HARRISHEALTH SYSTEM

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, August 18, 2022
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Mission

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

AGENDA

I.	**Call to Order and Record of Attendance**	**Ewan D. Johnson, MD, PhD**	**2 min**
II.	**Approval of the Minutes of Previous Meeting**	**Ewan D. Johnson, MD, PhD**	**1 min**
	• ASC at LBJ Governing Body Meeting – May 19, 2022		
III.	**General Action Item(s)**	**Ewan D. Johnson, MD, PhD**	**20 min**
	A. Consideration of Approval of the 2022–2023 Infection Control Program for the Ambulatory Surgical Center at LBJ Governing Body ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*
	B. Consideration of Approval of the 2022–2023 Quality Improvement Program for the Ambulatory Surgical Center at LBJ Governing Body ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*
	C. Consideration of Approval of the Governing Body Bylaws of the Ambulatory Surgical Center at LBJ Governing Body ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*
	D. Consideration of Approval of the Medical Staff Bylaws of the Ambulatory Surgical Center at LBJ Governing Body ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(5 min)*
IV.	**ASC at LBJ Medical Director and Administrator Reports**	**Ewan D. Johnson, MD, PhD**	**10 min**
	A. Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the Ambulatory Surgical Center at LBJ Governing Body, Including Questions and Answers ***– Dr. Scott Perry and Mr. Matthew Reeder***		*(10 min)*
	1. Implementation of Block Guidelines and Committee 2. Ask My Nurse Emergency Center Visit Mitigation Process		

V.	**Executive Session**	**Ewan D. Johnson, MD, PhD**	**25 min**
	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ Governing Body, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Possible Action Upon Return to Open Session, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ ***– Dr. Scott Perry***		*(10 min)*
	B. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Healthcare Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, Including Possible Action Regarding this Matter Upon Return to Open Session ***– Ms. Carolynn Jones***		*(5 min)*
	C. Report Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, Including Possible Action Upon Return to Open Session ***– Dr. Matasha Russell, Dr. Scott Perry and Mr. Matthew Reeder***		*(10 min)*
VI.	**Reconvene**	**Ewan D. Johnson, MD, PhD**	**1 min**
VII.	**Adjournment**	**Ewan D. Johnson, MD, PhD**	**1 min**

MINUTES OF THE HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
May 19, 2022
9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:01 a.m. by Ewan Johnson, MD, Chair. It was noted that a quorum present and the attendance was recorded.	**A copy of the attendance is appended to the archived minutes.**
II. Approval Of The Minutes Of The Previous Meeting	Approval of the Minutes of Previous Meetings: • ASC at LBJ Governing Body Meeting – February 17, 2022	**Motion No. 22.05-05** **Moved by Ms. Alicia Reyes, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Governing Body approve the minutes of the previous meeting. Motion carried.**
III. General Action Item(s)	**A.** Approval to Appoint or Reappoint Key Positions to the Ambulatory Surgical Center at LBJ Governing Body 1. Administrator – Matthew Reeder 2. Clinical Manager(s) – Rebecca Lee and Myles Matherne 3. Medical Director – Scott Perry 4. Business Office Manager – Pollie Martinez 5. QA/PI Officer – Amy Kimes 6. Medical Staff Privileges Officer – Adriana Barron 7. Infection Control Coordinator – Maria Taylor 8. Pharmacy Officer – Alvin Nnabuife 9. Risk Manager – Scott Stanley 10. Compliance Officer – Anthony Williams 11. Safety Officer – Harold Sias 12. Radiation Officer – Patricia Svolos 13. Privacy Officer – Catherine Walther 14. Medical Records Officer – Veronica De Leon	**Motion No. 22.05-06** **Moved by Ms. Jennifer Tijerina, seconded by Dr. Glorimar Medina, and unanimously passed that the Governing Body approve III.A. Motion carried.**

IV. ASC at LBJ Medical Director and Administrator Reports	**A.** Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the ASC at LBJ Including Questions and Answers Mr. Reeder stated that the biggest challenge in the ASC is staffing issues. He shared that the ASC is hosting a job fair on June 2, 2022 as they continue to focus on recruitment efforts. Mr. Reeder also discussed the opportunity for technician pay as well as specialty pay for ASC staff in the near future. He mentioned that the ASC is working collaboratively with physician leaders to implement a more appropriate surgical center based set of block guidelines which include a split block. Discussion ensued regarding the committee membership for block utilization as well as criteria for block allocation. Mr. Reeder mentioned that the committee will meet on a quarterly basis. Additionally, Mr. Reeder stated that the ASC launched its pilot program, Ask My Nurse, an interactive process that occurs over the telephone between registered nurse (RN) and patient. Copies of the MEC reports are available in the permanent record.	**As reported.**
V. Executive Session	At 9:21 a.m., Dr. Johnson stated that the Governing Body would enter into Executive Session under Texas Health & Safety Code Ann. §161.032 and Texas Occupations Code Ann. §160.007.	
VI. Reconvene	At 9:40 a.m., Dr. Johnson reconvened the meeting and stated that no action was taken in Executive Session.	
	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ Governing Body, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Possible Action Upon Return to Open Session, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ.	**Motion No. 22.05-07** **Moved by Ms. Jennifer Tijerina, seconded by Ms. Alicia Reyes, and unanimously passed that the Governing Body approve VI.A. Motion carried.**
	B. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Healthcare Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, Including Possible Action Regarding this Matter Upon Return to Open Session.	**No Action Taken.**
	C. Report Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, Including Possible Action Upon Return to Open Session.	**No Action Taken.**

VII. Adjournment	Moved by Ms. Alicia Reyes, seconded by Ms. Jennifer Tijerina, and unanimously approved to adjourn the meeting. There being no further business to come before the Governing Body, the meeting adjourned at 9:41 a.m.	

I certify that the foregoing are the Minutes of the Harris Health System ASC at LBJ Governing Body Meeting held on May 19, 2022.

Respectfully Submitted,

Ewan Johnson, M.D., Chair

Minutes transcribed by Cherry Pierson

Thursday, May 19, 2022

ASC at LBJ Governing Body Attendance

Note: For Zoom meeting attendance, 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.

ASC at LBJ GB BOARD MEMBERS PRESENT	ASC at LBJ GB BOARD MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Dr. Ewan Johnson (Chair)		
Dr. Arthur Bracey (Ex-Officio)		
Ms. Alicia Reyes		
Ms. Jennifer Tijerina		
Professor Marcia Johnson		
Dr. Glorimar Medina-Rivera		
Dr. Scott Perry, Medical Director, ASC		
Mr. Matthew Reeder, Administrator, ASC		

EXECUTIVE LEADERSHIP
Dr. Esmaeil Porsa, President & Chief Executive Officer
Ms. Amy Smith, Senior Vice President, Transitions & Post-Acute Care
Mr. Anthony Williams, Vice President, Compliance Officer
Dr. Jackie Brock, Executive Vice President & Chief Nursing Executive
Dr. Jason Chung, Associate Chief Medical Officer & Senior Vice President, Medical Affairs and Utilization
Dr. Jennifer Small, Interim Executive Vice President, Ambulatory Care Services
Dr. Joseph Kunisch, Vice President, Quality Programs
Mr. Louis Smith, Senior Executive Vice President & Chief Operating Officer
Dr. Matasha Russell, Chief Medical Officer, Ambulatory Care Services
Ms. Olga Rodriguez, Vice President, Community Engagement & Corporate Communications
Dr. Sandeep Markan, Chief of Staff, Ben Taub Hospital
Ms. Sara Thomas, Vice President Legal Affairs/Managing Attorney, Harris County Attorney's Office
Dr. Steven Brass, Executive Vice President & Chief Medical Executive
Dr. Tien Ko, Chief of Staff, Lyndon B. Johnson Hospital

OTHERS PRESENT	
Adriana Barron	Nicholas Bell
Amy Kimes	Paul Lopez
Cherry Pierson	Randy Manarang
Daniel Smith	Rebecca Lee
Elizabeth Winn	Tai Nguyen
Jennifer Zarate	Yasmin Othman
Jerald Summers	

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Consideration of Approval of the 2022–2023 Infection Control Program for the Ambulatory Surgical Center at LBJ Governing Body

ASC at LBJ
Infection Control Program
2022-2023

I. INTRODUCTION

A. Program Description

The Ambulatory Surgical Center at LBJ ("ASC") Infection Control Program ("Program") must maintain a program that minimizes infections and communicable diseases. The Infection Control Program (Program) at a minimum:

1. Provides a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice;
2. Maintains an ongoing program designed to prevent, control, and investigate infections and communicable diseases; and
3. Documents the consideration, selection, and implementation of nationally recognized infection control guidelines.

B. Program Principles and Goals

The ASC Program, under the direction of a designated and qualified professional who has training in infection control, works to accomplish the goals of:

1. Preventing, identifying, and managing infections and communicable diseases;
2. Immediately implementing corrective and preventative measures that result in improvement of infection control; and
3. Protecting the patients, workforce members, visitors, and others in the ASC.

