Our Family – Invest, reward and leverage our most important asset – Our Harris Health and medical school partners' dedicated staff

Our Home – Continue to invest in and modernize our medical equipment, information technology and facilities infrastructure.

Financial Stability – Creating a strong financial foundation to build towards Harris Health's future. To take advantage of the opportunity to design an innovative, value-based model for healthcare services;

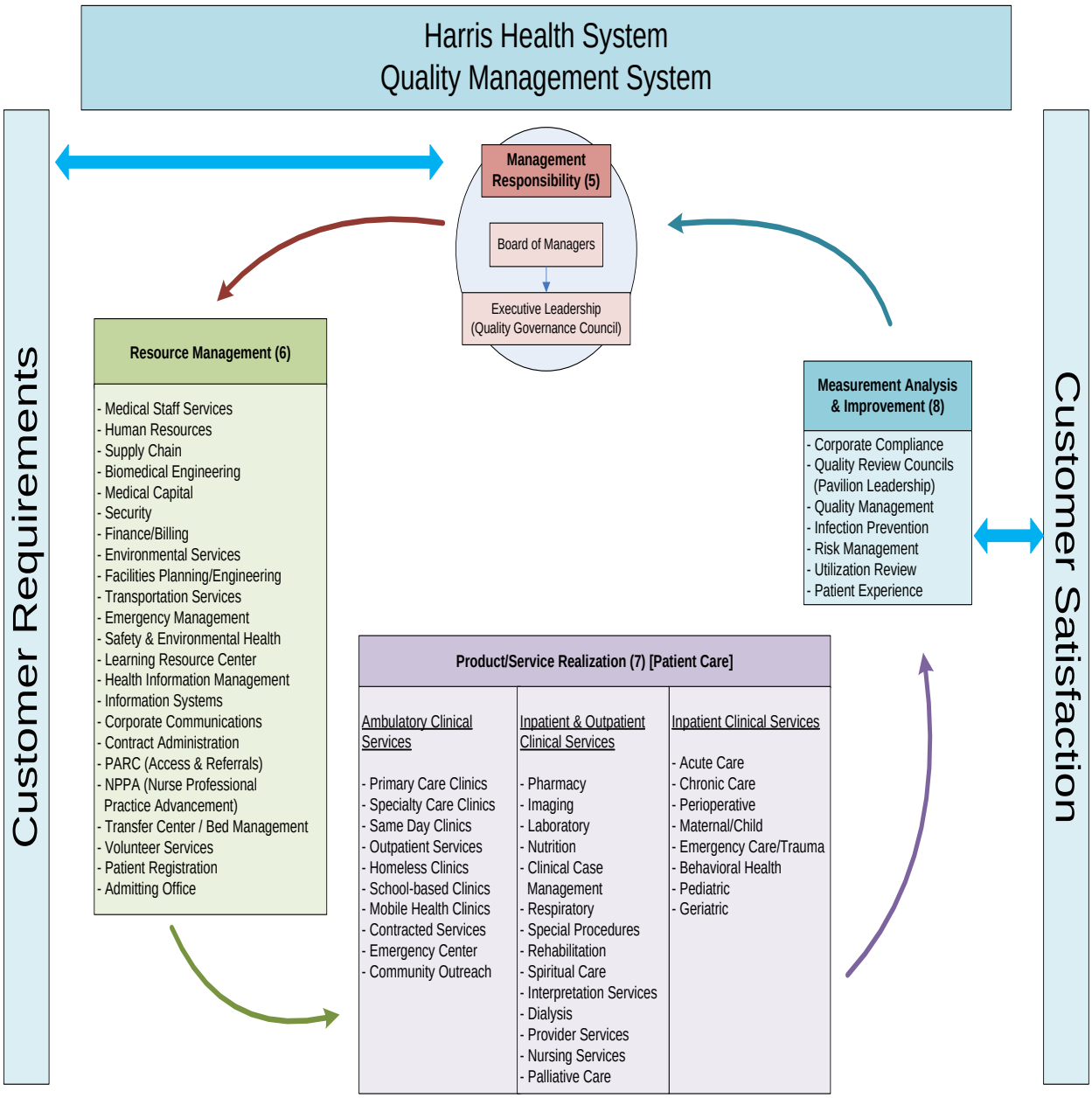
VI. SCOPE AND EXCLUSION

The Quality Manual encompasses all Harris Health System departments and services (including those furnished under contract or arrangement) that impact patient care, safety, and health outcomes.