The Ambulatory Surgical Center at LBJ (ASC) accomplishes the Program goals through a coordinated approach to risk reduction of infections. The Program incorporates the analysis of surveillance data to assure ongoing quality assessment and improvement and reports results of the assessment of surveillance data to the appropriate oversight agencies. Workforce members are oriented to the policies and procedures designed to control infections as well as infection control techniques.

II. PROCEDURE

The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. The procedures the ASC follows to maintain the environment include:

1. Utilization of Standard Precautions. Workforce members are expected to maintain an awareness of infection risks and to be on continual surveillance for process improvements;
2. Workforce members adherence to the ASC's Infection Control Plan and its associated policies;
3. Conduction of an annual Infection Control Risk Assessment which serves to guide the quality management activities for the Program; and
4. Analysis of trends and risk factors if infections are identified during surveillance, which will include but not limited to staff, environment and work processes.

Microbiology data, medical records, patient interviews, patient call back information, and physician information will contribute to assessment of Program improvement processes. Adherence to the Program includes but is not limited to:

a. Surveillance for healthcare acquired infections, antibiotic resistant pathogens, and infectious disease outbreaks;
b. Cleaning, disinfection, and sterilization procedures; and
c. Disposal of waste products.

Recommendations for Guidelines for Environmental Infection Control in ASC include but are not limited to:

a. The active involvement of infection preventionist during all phases of a healthcare facility's demolition, construction, and renovation. Activities should include performing a risk assessment of the necessary types of construction barriers.
b. Monitor and document with environmental rounds the negative airflow/ positive airflow in rooms.
c. Document / identify water damage. Repair and drying of wet structural materials within 72 hours, or removal of the wet material if drying is unlikely within 72 hours.
d. Results of infection analysis are reported to the appropriate ASC committees and workforce members to ensure accountability.

III. PROJECTS

A. Hand Hygiene Surveillance
   1. Results will average at or above 95% compliance each quarter
   2. Measurements will be through audits

B. Surgical Site Infections (SSI)
   1. Goal is to be at 0% each quarter.

C. ATP Monitoring
   1. Test the operating room suites, pre-operative bays, and post-operative bays
   2. Results will be maintained at a 99% pass rate each quarter

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Consideration of Approval of the 2022–2023 Quality Improvement Program for the Ambulatory Surgical Center at LBJ Governing Body

ASC at LBJ
Quality Improvement Program
2022-2023

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I. Introduction

A. Program Scope

The Ambulatory Surgical Center (ASC) at LBJ ("ASC") Quality Improvement Program ("Program") must include, but not be limited to, an ongoing demonstration of measurable improvement in patient health outcomes and patient safety and The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control, and other aspects of performance that includes care and services furnished in the ASC.

B. Program Description

The program serves as the foundation of the ASC's commitment to continuously improve the services provided at the ASC. The ASC strives to ensure:

1. Treatment that provides and incorporates effective, evidence-based practices;
2. Services delivered are appropriate to the population served;
3. Risk to patients and Workforce members is minimized and errors in the delivery of services are prevented;
4. Patient needs and expectations are respected and services are provided with sensitivity and kindness; and
5. Care is provided in a timely and efficient manner with appropriate coordination and continuity.

C. Program Principles

Quality improvement at the ASC is a systematic process based on the following principles taken from the Harris Health Quality Manual:

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:

1. Safe: Avoiding harm to patients from care that is intended to help them.
2. Timely: Reducing waits and sometimes-harmful delays for both those who receive and those who give care.
3. 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.)
4. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
5. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

6. 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.

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. so that we could learn from the event and prevent future occurrences.

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

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

Overview: Continuous Program Improvement Activities

The ASC utilizes improvement cycle to include but not limited to PDSA OR DMAIC as the methodology for performance improvement. The ASC 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.

Desired organizational performance results may be achieved through continuous education and involvement of workforce at all levels. Quality improvement involves multiple activities such as:

1. Monitoring the effectiveness and safety of services and quality of care;
2. Measuring and assessing the performance of the ASC's services through the collection and analysis of data;
3. Conducting quality improvement initiatives;
4. Tracking and examining adverse events to educate on and implement improvements that are sustained over time;
5. Taking action when indicated, which includes, but is not limited to, the implementation of new services and/or improvement of existing services

The tools used to conduct these activities are described in Appendix A Quality Improvement Tools.

II. Leadership and Organization

A. Overall Description

The ASC Quality Review Committee (QRC) with approval from the Governing Body must ensure the ASC conducts ongoing surveys and projects to monitor and evaluate the quality of patient care at the ASC that reflects the scope and complexity of services at the ASC. The QRC is required to initiate the regularly-scheduled Patient Safety Data Reporting (As defined in Appendix C) for a number of random cases, and when applicable, review unanticipated operative sequela per the American Association for Accreditation of Ambulatory Surgical Facilities.

B. QRC Membership

The QRC is a multidisciplinary team, including at a minimum, a team leader and an ASC leadership facilitator. The team leader will be trained in facilitation skills, be responsible for leading QRC meetings and remaining on-task, and focus the QRC on the process of improvement. The team leader and facilitator will be responsible for creating an agenda prior to each meeting, keeping the meeting paced, and evaluate effectiveness of the meeting and improve where necessary to facilitate meeting efficiency.

C. QRC Topic Selection

When a Quality Improvement (QI) study topic is presented, the QRC will define the purpose of the QI study topic. Defining it will include a description of the topic and the significance of the topic to the betterment of the ASC. Goals must be measurable, achievable, and verified by external or internal benchmark if available.

D. QRC Responsibilities

The QRC will communicate to the Governing Body, workforce members, and other pertinent recipients of ongoing Quality Improvement Program topics. The QRC will solicit input into ongoing QI initiatives as a means of continually improving performance. Additionally, the QRC will be responsible for:

1. Formation of a QRC;
2. Identifying opportunities for quality improvement;
3. Studying current ASC processes for establishment of specific quality improvement initiatives;
4. Establishing measurable, attainable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of ASC services;
5. Developing outcome measures;
6. Developing and approving the Quality Improvement Program;
7. Establishing a meeting schedule. At a minimum the QRC will meet quarterly or as needed.
8. Coordinating planned communication of the results of QI topics to the ASC; and

9. Reporting to the Governing Body on a regular basis.

Examples of communication methods of the results of the QI topic(s) may include, but are not limited to, the following:

1. Story boards and/or posters displayed in common areas;
2. QRC reporting to recipient group(s);
3. Newsletters and or handouts; or
4. Electronic in-service presentations.

E. ASC Leadership Responsibilities

ASC leadership, through a planned communication approach, will ensure the Governing Body, workforce members, and recipients have knowledge of and input into ongoing QI initiatives as a means of continually improving performance and effectiveness of services provided at the ASC. Additionally, ASC Leadership will:

1. Support and guide implementation of quality improvement studies;
2. Evaluate, review, and approve the Quality Improvement Plan annually; and
3. Provide quality metrics to Harris Health System's Quality Governing Council.

F. Strategic Goals and Quality Objectives

1. The ASC follows development of strategic pillars related to Quality and patient safety, people, population health management and infrastructure optimization.
2. Goals and Objectives have also been developed to support the commitment to Safety, Quality, and Performance Improvement. Please refer to the scorecard and the different metrics as identified in QRC.
3. Strategic Overview
    a. Quality and Patient Safety: The ASC demonstrate quality and patient safety as a core value where zero patient harm is not only a possibility but an exception.

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

Infrastructure Optimization: The ASC will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety and meet the current and future needs of the patients we serve.

As we look forward to the future, our patient care priorities will be implementation of a strong quality and patient safety, people, health management and infrastructure optimization. We will also continue the mission of training the next generation of health care professionals through teaching and development.

III. Quality Improvement Project Development

A. Program Goals and Objectives

The QRC identifies and defines goals and specific objectives to be accomplished each year. Progress in meeting these goals and objectives is part of the annual evaluation of quality improvement activities. The ongoing, long-term goals for the ASC QI Program and the objectives for accomplishing these goals for the year may include:

1. Implementation of quantitative measurement to assess key processes or outcomes;
2. Prioritization of identified problem-prone areas and goal-setting for their resolution;
3. Achievement of measurable improvement in the high risk, high volume, high priority areas;
4. Adherence to internal and external reporting requirements;
5. Education and training of managers, clinicians, and staff;
6. Target specific patient populations and define the amount of time needed to achieve the goal; and
7. Development and/or adoption of tools, such as practice guidelines, consumer surveys, and quality indicators to achieve defined goals.

B. Steps

1. Study Current Processes: The QRC shall use one of the tools in Appendix A to assist in the development of the Quality Improvement Plan.
2. Conduct Research: The QRC will meet with leadership members, clinicians, and staff to review quantitative data and clinical adverse occurrences to identify areas for improvement effolis. The QRC will agree on a specific outcome for an improvement effoli. The QRC will prepare a goal statement for establishing outcome measures and as the research is conducted the goal statement may be refined to be more specific. The QRC will use resources such as the National Library of Medicine (www.nlm.nih.gov) and the National Guideline Clearinghouse (www.guidelines.gov) to conduct research.
3. Prioritize: The QRC will list and prioritize quality improvement topics to be in alignment with the overall goals of the ASC.
4. Benchmark: The QRC will use benchmarks as a key performance improvement tool. Examples of sources for benchmarking include VMG Health (www.vmghealth.com) and the Surgical Outcomes

Information Exchange (www.soix.us). Professional organizations can be consulted for benchmark data as well.

5. Outcome Measurements: Outcome measures will be appropriate and patient focused as well as consistent with the mission and goals of the ASC. Tools such as the clinical value compass (http://clinicalmicrosystem.org/wp-content/uploads/2014/07/clinical-value-compass:pdf) are available to examine processes to guide initiatives.
6. Operational Definitions: Operational definitions will be clear descriptions of specific clinical indicators and the methods by which they will be measured. The definitions will be reliable, valid, and provide consistent and accurate results over time.

IV. Performance Measurement

Performance measurement is used to monitor aspects of the ASC's current QI programs, its systems, and processes. The QRC will compare its current performance with the previous year's performance, as well as benchmarks, to identify opportunities for improvement.

A. Performance Measurement Steps

1. Assessment of the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level;
2. Identification of problems and opportunities to improve the performance of processes;
3. Assessment of the outcome of the care provided; and
4. Assessment of whether a new or improved process meets performance expectations.

B. Measurement and Assessment

1. Selection of a process or outcome to be measured, based on priority;
2. Identification and/or development of performance indicators for the selected process or outcome to be measured;
3. Aggregation of data to quantify the selected process or outcome
4. Assessment of performance indicators at planned and regular intervals;
5. Taking action to address discrepancies when performance indicators show a process is not stable, is not performing at an expected level, or represents an opportunity for quality improvement; and
6. Reporting findings, actions, and conclusions as a result of performance assessment

C. Selection of Performance indicators

A performance indicator is a quantitative tool that provides information about the performance of a clinical process, service, function, or outcome. Selection of a performance indicator is based on the following considerations:

1. Relevance to mission-whether the indicator addresses the population served; and
2. Clinical importance-whether the indicator addresses a clinically important process that is, high volume, problem prone, or high risk.

D. Characteristics of a Performance Indicator

Factors to consider in determining which indicator(s) to use include:

1. Scientific Foundation- the relationship between the indicator and the process, system, or clinical outcome being measured;
2. Validity-whether the indicator assesses what it purports to assess;
3. Resource Availability-the relationship of the results of the indicator to the cost involved and the availability of staffing
4. Patient Preferences-the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences; and
5. Meaningfulness-whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement efforts.

E. Performance Indicator Measurement Tools

Measurement tools can help the ASC gauge the current state of QI activities as well as help the ASC understand whether there is a need for modification of the QI activity. There are three main types of measurement tools:

1. Structural-Measures the ASC's capacity and the conditions in which care is provided by looking at factors such as the ASC's staff, facilities, and/or IT systems.
2. Process-Measures how services are provided, i.e., whether an activity proven to benefit patients was performed, such as writing a prescription or administering a drug.
3. Outcome-Outcomes measure the results of health care. This could include whether the patient's health improved or whether the patient was satisfied with the services received.
4. Balancing Measures-This tool ensures that if changes are made to one part of the system, it doesn't cause problems in another part of the system.

An example of a performance indicator measurement tool is presented in the following Table 1.

Table 1

Prophylactic IV Antibiotic Timing	
Measure Type	**Process**
Description	This measure is used to assess whether intravenous antibiotics given for

	prevention of surgical site infection were administered on time.
Numerator/Denominator	Numerator: Number of Ambulatory Surgery Center (ASC) admissions with an order for a prophylactic IV antibiotic for prevention of surgical site infection who received the prophylactic antibiotic on time.
	Denominator: All ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of surgical site infection.
Inclusions/Exclusions	Numerator Exclusions: None.
	Denominator Exclusions: ASC admissions with a preoperative order for a prophylactic IV antibiotic for prevention of infections other than surgical site infections (e.g. bacterial endocarditis); ASC admissions with a preoperative order for a prophylactic antibiotic not administered by the intravenous route.
Data Sources	ASC medical records, as well as medication administration records, and variance reports may serve as data sources. Clinical logs designed to capture information relevant to prophylactic IV antibiotic administration are also potential sources.
Data Element Definitions	Admission: completion of registration upon entry into the facility.
	Antibiotic administered on time: Antibiotic infusion is *initiated* within one hour prior to the time of the initial surgical incision or the beginning of the procedure (e.g., introduction of endoscope, inse1iion of needle, inflation of tourniquet) or two hours prior if vancomycin or fluoroquinolones are administered.
	Intravenous: Administration of a drug within a vein, including bolus, infusion or IV piggyback.
	Order: a written order, verbal order, standing order or standing protocol.
	Prophylactic antibiotic: an antibiotic prescribed with the intent of reducing the probability of an infection related to an invasive procedure. For purposes of this measure, the following antibiotics are considered prophylaxis for surgical site infections: Ampicillin/sulbactam, Aztreonam, Cefazolin, Cefmetazole, Cefotetan, Cefoxitin, Cefuroxime, Ciprofloxacin, Clindamycin, Ertapenem, Eryth:romycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

F. Assessment

Assessment is accomplished by comparing actual performance of an indicator with past performance over time, benchmark data, internal goals or self-established expected levels of performance, evidence-based practices, and/or similar service providers.

V. Testing for Improvement

The Model for Improvement, developed by Associate in Process Improvement, provides a framework for developing, testing, and implementing change. This model is a tool for accelerating improvement and can successfully improve care processes and outcomes. The model is comprised of two paiis:

A. Three fundamental questions that are essential for guiding improvement:

1. What is the ASC trying to accomplish? The ASC's response to this question helps to clarify which improvements the ASC should target and the ASC's desired results.

2. How will the ASC know that a change is an improvement? Actual improvement can only be proven through measurement. The ASC should determine how it wants things to be different when a change is implemented and agree on what data needs to be collected for measuring. A measureable outcome that demonstrates movement toward the desired result is considered an improvement.
3. What changes can the ASC make that will result in improvement? Improvement occurs only when a change is implemented, but not all changes result in improvement. One way to identify whether a change will result in improvement is to test the change before implementing it.

Figure 2.1: Model for Improvement

B. The "Plan-Do-Study-Act" (PDSA)

The PDSA cycle tests and implements a change in a real-work setting. The PDSA cycle is shorthand for testing a change by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

1. Plan

   Before changes are tested, the team should secure the support of those individuals and departments that will be affected. Whether the reason for change is due to patient challenges, unreliability, or a continual improvement opportunity, it is important to keep people informed. This ensures their cooperation and results in an effective test of change.
2. Do

Testing the change occurs during the Do stage. The QI team tests the change and collects the required data to evaluate the change. Any problems and observations during the test are documented.

3. Study

   In the Study stage, the QI team learns all it can from the data collected during the Do and considers the following:

   - Is the process improved?
   - If improved, by how much?
   - Is the objective for improvement met?
   - Is the process more difficult using new methods? Did anything unexpected happen?
   - Is there something else to learn?

4. Act

   The responses derived from the Study stage define the QI team's tasks for the Act stage. For example, if the process is not improved, the QI team may review the change tested to determine the reason, then further refine the process, or plan another test cycle. The QI team may choose to start again with a new test cycle based on the analysis. If the problem is unsolved, the QI team may return to the Plan stage to consider new options. If the process improves, the QI team should determine whether the improvement is adequate. For example, if the improvement speeds up the process, the QI team should evaluate the improvement to determine whether the change is fast enough to meet its requirements. If not, the QI team may consider additional methods to modify the process until its improvement objectives are met. It also may consider testing the same step of the process, or possibly a different step in the process, to reach its overall goal. Again, the QI team is back at the Plan stage of the PDSA cycle. For most system changes in health care, multiple small tests of change are needed to improve one system. These tests are performed in a very short time so overall improvements can be accomplished efficiently.

VI. Evaluation

Measuring the actual change process is the only way to know if change results in an improvement. The ASC's QI team actions are determined by what it learns from the change. This stage includes analyzing the test cycles, reflecting on what was learned, comparing predictions to the data collected, and making decisions. Since change in one area of the organization can impact another, it is imp01iant to review the entire system and ensure another area is not adversely affected.

An evaluation is completed at the end of each calendar year. The evaluation summarizes the goals and objectives of the Quality Improvement Program, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings. The evaluation will contain the following elements:

1. A summary of the progress towards meeting the goals/objectives.
2. A summary of progress towards goals, including progress in relation to overall ASC goal(s).
3. A summary of the findings for each of the indicators used during the year (the summaries should include both the outcomes of the measurement process, the conclusions, and actions taken in response to these outcomes)
4. A summary of progress in relation to Quality Initiative(s):
5. For each initiative, provide a brief description of what activities took place including the results on your indicator.
6. What are the next steps?
7. How are the results sustained?
8. Describe implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes at your program in the corning year.
9. Any recommendations based upon the evaluation of the quality initiatives, and the actions the QRC determines are necessary to improve the effectiveness of the QI Program moving forward.

APPENDIX A

Quality Improvement Tools: The following tools are available to assist in the Quality Improvement process.