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

1. Three (3) hospitals: Two (2) Acute Care and One (1) Specialty
2. Sixteen (16) Community Health Centers;
3. Two (2) Pediatric and Adolescent Health Centers;
4. Ten (10) Homeless Shelter Sites;
5. Five (5) School Based Clinics;
6. Dialysis Centers;
7. Six (6) Mobile Health Clinics;
8. Five (5) Specialty Clinic Sites;
9. Six (6) Same-Day Clinics;
10. Dental Center;
11. Contracted Outside Medical Services;
12. "Ask My Nurse" 24/7 Telephone Nurse Triage line; and
13. Harris Health System EMS.

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



C. Services: The services provided are detailed in the Harris Health System Schedule of Benefits – Authorization Matrix. Refer to Harris Health Intranet Site.

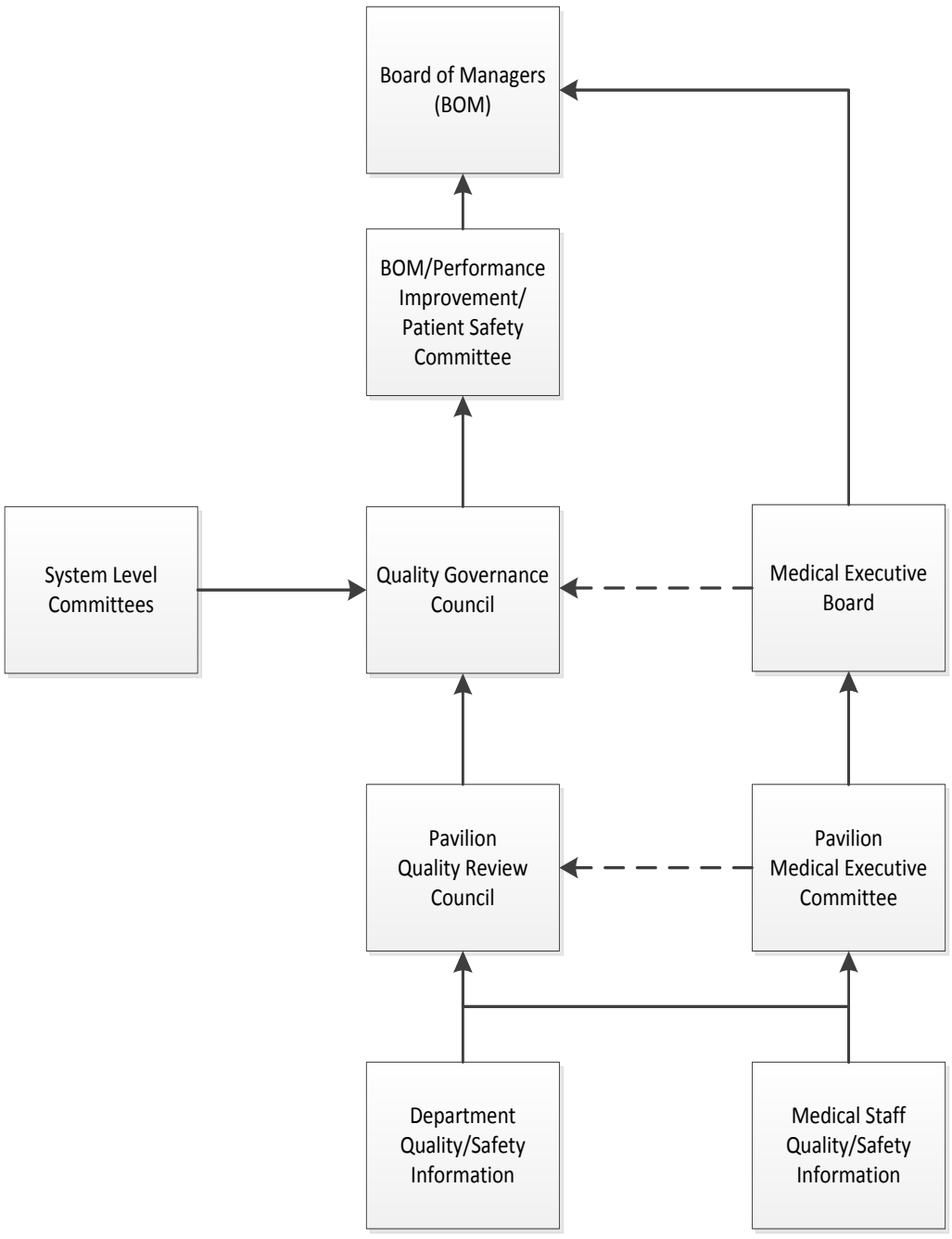
D. Exclusion: Harris Health System has determined an exclusion from the requirements defined with ISO 9001 Clause 7.3 for Product Design and Development. Harris Health System only uses proven methods, treatments, equipment, and medications. Harris Health System does not participate in the design and development of new methods, treatments, or medications.