Flow Charting: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the QI team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the QI team may want to then re- plot the modified process to show how the redefined process should occur. Two flow chart processes the QRC may consider are clinical pathways and Failure Mode Effects Analysis (FMEA).

Brainstorming: A tool used to bring out the ideas of each individual and present them in an orderly fashion. Essential to brainstorming is to provide an environment free of criticism. QI team members generate issues and agree to "defer judgement" on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take.

Decision-making Tools: While not all decisions are made by QI teams, two tools can be helpful when QI teams need to make decisions.

1. Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a sh01i list identifying what is important to the QI team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of QI team agreement.
2. Nominal Group is a technique used to identify and rank issues.

Affinity Diagram: The Affinity Diagram is often used to group ideas generated by brainstorming. The Affinity Diagram is a tool that gathers large amounts of data (ideas, issues, opinions) and organizes this data into groupings based on natural relationships. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. As a rule of thumb, if less than 15 items of information have been identified, the affinity process is not needed.

Cause and Effect Diagram (also called a fishbone or Ishakawa diagram): This is a tool that helps identify, sort, and display causes of a specific event. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a

problem. The structure of the diagram helps QI team members think in a very systematic way. Cause and effect diagrams allow the QI team to identify and graphically display all possible causes related to a process, procedure or system failure.

Histogram: A histogram is a ve1iical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation.

Pareto Chart: Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process by helping to identify which problems need further study, which causes to address first, and which problems are the "biggest problems."

Run Chart: A Run Chart shows how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed.

Control Chart: A control chart is a statistical tool used to distinguish between variation(s) in a process that result from (a) common causes and (b) special causes. Common cause variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing whether data falls within control limits based on plus or minus specific standard deviations from the center line.

Bench Marking: A benchmark is a point of reference by which something can be measured, compared, or judged. A benchmark may be an industry standard against which a program indicator is monitored and found to be above, below or comparable to the benchmark.

Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

Appendix B

ASC CMS QUALITY REPORTING MANUAL

Measure Information Form

Measure Title: Patient Fall

Measure ID #: ASC-2

Quality Reporting Option: Claims-based outcome measure

Reporting Mechanisms: Medicare Part B Fee-for-Service Claims, including for Medicare Railroad Retirement Board beneficiaries and Medicare Secondary Payer claims

Reporting Period: The reporting period for Medicare claims begins January 1 and continues until December 31 of each calendar year.

Reporting Required By: All entities paid under the Medicare Ambulatory Surgical Center Fee Schedule (ASCFS), regardless of specialty or case mix

Description: The number of admissions (patients) who experience a fall within the ASC

Denominator: All ASC admissions
Inclusions: All ASC admissions
Exclusions: None

Numerator: ASC admissions experiencing a fall within the confines of the ASC
Inclusions: ASC admissions experiencing a fall within the confines of the ASC
Exclusions: ASC admissions experiencing a fall outside the ASC

Numerator Quality-Data Coding Options for Reporting:
08910: Patient documented to have experienced a fall within the ASC
08911: Patient documented not to have experienced a fall within the ASC
08907: Patient documented not to have experienced any of the following events: a burn prior to discharge; a fall within the facility; wrong site, wrong side, wrong patient, wrong procedure, or wrong implant event; or a hospital transfer or hospital admission upon discharge from the facility
Note: If using code 08910 or 08911, do not use code 08907.

Definitions:

Admission- Completion of registration upon entry into the facility

Fall- A sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions (source: National Center for Patient Safety)

Selection Basis: "Falls per 100,000 patient days" has been endorsed as a serious reportable event by the NQF. While ASCs have a relatively low incidence of adverse events in general; information regarding the incidence of patient falls is not currently available. However, stakeholders have expressed a general interest in the public reporting of such adverse events. Due to the use of anxiolytics, sedatives, and anesthetic agents as adjuncts to procedures, patients undergoing outpatient surgery are at increased risk for falls.

Clinical Recommendation Statements: According to the Agency for Healthcare Research and Quality's Prevention of Falls in Acute Care guideline, patient falls may be reduced by following a four-step approach: 1) evaluating and identifying risk factors for falls in the older patient; 2) developing an appropriate plan of care for prevention; 3) performing a comprehensive evaluation of falls that occur; and 4) performing a post-fall revision of plan of care as appropriate. Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

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APPENDIX C:

PATIENT SAFETY DATA REPORTING

I. In General:

A. Patient Safety Data Reporting is performed every month and reported quarterly. It includes the reporting of 3 Random Cases for each physician per quarter and all Adverse Events using the required AAAASF forms and reporting format. A random sample of the cases for each surgeon must include the first case done by each surgeon each month during the rep01iing period for a total of three cases, plus all adverse events.

B. If a surgeon has performed less than three cases during a repo1iing period that must be reported to the AAAASF Central Office on the provider exemption form and all of that surgeon's cases during the reporting period must be reported.

C. Patient Safety Data Reporting in the ASC at LBJ will be done either by a recognized peer review organization or by a physician, podiatrist, or oral and maxillofacial surgeon, who is not the operating room surgeon.

II. Random Case Review:

A. All random case reviews must include an assessment of the following:

1. Adequacy and legibility of the history and physical exam;
2. Adequacy and appropriateness of the surgical consent form;
3. Presence of the appropriate laboratory, EKG, and radiographic reports;
4. Presence of a dictated or written operative repo1i, or its equivalent;
5. Anesthesia record;
6. Presence of instructions for post-operative and follow-up care; and
7. Documentation of complications;

III. Adverse Events:

A. All adverse events which occur within thirty (30) days of surgery are reviewed, including but not limited to the following:

1. An Unplanned hospital admission;
2. A return to the operating room due to a complication of a previous procedure;
3. Untoward result of procedure such as an infection, bleeding, wound dehiscence, or inadvertent injury to another bodily structure;
4. Cardiac or respiratory problems during a stay at the ASC at LBJ or within forty-eight (48) hours of discharge;

5. An allergic reaction to medication;
6. An incorrect needle or sponge count;
7. A patient or family complaint; and
8. An equipment malfunction leading to an injury or potential injury to the patient.

B. Each adverse event chart review includes an assessment of the following information, in addition to the operative procedure performed:

1. Identification of the problem;
2. Immediate treatment or disposition of the case;
3. The patient's outcome;
4. An analysis of the reason for the problem; and
5. An assessment of the efficacy of the treatment.

IV. Death:

A. Any death occurring within thirty (30) days of a procedure done in the ASC at LBJ must be reported to AAAASF within five (5) days of notification of the death.

To obtain a copy of AAAASF's Patient Safety Data Repotting exemption forms, please follow the below link: https://www.aaaasf.org/patient-safety-data-reporting-documents/

APPENDIX D:

AAAASF PATIENT SAFETY DATA REPORTING RANDOM CASE FORM

To obtain a copy of AAAASF's Patient Safety Data Reporting Random Case form, please follow the below link:

https://www.aaaasf.org/patient-safety-data-reporting-documents

APPENDIX E:

AAAASF PEER REVIEW ADVERSE EVENT FORM

To obtain a copy of AAAASF's Adverse Event Review form, please follow the below link:

https://www.aaaasf.org/patient-safety-data-reporting-documents

STRATEGIC GOALS AND QUALITY OBJECTIVES

The ASC follows development of strategic pillars related to Quality and patient safety, people, population health management and infrastructure optimization.

Goals and Objectives have also been developed to support the commitment to Safety, Quality and Performance Improvement. Please refer to the scorecard and the different metrics as identified in QRC.

Strategic Plan Overview:

- Quality and patient safety: The ASC demonstrate quality and patient safety as a core value where zero patient harm is not only a possibility but an expectation.
- People: The ASC will enhance the patient, employee and medical staff experience and develop a culture of respect, recognition and trust by actively listening to feedback and developing strategies to address high-impact areas of opportunity.

Infrastructure optimization: The ASC will invest in and optimize infrastructure related to facilities, information technology (IT) and telehealth, information security, and health informatics to increase value, ensure safety and meet the current and future needs of the patients we serve.

As we look toward the future, our patient care priorities will be implementation of a strong quality and patient safety, people, health management and infrastructure optimization. We will also continue the mission of training the next generation of health care professionals through teaching and development.

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Consideration of Approval of the Governing Body Bylaws of the Ambulatory Surgical Center at LBJ Governing Body

Final

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

GOVERNING BODY BYLAWS OF

THE AMBULATORY SURGICAL CENTER (ASC) AT LBJ

Final

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PREAMBLE

WHEREAS, The Ambulatory Surgical Center at LBJ, ("ASC") is an ambulatory surgical center, as defined in Title 25, Part 1, Chapter 135, of the Texas Administrative Code, as amended; and

WHEREAS, the ASC is wholly owned by the Harris County Hospital District d/b/a Harris Health System ("Harris Health"), which is organized under the laws of the State of Texas and pursuant to Chapter 281 of the Texas Health and Safety Code Ann. as amended; and

WHEREAS, the ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services will not exceed twenty-four (24) hours following an admission; and

WHEREAS, subject to oversight by the Harris Health Board of Trustees, the ASC Governing Body assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's operation, including the quality and safety of the medical care in the ASC, and holding the medical staff of the ASC accountable to fulfill the ASC's obligations to its patients; and

THEREFORE, the practitioners and Advanced Practice Professionals practicing in the ASC shall carry out the functions delegated to the medical staff of the ASC by the Governing Body in compliance with these Bylaws and the Medical Staff Bylaws of the ASC.

DEFINITIONS

1. The term "Advanced Practice Professional" means an individual who holds a state license in his/her profession as well as other educational credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Optometrist (OD), Certified Nurse Midwife (CNM), Clinical Psychologist, Registered Dietician, Microbiologist, Pathology Assistant, and other non-physician healthcare providers/researchers who provide services to patients in categories approved by the Board of Trustees.
2. The term "Medical Staff" means all practitioners (as such term is defined below) who maintain privileges to treat patients in the ASC.
3. The term "Medical Director" shall refer to the person filling that office pursuant to Article VI.
4. The term "ASC Governing Body" means the body with governing authority of the ASC. The ASC Governing Body has oversight and accountability for the quality assessment and performance improvement program, and ensures that the facility policies and programs are administered to provide quality healthcare in a safe environment. "Ex-officio" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

ARTICLE I: NAME

The name of the organization governed by these Bylaws shall be The Ambulatory Surgical Center

at LBJ (ASC).

ARTICLE II: PURPOSE

The purposes of this organization are:

1. To operate a licensed, certified, and accredited ambulatory surgery center;
2. To provide the best possible care for all patients admitted to or treated in any of the facilities, departments, or services of the ASC;
3. To provide the community with a facility in which medical and surgical procedures can be safely carried out on a short-stay basis;
4. To ensure a high level of professional performance of all Medical Staff members authorized to practice in the ASC through appropriate delineation of the clinical privileges that each Medical Staff member may exercise (see Article VII) and through an ongoing review and evaluation of each Medical Staff member's performance; and
5. To provide an appropriate educational setting for Medical Staff members that will maintain medical and scientific standards that will lead to continuous advancement in professional knowledge and skill.

ARTICLE III: ASC GOVERNING BODY

Section 1. General Responsibilities

The ASC Governing Body is responsible for determining, implementing, and monitoring policies governing the ASC's total operation. The ASC Governing Body has oversight and accountability for the quality assessment and performance improvement program, and ensures that the facility policies and programs are administered to provide quality healthcare in a safe environment. The ASC Governing Body is also responsible for developing and maintaining a disaster preparedness plan. The ASC Governing Body may delegate day-to-day operational responsibilities to administrative, medical, or other personnel, but retains the ultimate responsibility for the overall operations of the ASC and quality of its services. Any delegation of the ASC Governing Body's authority must be documented in writing. The ASC Governing Body is responsible for ensuring that the Harris Health Board of Trustees ("Board of Trustees") is provided with ASC operating and quality reports on at least a quarterly basis. The ASC quality reports may be reported to the Harris Health Quality Governance Council, who reports to the Board of Trustees.

Commented [TLS1]: Is this happening?

Section 2. Appointment, Number, Term, Membership and Qualifications

The members of the ASC Governing Body shall be appointed by the Board of Trustees.

The ASC Governing Body shall consist of six (6) members. The ASC Governing Body will include three (3) members of the Board of Trustees appointed to be on the ASC Governing Body. Each of the three (3) members who are also members of the Board of Trustees shall hold office for two (2) years

or until his/her resignation, retirement, removal, disqualification or his/her successor is appointed by the Board of Trustees. The terms of three (3) members who are also members of the Board of Trustees expire on November 1st of odd years and the term of one member expires on November 1st of even years. These three (3) members will continue to serve until their successors are appointed. These three (3) members are eligible for reappointment at the discretion of the Board of Trustees. The Harris Health Executive Vice President and Chief Nursing Executive shall also be a voting member of the ASC Governing Body. The members of the ASC Governing Body shall also include two (2) non-voting ex-officio members: the Medical Director of the ASC and the Nursing Director/Administrator of the ASC. In the event of a tie vote of the voting members of the Governing Body, the Medical Director shall cast the deciding vote. All ASC Governing Body members serve without compensation and may be removed, with or without cause, by the Board of Trustees.

Section 3. Powers Reserved to Harris Health Board of Trustees

The ASC Governing Body has no authority to commit expenditures of Harris Health funds without prior approval by the Board of Trustees and compliance with the Harris Health Purchasing Manual.

ARTICLE IV: MEETING OF GOVERNING BODY

Section 1. Regular Meetings

The ASC Governing Body shall meet a minimum of four (4) times per year, one of these meeting shall serve as an annual meeting of the ASC Governing Body. The meeting shall be held at such place as the ASC Governing Body may designate. Additional meetings may be held at the discretion of the ASC Governing Body to conduct the business of the ASC.

Regular meetings shall include, without limitation, the following items:

a. Disposition of minutes of previous meetings;
b. Consent Items;
c. Reports and recommendations from the Medical Executive Committee regarding credentialing and peer review and from the Quality Review Council regarding quality of care for the ASC Governing Body's consideration;
d. Items relating to fiscal affairs, including statistical and financial reports, together with cumulative reports for the fiscal year-to-date;
e. Reports and items from standing committees; if any;
f. Reports and items from special committees, if any;
g. Miscellaneous items;
h. Administrator's Report;
i. Medical Director's Report; and
j. Executive session items.

Commented [TLS2]: Does ASC have consent agenda items?

Commented [TLS3]: Are there committees of the ASC?

Commented [JCR4]: We need to replace this with someone else's report, but I'm not sure who. Maureen? Matt?

Section 2. Special or Emergency Meetings

Special meetings of the ASC Governing Body may be called by the Chair or another Member of the ASC Governing Body. A special meeting shall be for the purpose of considering the item or items on the agenda for such a meeting.

Section 3. Notice of Meetings

For all regular meetings, the members shall be notified in writing not less than seventy-two (72) hours in advance of the scheduled meeting.

A schedule of regular meetings of the ASC Governing Body shall be published annually.

For special or emergency meetings, dependent upon the time available and the urgency of the occasion, members may be notified by mail, telephone, e-mail, or facsimile transmittal, setting out the date, time, and specific purpose of the special or emergency meeting.

Notice of each meeting shall be posted as required by the Texas Open Meetings Act.

Section 4. Quorum

The presence of at least three (3) ASC Governing Body voting members, two (2) of whom are also members of the Board of Trustees, shall constitute a quorum for the transaction of business.

Section 5. Attendance

Each member of the ASC Governing Body is expected to attend at least 70% (seventy percent) of the regularly scheduled meetings, including appropriate committee meetings during any 12-month period.

Section 6. Manner of Acting

Except as otherwise provided in these bylaws, the act of the majority of the members present at a meeting at which a quorum is present shall be the act of the ASC Governing Body.

Section 7. Public Meetings

All meetings of the ASC Governing Body shall be open to the public, except that the ASC Governing Body may hold Executive Sessions in accordance with the Texas Open Meetings Act.

Section 8. Committees of the ASC Governing Body

The ASC Governing Body, by resolution adopted by a majority of the members of the ASC Governing Body present at a meeting at which a quorum is present, may designate members to constitute committees, standing or special. The committees shall make recommendations to the ASC Governing Body.

Section 9. Rules of Order

a. Robert's Rules of Order Newly Revised (12th edition, or such later edition, as may be appropriate) shall govern the proceedings of the meetings of the ASC Governing Body in all matters not inconsistent with these Bylaws or the Constitution and laws of the State of Texas. Notwithstanding anything contained in such Rules to the contrary, the Chair of the ASC

Governing Body may vote on any matter before the ASC Governing Body.

b. If any member or members in the minority on any question wishes to present a written minority opinion to the ASC Governing Body Secretary, such opinion shall be filed with the permanent records of ASC.

c. The ASC Governing Body shall not entertain any motions or resolutions involving the expenditure of Harris Health funds of the ASC until the availability of such funds is certified to the ASC Governing Body by the Chief Financial Officer of Harris Health or his/her designee.

ARTICLE V: OFFICERS

Section 1. Officers of the ASC Governing Body

The ASC Governing Body at its annual meeting to be held in March of each year shall elect a Chair, and may elect such other officers, which may include a Vice Chair, a Secretary, and other officers and assistant officers, as the ASC Governing Body deems necessary or advisable for the efficient operation of the ASC's affairs. Any two or more offices may be held by the same person.

Section 2. Election and Term

Officers of the ASC, if any, shall be elected bi-annually by the ASC Governing Body at the March Annual Meeting of the ASC Governing Body. Each officer shall hold office until his successor shall have been duly elected or until his or her prior death, resignation, or removal.

Commented [TCM5]: If it's bi-annually shouldn't we put another month? All we have is March.