VII. STRUCTURE, GOVERNANCE AND LEADERSHIP RESPONSIBILITIES

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

The diagram below illustrates the Quality Management System structure.

A. Quality Management System Diagram:



B. Governance

1. Board of Managers

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

2. BOM Performance Improvement and Patient Safety Committee

Oversees the Quality, Safety and Performance Improvement (PI) Programs of Harris Health System in order to maintain high quality service, patient and staff safety, and overall satisfaction within Harris Health System

3. Quality Governance Council (QGC)

The QGC provides executive oversight for Harris Health System's Quality Management System to support and facilitate the continual improvement of quality health care. The QGC is assigned responsibility for continuous review in a self-assessment perspective to determine if the Quality Management System has been effectively implemented and maintained. This QGC is responsible for evaluating National Integrated Accreditation for Healthcare Organizations (NIAHO) standards, International Standards (ISO) clauses, CMS and other regulations validating conformance through existing monitors or initiation of monitors where current conformance is unknown or not recently documented. To assure the QMS has been effectively implemented and maintained by assessing accreditation survey readiness, conformance to regulatory standards, corrections and corrective action plans, preventive action plans, Internal Quality Audit (IQA) performance improvement teams and initiatives, regulatory complaints and complaint investigations. Refer to QGC Bylaws for its charter, membership composition and committee's oversight responsibility.

4. Pavilion Quality Review Council (QRC)

The QRC provides oversight for the Quality Management System at the Pavilion level. Each Pavilion has its own QRC. The QRC is assigned responsibility for continuous review in a self-assessment perspective to determine the Quality Management System has been effectively implemented and maintained at the pavilion. The QRC is responsible for measurement, monitoring and analysis of the National Integrated Accreditation for Healthcare Organizations (NIAHO) QM.7 Standard Requirements (SR).1-SR.18 and other regulatory findings validating conformance through existing monitors or initiation of monitors where current conformance is unknown or not recently documented. The QRC develop

their goals to align with the Harris Health System strategic initiatives and the Harris Health System missions and vision. The QRCs may also charter performance improvement teams for issues that are specific to issues or 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 charters, membership composition and oversight responsibility.

5. Medical Executive Board and Pavilion Medical Executive Committees

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

6. System Level Committees

Harris Health System has multiple forums with specific functions that support the Quality Management System. These committees include but are not limited to the following:

- Evidence Based Practice Committee (EBPC)

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

- Policy and Procedure Committees

  This committee reviews and approves all policies related to the provision of patient care. It sets standardization for policy format, review frequency and approval processes for Harris Health System. The Interdisciplinary Care Committee (ICC) reviews policy related to patient care. The Operational Policy Committee (OPC) reviews policy related to operations that support the delivery of patient care.