Section 3. Duties of the Officers

a. Duties of the Chair

The Chair shall preside at all meetings of the Governing Body. With the approval of the Governing Body, the Chair may appoint various committees as necessary to accomplish the goals of the Governing Body.

b. Duties of the Vice Chair

The Vice Chair shall perform the duties of the Chair in his/her absence or in the event of his/her resignation, death, disability, or removal pending election of a successor Chair.

c. Duties of the Secretary

The Secretary shall see that suitable records are maintained of each meeting of the Governing Body and committees of the Governing Body, and shall submit the minutes at the next meeting of the Governing Body or committee, as applicable. After approval, such records shall be read and signed by the Chair or the member presiding, and attested by the Secretary of the meeting, if applicable.

The Secretary shall cause all members of the Governing Body to be notified of all Governing Body meetings in the following fashion:

For all regular meetings, the members shall be notified in writing not less than seventy-two (72) hours in advance of the scheduled meeting.

b. For special or emergency meetings, dependent upon the time available and the urgency of the occasion, members may be notified by mail, telephone, e-mail, or facsimile transmittal, setting out the date, time, and specific purpose of the special or emergency meeting.

Notice of each meeting shall be posted as required by the Texas Open Meetings Act.

ARTICLE VI: ADMINISTRATION

Section 1. ASC Governing Body Responsibilities

1. *Medical Staff.* The ASC Governing Body is responsible for the conduct of the members of the ASC Medical Staff. In fulfillment of this responsibility, the ASC Governing Body shall provide for the establishment of a Medical Staff and shall act as the final authority with regard to all appointments, the granting, restricting or revocation of clinical privileges; all corrective action and the involuntary termination of staff membership. The ASC Governing Body shall approve the Medical Staff Bylaws, its organizational structure and rules and regulations. The ASC Governing Body reserves the right to change the Bylaws of the Medical Staff when, after due course, the Medical Staff has failed to do so when necessary in order to comply with the passage of law, change in accreditation standards or other changes in federal or state laws or statutes.
2. *Administration.* The ASC Governing Body is responsible for the appropriate management and administration of the ASC. In fulfillment of this responsibility, the ASC Governing Body shall employ an appropriate qualified, competent Administrator; establish an annual operating budget; and establish such policies as are necessary to properly guide the ASC's operations.
3. *Quality Improvement.* The ASC Governing Body is responsible for utilization, quality, appropriateness of procedures, and the appropriateness of medical care rendered by and at the ASC. In fulfillment of this responsibility, the ASC Governing Body shall cause to be established a Quality Improvement program, which will effectively monitor the quality of care and utilization of facilities with the reports of such activities, made to the ASC Governing Body at least annually.
4. *Standards.* The ASC Governing Body is responsible for maintaining the ASC programs and services in line with the community and other appropriate standards. In fulfillment of this responsibility, the ASC Governing Body directs that the ASC meet and maintain standards for licensure as an ambulatory surgery center in the state of Texas, for participation in the Medicare program, and accreditation by an organization of the ASC Governing Body's choice.

Section 2. Administrator

1. *Appointment.* The Administrator shall be approved by the ASC Governing Body and must be a Registered Nurse.
2. *Responsibilities.* The duties of the Administrator include:

A. Execute the mission and goals of the facility.

B. Provide for careful maintenance of patient rights.
C. Call upon and coordinate use of corporate personnel and system resources. This includes but is not limited to, corporate legal and financial data processing, staffing, credentialing, marketing, human resources, and development expertise.
D. Build the ASC's reputation with the community in general.
E. Provide responsibility for business development of the center in conjunction with Harris Health System Business Development/Marketing Department.
F. Participate in professional and community organizations to promote public relations in areas relating to healthcare.
G. Understand, implement, and maintain personnel policies, employee benefits, a wage and salary program, and appropriate job descriptions that have approval by the ASC Governing Body
H. Establish and maintain appropriate internal organizational lines of communication, authority, and accountability. Develops improved management techniques and practices.
I. Assist in negotiation and execution of ASC contracts.
J. Participates and coordinates selection and training of new management team members.
K. Coordinates, with members of the management team, the center's philosophy and objectives related to staff performance standards, policies and procedures, job classifications, and compliance with government regulations.
L. Assist the Medical Staff in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
M. Provide a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
N. Ensure that appropriate policies and procedures are developed by the Medical Staff for the safe, effective conduct of business and provision of patient care.
O. Assist the Medical Staff in developing Quality Improvement, Risk Management and Peer Review programs in accordance with applicable standards.
P. Ensure that all provisions are made for ancillary services including laboratory, radiology, and pathology services; and assure that appropriate transfer agreements have been entered into with a local hospital.
Q. Ensure that the organization does not discriminate on the basis of race, creed, sex, national origin or religion.
R. Formulate short and long range plans in accordance with the missions and goals of the facility.

Section 3. Medical Director

1. *Appointment.* The Medical Director shall be appointed and approved by the ASC Governing Body and shall serve for a period of two (2) years. The Governing Body may reappoint the Medical Director for additional two-year terms unless the appointment is otherwise cancelled by the Governing Body or the Medical Director. The Medical Director appointment may be cancelled by either the Governing Body or the Medical Director by providing thirty (30) days written notice to either party. The Medical Director shall perform the duties assigned by the ASC's Governing Body and by the Governing Body Bylaws and Medical Staff Bylaws of the ASC.
2. *Responsibilities.* The Medical Director is invested with the following duties and prerogatives:

A. Call and preside over Quality Improvement (QI) meetings.
B. Facilitate adherence of the Medical Staff of the ASC to the ASC Bylaws.
C. Be chief spokesperson and enunciator of policy for the Medical Staff.

D. Monitor adherence to policies with respect to patient rights.
E. Assist the Administrator in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
F. Assist the Administrator in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
G. Take the initiative in developing, on behalf of the Medical Staff, appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures of the ASC. The Medical Director shall be specifically authorized to approve (after consultation with the appropriate QI specialty representatives) and implement policies and procedures (subject to such subsequent QI review and ASC Governing Body ratification).
H. Take the initiative in developing, on behalf of the Medical Staff, Quality Improvement, Risk Management, and Peer Review programs in accordance with applicable standards.
I. Advise the Administrator in arranging for ancillary services including laboratory, radiology, and pathology services.
J. Carry out all other duties specifically entrusted to him/her by the QI, ASC Governing Body or any other provision of these Bylaws.

Section 4. Appointment /Reappointment of Members of the Medical Staff

The ASC Governing Body shall approve the mechanism for initial appointment and biennial reappointment to the Medical Staff. This process shall be identified in the ASC Medical Staff Bylaws. The ASC Governing Body shall approve the delineation of clinical privileges and shall act to approve/disapprove changes to the delineation of clinical privileges recommended by the ASC's Medical Executive Committee. The ASC's Medical Executive Committee shall review the applications and qualifications of all applicants to the Medical Staff and recommend to the ASC Governing Body professionals for appointment to the Medical Staff. The authority to approve members of the ASC Medical Staff resides solely with the ASC Governing Body.

Commented [TLS6]: Bi-annual?

Do we want it to happen twice a year or once every two years? If it's the former then it's biannual.

ARTICLE VII: GENERAL PROVISIONS

Section 1. Indemnification

Subject to consultation with the Harris County Attorney's Office and prior approval by the Board of Trustees, the ASC Governing Body may engage private legal counsel to represent a member of the ASC Governing Body in any legal matter arising out of the good faith performance of his/her public duties. To the extent permitted by law, each member of the ASC Governing Body may be indemnified by Harris Health against any other costs, expenses, and liabilities which are imposed upon or reasonably incurred by him/her by reason of his/her being or having been such member subject to approval by the Board of Trustees except if the member has been guilty of fraud, acted in bad faith, or engaged in gross negligence or willful misconduct. Provision of private legal counsel and/or indemnification in any legal matter must be conditioned on a finding by the Board of Trustees that 1) the provision of the defense and/or indemnification is in the public interest and not merely in the private interest of the member involved, and 2) the member was acting in good faith within the scope of his or her official duties. A not to exceed amount, reasonable legal fees, and customary expenses shall be advanced to the member upon his/her execution of an undertaking letter to Harris Health agreeing that upon a finding of the Harris Health Board of Trustees or a final court determination that

the indemnified member was not acting in good faith that he/she shall reimburse Harris Health for advanced legal fees and expenses.

Section 2. Fiscal Year

The fiscal year of the ASC begins on March 1 and ends on the last day of February.

Section 3. Amendments

Except as otherwise provided herein, these bylaws may be amended upon:

A majority vote of the ASC Governing Body and approval by a majority of the Board of Trustees.

Section 4. Minutes, Books, and Records

The ASC shall keep correct and complete books and records and shall also keep minutes of the proceedings of the ASC Governing Body and committees. The books, records and papers of the ASC shall be at all times, during reasonable business hours, subject to inspection as provided by the Texas Public Information Act. The ASC Medical Staff Bylaws shall also be available for inspection.

Section 5. Review

These Bylaws shall be reviewed annually by the ASC Governing Body.

Section 6. Conflict of Laws

If any provision of these Bylaws conflicts with any statute or other law of the State of Texas, such statute or law, as long as it is in effect, shall take precedence over these Bylaws.

Section 7. Adoption

These Bylaws become effective immediately upon the later date of their acceptance and adoption by both the ASC Governing Body and the Board of Trustees.

Accepted and adopted by the Harris Health Board of Trustees of the Harris County Hospital District d/b/a Harris Health System in Harris County, Texas on Thursday, _____ ____, 2021.

Accepted and adopted by the ASC Governing Body in Harris County, Texas on _____ [Insert Date].

_____
Ewan Johnson, M.D., Ph.D.
Chair, ASC Governing Body
The Ambulatory Surgical Center (ASC) at LBJ

_____
Kimberly Monday, MD
Chair, Board of Trustees
Harris County Hospital District d/b/a
Harris Health System

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Consideration of Approval of the Medical Staff Bylaws of the Ambulatory Surgical Center at LBJ Governing Body

Medical Staff Bylaws

February 2021

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

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HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

BYLAWS

OF THE

AMBULATORY SURGICAL CENTER (ASC) AT LBJ HOSPITAL

MEDICAL STAFF

PREAMBLE

WHEREAS The Ambulatory Surgical Center at LBJ, (ASC) is an ambulatory surgical center, as defined in Title 25, Part 1, Chapter 135, of the Texas Administrative Code, as amended; and

WHEREAS, the ASC is wholly owned by the Harris County Hospital District d/b/a Harris Health System (Harris Health), which is organized under the laws of the State of Texas and pursuant to Chapter 281 of the Texas Health and Safety Code Ann. as amended; and

WHEREAS, the ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services will not exceed twenty-four (24) hours following an admission; and

WHEREAS, subject to oversight by the Harris Health Board of Trustees, the ASC Governing Body assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's operation, including the quality and safety of the medical care in the ASC, and holding the medical staff accountable to fulfill the ASC's obligations to its patients; and

WHERAS, the ASC Governing Body has approved these ASC Medical Staff Bylaws.

THEREFORE, the Practitioners and Advanced Practice Professionals practicing in the ASC shall carry out the functions delegated to the Medical Staff by the Governing Body in compliance with these Bylaws.

DEFINITIONS

Whenever the context requires, words of masculine gender used herein shall include the feminine and the neuter, and words used in the singular shall include the plural.

1. The term **"ACTIVE STAFF"** shall consist of those Medical Staff members who assume all the functions and responsibilities of membership on the Active staff.
2. The term **"ADVANCED PRACTICE PROFESSIONAL" (APP)** shall be defined as an individual who holds a state license in their profession as well as other educational credentials attesting to training and qualifications to provide services in one or more of the following categories: Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS).

3. The term "**AFFILIATE STAFF"** shall consist of Medical Staff members who may provide patient care and participate in staff activities in a non-voting capacity.

4. The term "**ATTENDING STAFF**" means all Medical Staff holding faculty appointments at The University of Texas Health Science Center at Houston, and/or Baylor College of Medicine and approved by the credentialing mechanisms of the ASC. Medical school faculty appointment status is not required for Practitioners or Advanced Practice Professionals employed by Harris Health, or Contract Practitioners.

5. The term "**BOARD CERTIFIED"** means a designation that the Practitioner is certified in his or her specialty by the American Board of Medical Specialties, American Osteopathic Association, Amercian Board of Dental Specialties, or American Board of Podiatric Medicine.

6. The term "**BOARD ELIGIBLE**" means a designation that the Practitioner has satisfied all requirements to be eligible to take the certification examination(s) in accordance with appropriate certifying board.

6. The term **"CLEAN APPLICATION"** shall mean a completed application in which all aspects of the application are complete; all references have been returned with all questions fully answered as either superior or good; the applicant has not been a party to any malpractice cases, adverse actions involving medical staff membership, clinical privileges or licensure/certification requiring further investigation; and all training, licensure, National Practitioner Data Bank, and OIG database information has been verified, with the results of such verification found to be acceptable. The term "Clean Application" may also be applied to an application from a Medical Staff member requesting new clinical privileges.

7. The term **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the permission granted by the Governing Body to a Practitioner to provide those diagnostic, therapeutic, medical, or surgical services which the Practitioner has been approved to render.

8. The term **"COMPLETED APPLICATION"** shall mean a signed Texas State Standardized Application and ASC Addendum in which all questions have been answered, current copy of licensure (State, DEA, DPS), peer reference letters, delineation of clinical privileges or job description, current appropriate professional liability insurance, National Practitioner Data Bank, OIG, Board Status, hospital affiliations, and verification of any other relevant information from other professional organizations according to the ASC Medical Staff Bylaws and Credentialing Procedures Manual. Additionally, all information and documentation has been provided, and all verifications solicited by the ASC have been received and require no further investigation. A completed application may be determined to be incomplete, based upon the review of Medical Staff Services, the Medical Director, or the Medical Executive Committee.

10. The term "**CONTRACT PRACTITIONER**" means, unless otherwise expressly limited, all physicians, podiatrists, or dentists who are appointed to the Medical Staff and (i) whose patient care services are contracted for by Harris Health and are performed within the ASC; (ii) are not affiliated with Baylor College of Medicine and/or The University of Texas Health Science Center at Houston; and (iii) are not employed by Harris Health to provide healthcare services at designated Harris Health Facilities. All Contract Practitioners will be categorized as Affiliate Staff.

11. The term "**CREDENTIALING PROCEDURES MANUAL"** shall mean the policy containing additional details related to the credentialing process of the ASC, as further detailed in Article XVI of these Bylaws.

12. The term **"DAYS"** shall mean calendar days, including Saturdays, Sundays, and holidays unless otherwise specified herein. Days are counted beginning on the day following the transmittal or receipt of a notice or other required correspondence.

13. The term **"DENTIST"** means an individual with a D.D.S. or equivalent degree licensed or authorized to practice dentistry by the State of Texas.

14. The term **"EXECUTIVE SESSION"** means any meeting or portion of any meeting, of any section, department, or committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed.

15. The term **"EX-OFFICIO"** shall mean service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, refers to a position without voting rights.

16. The term **"FEDERAL HEALTH CARE PROGRAM"** shall mean any plan or program that provides health benefits whether through insurance or otherwise, which is funded directly in whole or in part by the United States government or a state health program (with the exception of the Federal Employees Health Benefits program). The most significant federal health care programs are Medicare, Medicaid, Blue Cross Federal Employees Program (FEP)/Tricare/CHAMPUS and the veterans' programs.

17. The term **"FELLOW"** means a physician who has completed his or her residency training and is engaged in further training in a specialized area under the direct supervision of a specialized member of the Medical Staff.

18. The term **"GOOD STANDING"** means that, at the time of his or her most recent appointment, this individual was deemed to have met the following requirements: satisfactory clinical competence, satisfactory technical skill/judgment, satisfactory results of Quality Assurance activity, satisfactory adherence to ASC Medical Staff Bylaws, satisfactory medical records completion, satisfactory physical mental health completion, satisfactory relationships to peers and status.

19. The term **"GOVERNING BODY"** means the Governing Body of the ASC.

20. The term **"HARRIS HEALTH"** shall mean the Harris County Hospital District d/b/a Harris Health System, a group of general, tertiary care, clinics, and teaching hospital campuses located in Harris County, Texas, including the Ben Taub General Hospital campus, the Quentin Mease Community Hospital campus, the Lyndon B. Johnson General Hospital campus, the Ambulatory Surgery Center at LBJ Hospital, and other locations licensed or accredited as part of Harris Health, including the clinics of the Ambulatory Care Services (collectively, "Harris Health Facilities").

20. The term **"INELIGIBLE PERSON"** means any individual or entity that: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in any federal and/or state health care programs or in federal and/or state procurement or nonprocurement programs (this includes persons who are on the List of Excluded Individuals or Entities of the Inspector General, List of Parties Excluded from Federal Programs by the General Services Administration or the Medicaid Sanction List); or (ii) has been convicted of a criminal offense related to the provision of a health care program that falls within the ambit of 42 U.S.C. §1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

21. The term **"MEDICAL EXECUTIVE COMMITTEE"** means the committee with authority to exercise ASC-wide functions on behalf of the Medical Staff.

22. The term **"MEDICAL STAFF"** means all physicians, dentists, podiatrists and oral-maxillofacial surgeons who are appointed to the Medical Staff to provide healthcare services at designated Harris Health facilities and who either (i) hold a faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston, (ii) are employed by Harris Health, or (iii) are Contract Practitioners. Medical school faculty appointment status is not required for Practitioners or Advanced Practice Professionals employed by Harris Health or Contract Practitioners.

23. The term "**PEER**" shall mean an individual who practices in the same profession as the Practitioner under review. The level of subject-matter expertise required to provide meaningful evaluation of a Practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that specific surgical specialty. The Medical Executive Committee shall determine the degree of subject matter expertise required on a case-by-case basis.

24. The term "**PEER REVIEW**" shall mean the evaluation of medical and healthcare services, including evaluation of the qualifications and professional conduct of professional healthcare practitioners and of patient care provided by those Practitioners. The Practitioner is evaluated based on generally recognized standards of care. The Medical Executive Committee conducts a peer review with input from one or more Practitioner colleagues (peers).

25. The term **"PHYSICIAN"** means an individual with an M.D., D.O. or equivalent degree currently licensed to practice medicine in the State of Texas.