- Physical Environment

  This committee ensures that 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.

7. Department/Service Committees/Councils

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

8. Medical Staff Committees

Harris Health System Medical Staff Bylaws outlines Medical Staff Committees and their duties. These committees are coordinated through Harris Health System 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 organization quality information and share Medical Staff quality information with appropriate Harris Health System quality forums. Refer to the Medical Staff Bylaws for the various committees' charter, membership composition and oversight responsibility.

C. Quality Programs and Accreditation

The Harris Health System Quality Programs and Accreditation (QP&A) Department has an integral role in facilitating quality, safety, and performance improvement activities and forums. The QP&A Department collaborates with Medical Staff, Harris Health System leadership, and staff to facilitate measurement and improvement in an effective and timely manner. The QP&A Department also assists in the implementation of an interdisciplinary approach and provides quality resources through an integrated delivery network and information management.

VIII. DOCUMENTED PROCEDURES

Consistent with the ISO 9001:2008 requirements, Harris Health System implements the following documents to maintain a quality management system.

Document Type	Document Name	Document #
ISO Documented Procedures	Control of Documents	2000.0
	Control of Records	3000.0
	Internal Audits	5000.0
	Control of Nonconforming Product	4000.0
	Corrective Action	7000.0
	Preventive Action	6000.0

IX. MEASUREMENT, ANALYSIS AND IMPROVEMENT

Measurement of processes and outcomes are essential for performance improvement. Both process and outcomes 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. These indicators are reflected in the department, pavilion and system scorecard.

B. Internal Quality Audits (IQA)

Performance indicators related to IQA include compliance to its schedule and the adequacy of the Quality Management System.

C. Reporting Communication

Effective communication is fundamental to 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 through system, pavilion, and departmental quality councils, committees and other forums, as well as, departmental and unit leadership and staff meetings.

Harris Health follows the National Integrated Accreditation for Healthcare Organizations (NIAHO) standard, Quality Management System section 7, 1-18 (QM.7 SR.1-18) recommendation to monitor for the inputs and outputs of the Quality Management System. It also correlates with the ISO (International Standard) 9001:2008 5.6.2 Clause and NIAHO Standard QM.6 SR.1 for the quality oversight structure and management review functions. The reporting schedule is established annually based on the evaluation and needs of the organization.

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

1. Quality information request, design and approval

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

2. Data Management

Data Acquisition/Collection: Quality Programs & Accreditation Department provides data collection support for some indicators. The data collection for all other indicators is the responsibility of the accountable department where the specific indicator is indicated. Acquiring and responding to real time data is the key to impact current performance/quality of patient care.

a. 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 statistical significant when the data is analyzed for process improvement:

i. For a population size fewer than thirty (30) cases, the sample size is one hundred percent (100%);
ii. 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
iii. 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. Analysis Display and Report Development

Harris Health System 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.

Data is aggregated and displayed to support the identification of patterns; analysis of trends over time, applicable benchmarking, and best practice comparisons. Reports are validated to assure correct representation of the information being presented and should demonstrate the quality or effectiveness of patient care.

5. Benchmarking

Benchmarking Harris Health System's performance relative to other organizations is accomplished through participating in a variety of comparative databases. Harris Health System utilizes benchmark/comparatives data at the highest level appropriate and available.

X. QUALITY GOALS

Harris Health System Pavilion Quality Scorecard

Quality Indicators	Benchmark / Goal 2016	Harris Health 2015 YTD
Mortality		
Mortality Rate	*	**1.51%**
Blood Utilization		
Crossmatch/Transfusion Ratio	≤ **1.79**	≤ **1.49**
Core Measures		
(SCIP-Inf-1g) Prophylaxis. antibiotic received within 1 hr. prior to surgical incision (Hysterectomy)	≥ **98.7**	**95.2%**
IMM-2 Influenza Immunization	≥ **92.4%**	**90.8%**
PCM-1 Elective Delivery	≤ **5.2%**	**3.1%**
(VTE-3) VTE patients with Anticoagulation Overlap Therapy	≥ **91.4%**	**89.7%**
(VTE-5) VTE Discharge Instructions	≥ **69.6%**	**91.0%**
(VTE-6) Incidence of Potentially-Preventable VTE	≤ **11.2%**	**1.9%**
Readmissions		
Readmission Rate - All Cause	≤ **16%**	**10.6%**
AMI Readmission Rate	≤ **17%**	**10.9%**
Heart Failure Readmission Rate	≤ **22%**	**18.9%**
Pneumonia Readmission Rate	≤ **18%**	**7.5%**
COPD Readmission Rate	≤ **20.7%**	**16.8%**
Patient Falls		
In-Patient Falls (In 1,000 Patient Days)	≤ **2.50**	**1.45**
Quentin Mease (In 1,000 Patient Days)	≤ **7.50**	**4.86**
Out-Patient Falls (In 10,000 Patient Visits)	*	**1.80**
Significant Injuries	**0**	**8**
Hospital Based Inpatient Psychiatric		
Total Number of Admissions	*	**83**
Readmission	≤ **12%**	**4.0%**
Average LOS	≤ **7.5**	**6.98**
Restraint (hours / 1000 patient care hours)	< **0.11**	**0.056**
Admission Screening	≥ **90.0%**	**97.4%**
Seclusion (hours/1000 pt hours)	< **4.69**	**1.084**
Justification for Antipsychotic Medications ≥ 2	≥ **90.0%**	**100%**

Quality Indicators	Benchmark / Goal 2016	Harris Health 2015 YTD
Patient Satisfaction		
	≥ % Value	
Adult Inpatient (HCAHPS)	**BT | LBJ | HHS**	
Communication With Nurses	**79.2 | 79.2 | 79.2**	**75.2%**
Communication with Doctors	**83.7 | 84.5 | 83.9**	**82.7%**
Responsiveness of Hospital Staff	**69.2 | 70.1 | 69.5**	**68.9%**
Pain Management	**72.5 | 72.3 | 72.4**	**70.7%**
Communication About Medicines	**68.1 | 68.9 | 68.8**	**67.6%**
Cleanliness of Hospital	**72.8 | 72.4 | 70.4**	**69.9%**
Quietness of Hospital	**65.1 | 67.4 | 66.0**	**65.1%**
Discharge Information	**87.6 | 89.3 | 88.2**	**87.1%**
Care Transition	**61.1 | 61.7 | 61.3**	**59.9%**
Overall Rating of Hospital 9&10	**77.1 | 80.5 | 78.3**	**77.1%**
Ambulatory Care CG CAHPS		
Recommend Office	**72.5%**	**70.5%**
Care Coordination	**65.1%**	**62.1%**
Courteous and Helpful Office Staff	**73.8%**	**71.9%**
Timely Care, Appointments, & Info	**52.8%**	**47.3%**
Physician Communication Quality	**78.7%**	**76.2%**
Patient's Rating of Provider 9 & 10	**76.6%**	**74.8%**
Other Survey Lines		
Emergency Center	**47.9 | 56.1 | 51.1**	**46.3%**
Ambulatory Surgery	**79.7 | 83.2 | 81.5**	**79.5%**
LBJ Ambulatory Surgery Outpatient Center	**83.2%**	*****
Outpatient Rehabilitation	**83.3 | 81.9 | 82.8**	**82.4%**

*No established benchmark

Harris Health System Executive Quality Scorecard

The Harris Health Quality Scorecard will be renamed as the Harris Health System Executive Quality Scorecard to reflect the following nationally reported benchmarks that measure achievements of quality of care. The outcome measures are:

- Value-Based Purchasing – Based on the Affordable Care Act that rewards acute-care hospitals with incentive payments for the quality of care provided.
    - Survey of Patient's Experiences (25%)
    - Safety (25%)
    - Efficiency and Cost Reduction (25%)

  - Clinical Care – Outcomes (25%)
- Readmission Reduction Program – Based on the Affordable Care Act that penalizes hospitals with higher-than-expected readmissions for specific clinical conditions.
- Hospital-Acquired Conditions (HAC) Reduction Program – Based on the Affordable Care Act that reduces hospital payments by 1 percent if the organization ranks among the lowest-performing 25 percent with regard to HACs.
  - Domain 1 – Patient Safety Indicators
  - Domain 2 – Hospital-Acquired Infections
- Present on Admission Indicators - Based on the Deficit Reduction Act of 2005 whereby hospitals will no longer receive additional payment for cases in which one of the selected conditions was not present on admission.
- Potentially Preventable Complications – Based on Texas Medicaid that defines potentially preventable complications that occurred during an inpatient stay.
- Potentially Preventable Readmissions – Based on Texas Medicaid that defines potentially preventable readmission that is clinically related to the initial hospital admission.

XI. CONTINUAL IMPROVEMENT (PERFORMANCE IMPROVEMENT)

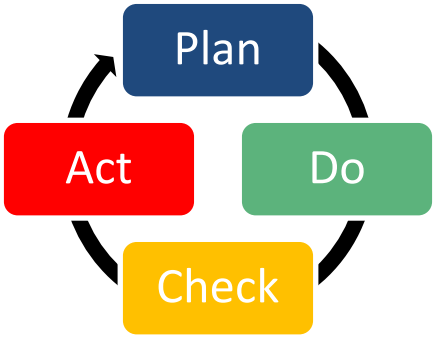
A. Overview

Harris Health System utilizes the Plan Do Check Act improvement cycle as the methodology for performance improvement. Harris Health System shall continually improve their quality management system through the use of the quality policy, quality objectives, audit results, analysis of data, corrective and preventative actions and management review.

Improvement project will be initiated and chartered via an effective planning process. A prioritization matrix shall be deployed when multiple opportunities for improvement exists. This provides leadership an objective assessment of which opportunities should be considered as first priority.

B. Models for Improvement

1. PDCA – Plan-Do-Check-Act



This is the method of choice used at Harris Health System. It promotes a trial-and-learning approach to improvement efforts. A standardized document for Corrective Action Plan or Correction using PDCA can be found on the Harris Health System Intranet "forms" section.

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 issue identification and reporting. Basic education is provided to all employees during general orientation. Training in PI, measurement and monitoring techniques and the use of the PDCA methodology are also provided on a recurring basis. The Quality Programs & Accreditation Department provides on-line and face-to-face education sessions regarding performance improvement to the leadership and staff.

D. Coordination and Support

In order to coordinate and support PI activities, the Department of Performance Improvement for Harris Health System shall:

1. Assist in the development and review of PI initiative request and design;
2. Identify and prioritize PI activities in collaboration with the QRC and QGC;
3. Ensure the availability, integrity and accurate analysis and validation of data used to document and evaluate outcomes;
4. Collaborate with PI teams and sponsors to support the PI initiative;
5. Apply and educate others on Harris Health System's PI methodology, PDCA as a continual quality improvement model;
6. Consult regarding PI activities at all levels to encourage and support continual improvement.
7. Provide facilitation for PI teams as needed;
8. Assure reporting of PI teams progress and outcomes at the appropriate forums; and
9. Collaborate with PI teams and sponsors to establish a method for monitoring the change process and outcomes.

E. Point of Service Performance Improvement

Staff at all levels in the organization is trained on Harris Health System'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.

System Performance Improvement Projects

Continuation of the 2015 System Performance Improvement projects until completion as noted below:

July 2015 to June 2016

Project	Description
Sepsis	Optimization of patient care management for sepsis alert and response.
Readmission Reduction Plan:	CHF Discharge Phone Calls within 24-48 hours of discharge to bridge patient needs prior to first outpatient appointment
Document Control	ISO 9001 Standardize all documents to the most current version through identification, inventory and clean-up to a singular forms database
Record Control	ISO 9001 Standardize all record management that includes identification, storage, protection, retrieval, retention time and disposition of records.

January 2016 to December 2016

Project	Description
Time Out	A "time out", before starting the procedure, to confirm that the correct patient, site and procedure have been identified, and that all required documents and equipment are available and ready for use. [1]
Hand Hygiene	Hand hygiene practices are key prevention measures in healthcare settings and can prevent potentially fatal infections from spreading from patient to patient.[2]
Just Culture	Creating an open, fair and learning culture designing safe systems and managing behavioral choices. [3] Just culture recognizes that human error and faulty systems can cause a mistake, and encourages the investigation of what led to the error instead of an immediate rush to blame a person. [4.]

Data Analysis Tools

Data analysis will be done to identify trends to assist leadership in achieving established goals. Patient detail specific data including comorbidity and care management along with root cause analysis will be utilized to identify trends. Additional electronic tools will be utilized to support the translation of the data analysis to action plans.

XII. PATIENT SAFETY/RISK MANAGEMENT

A. Refer to Patient Safety Plan on how Harris Health structure and manage patient safety.

.

XIII. CONFIDENTIALITY & PRIVILEGE

BOM Performance Improvement and Patient Safety Committee

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

PRIVILEGE/CONFIDENTIALITY OF QUALITY MANUAL ACTIVITIES

Quality Manual Committees and Councils, (Quality Committee/Council) described in the Quality Manual all function as "medical committees" and/or "medical peer review committees" pursuant to state law. The Quality Committee/Council's records and proceedings are, therefore, confidential, legally privileged, and protected from discovery under certain circumstances.

The function that the Quality Committee/Council performs determines the protected status of its activities. Information is protected by the privilege if it is sought out or brought to the attention of the medical committee and/or medical peer review committee for purposes of an investigation, review, or other deliberative proceeding. Medical peer review activities include the evaluation of medical and health care services, including the evaluation of the qualifications of professional health care practitioners and of patient care provided by those practitioners. These review activities include evaluating the merits of complaints involving health-care practitioners, and determinations or recommendations regarding those complaints. The medical peer review privilege applies to records and proceedings of the committee, and oral and written communications made to a medical peer review committee when engaged in medical peer review activities. Medical committee activities also include the evaluation of medical and health care services. The medical committee privilege protection extends to the minutes of meetings, correspondence between committee members relating to the deliberative process, and any final committee product, such as any recommendation or determination.

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

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

A. The annual evaluation and revision of the Manual will be part of the organization's strategic planning process and the plan will reflect Harris Health System's strategic goals and the recommendations that come from the evaluation of the prior year's Manual. Each year, the QGC will evaluate the effectiveness of the prior year's Manual, 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 outcomes of this process is a plan that supports Harris Health System's strategic goals and high-level improvement priorities that create a set of aligned improvement initiatives for the next year.

XIV. REFERENCES

1. CMS - Center for Clinical Standards and Quality/Survey & Certification Group**.** Revised

Guidance Related to New & Revised Regulations for Hospitals, Ambulatory Surgical Centers (ASCs), Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). January 30, 2015. Page 26.

2. Hand Hygiene. www.cdc.gov/features/handhygiene. Healthy Living.

3. Just Culture Position Statement. Nursingworld.org/psjustculture. Congress on Nursing Practice and Economics. Interpretation of the Just Culture Concept and application for nursing and healthcare in a variety of settings. January 28, 2010. Page 4.

4. Brewer, K. MSN, RN. How a Just Culture Can Improve Safety in Healthcare. www.medscape.com/viewarticle/746089_2. American Nurse Today. 2011;9(6).

5. National Integrated Accreditation for Healthcare Organizations (NIAHO). Version 11. Revision 11 2014-06-17.

6. ISO 9001:2008 Quality Management System.