26. The term **"PODIATRIST"** means an individual with a D.P.M. or equivalent degree licensed to practice podiatry by the State of Texas.

27. The term **"PRACTITIONER"** means, unless otherwise expressly limited, any Physician, Podiatrist or Dentist holding a current license to practice in the State of Texas.

28. The term **"RESIDENT/INTERN/HOUSESTAFF/FELLOW"** means an individual who, licensed as appropriate, is a graduate of a medical, dental, osteopathic, or podiatric school and who is appointed to the ASC's professional graduate training program and who participates in patient care under the direction of Medical Staff members who have Clinical Privileges for the services provided by the Housestaff.

29. The term **"SPECIAL NOTICE"** shall mean written notification sent by certified or registered mail, return receipt requested, or by personal or e-mail delivery with a receipt of delivery or attempted delivery obtained.

30. The term **"STATE"** shall mean the State of Texas.

31. The term **"STATE BOARD"** shall mean, as applicable, the Texas Medical Board, the State Board of Dental Examiners, the State Board of Podiatric Examiners, or such other licensing board that may license individuals who have clinical privileges at the ASC.

ARTICLE I — NAME

The name of this organization governed by these Bylaws shall be The Ambulatory Surgical Center (ASC) at LBJ (hereinafter referred to as the "ASC").

ARTICLE II — PURPOSE

The purposes of this organization are:

1. To operate a licensed, certified, and accredited ambulatory surgery center;
2. To provide the best possible care for all patients admitted to or treated in any of the facilities, departments, or services of the ASC;
3. To provide the community with a facility in which medical and surgical procedures can be safely carried out on a short-stay basis;
3. To ensure a high level of professional performance of all Medical Staff members authorized to practice in the ASC through appropriate delineation of the clinical privileges that each Medical Staff member may exercise (see Article VII) and through an ongoing review and evaluation of each Medical Staff member's performance;
4. To provide an appropriate educational setting for Medical Staff members that will maintain medical and scientific standards that will lead to continuous advancement in professional knowledge and skill;
5. To initiate and maintain ASC Medical Staff Bylaws for self-governance of the Medical Staff;
6. To provide a means for communication and conflict resolution regarding issues that are of concern to the Medical Staff and the ASC.

ARTICLE III — MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff of the ASC is a privilege which shall be extended, without discrimination as to race, sex, religion, disability, national origin, or age only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in these Bylaws, and does not in any way imply or preclude employment status by Harris Health. Membership on the Medical Staff shall confer only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

Section 2. Scope

Only Practitioners qualified to practice in the following specialties are to be granted membership on the Medical Staff of the ASC:

- Anesthesiology;
- General Surgery;
- Obstetrics and Gynecology;
- Ophthalmology;
- Oral Maxillofacial Surgery;
- Orthopedic Surgery;
- Otorhinolaryngology;
- Plastic Surgery; and

- Urology.

Section 3. Qualifications for Membership

a. Only individuals who have no health problems that could affect his or her ability to perform the privileges requested and can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others so as to assure the Medical Staff and ASC Governing Body that patients treated by them will be given a high quality of medical care, shall be qualified for membership on the Medical Staff.

b. Only individuals who have and continue to maintain current unrestricted admitting privileges, in Good Standing, at Harris Health.

c. Only individuals who are Board Certified or Board Eligible in his or her specialty practice area.

d. Only individuals who have current licenses and certificates. Medical Staff members must have unrestricted licenses and certificates, with no past adverse licensure actions(s) (e.g. probation, suspension, revocation). Past adverse licensure action(s) do not include action(s) taken for administrative reasons, such as failure to timely pay licensure fees. Required licenses and certificates include:

- State of Texas license to practice medicine, osteopathy, podiatry, or dentistry;
- United States and Texas Controlled Substances Registration Certificates (DEA/DPS), with exceptions approved by the Credentials Committee;
- National Provider Identifier (NPI); and
- Professional liability insurance covering the exercise of all requested privileges, except for Physicians employed by Harris Health, whose liability is governed by the Texas Tort Claims Act.

e. Only Practitioners who have no record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any other healthcare facility for reasons related to professional competence or conduct.

d. No Practitioner shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the ASC merely by virtue of the fact that he or she is duly licensed to practice medicine, osteopathy, podiatry, or dentistry in this State or in any other state, or that he or she is a member of any professional organization, or that he or she had in the past, or presently has, such privileges at another ambulatory surgical center.

e. Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he or she will strictly abide with all provisions of these ASC Medical Staff Bylaws.

f. The Practitioner will remain in Good Standing so long as he or she is a member of the Medical Staff.

g. The Practitioner is required to be eligible to participate in federal and/or State healthcare programs. The Practitioner may not currently be an Ineligible Person and shall not become an Ineligible Person during any term of membership. The Practitioner must also have no record of conviction of Medicare, Medicaid or insurance fraud and abuse.

(1) A Practitioner is required to disclose immediately any debarment, exclusion, or other event that makes the person an Ineligible Person.

(2) An Ineligible Person is immediately disqualified for membership to the Medical Staff or the granting of clinical privileges or practice prerogatives.

h. A Practitioner who does not meet one or more of the qualifications for membership described above may request the Medical Director to waive one or more of the qualifications for membership. The Medical Director's determination not to waive one or more of the qualifications for membership is not a denial of the Practitioner's application for Medical Staff membership, is not reportable to the National Practitioner Databank, and does not entitle the Applicant to the fair hearing rights as described in Article IX of these Bylaws.

Section 3. Basic Responsibilities of Medical Staff Membership

The following responsibilities shall govern the professional conduct of Medical Staff members and failure to meet these responsibilities shall be cause for suspension of privileges or dismissal from the Medical Staff:

a. The principal objective of the Medical Staff is to render service to humanity with full respect for the dignity of each person. Medical Staff members should merit the confidence of patients entrusted to their care, rendering to each a full measure of service, devotion and continuity of care. Medical Staff members are responsible for the quality of the medical care provided to patients.

b. Medical Staff members should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional qualifications.

c. Medical Staff members should observe all laws, uphold the dignity and honor of their profession and accept self-imposed disciplines. They should report without hesitation, illegal or unethical conduct by other Medical Staff members and self-report their own illegal or unethical conduct. Reports should be made to the Administrator or Medical Director, who will report the information to Medical Staff Services.

d. Medical Staff members should self-report any physical, behavioral or mental impairment that could affect his or her ability to perform his or her clinical privileges, or treatment for the impairment that occurs at any point during his or her Medical Staff membership. Reports should be made to the Administrator or Medical Director, who will report the information to Medical Staff Services.

e. In an emergency, Medical Staff members should render services to the best of their abilities. Having undertaken the care of a patient, a Medical Staff member may not neglect him or her.

f. Medical Staff members should not solicit patients.

g. Medical Staff members should not dispense of their services under terms or conditions that tend to interfere with or impair the free and complete exercise of their professional judgment and skill or tend to cause a deterioration of the quality of their care.

h. Medical Staff members should seek consultation upon request, in doubtful or difficult cases, or whenever it appears that the quality of service may be enhanced thereby.

i. Medical Staff members may not reveal the confidences entrusted to them in the course of professional attendance unless they are required to do so by law or unless it becomes necessary in order to protect the welfare of an individual or of the community.

k. Medical Staff members must abide by the ASC Medical Staff Bylaws, Rules and Regulations, and Medical Staff and applicable ASC and Harris Health policies and procedures.

l. Medical Staff members must participate cooperatively in quality review and peer evaluation activities, both as a committee member and in conjunction with evaluation of his or her own performance or professional qualifications.

m. Medical Staff members must prepare and complete medical records in a timely fashion for all patients to whom the member provides care in the ASC.

n. Medical Staff members are accountable to the Governing Body.

Section 4. Conditions and Duration of Appointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the Medical Executive Committee.

b. Initial appointments shall be acted upon following submittal of a Completed Application.

c. All appointments to the Medical Staff shall be for a period of not more than two years.

e. Appointment or reappointment to the Medical Staff confers on the appointee only such clinical privileges as have been approved by the Governing Body.

f. Each application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgement of a Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by the ASC Medical Staff Bylaws, Rules and Regulations, to accept committee assignments and to accept staff assignments in the ASC. All Medical Staff members shall carry an appropriate level of professional liability insurance as determined by the Governing Body of the ASC.

g. Appointments and reappointments to the Medical Staff shall always conform to applicable State and Federal laws.

Section 5. Leave of Absence

a. Requesting a Leave of Absence. A Practitioner may submit a written request to Medical Staff Services for a leave of absence 30 days prior to the requested leave, unless related to a Medical Leave of Absence. Upon favorable recommendation by the Medical Director, the Medical Executive Committee may consider a voluntary leave of absence for up to one (1) year. An additional one (1) year may be granted for good cause in accordance with policy. During the period of the leave, the Practitioner shall not exercise clinical privileges at the ASC, and the Practitioner's rights and responsibilities shall be inactive. All medical records must be completed prior to granting a leave of absence unless circumstances would not make this feasible.

b. Termination of Leave. At least 45 days prior to the termination of the leave of absence, or at any earlier time, the Practitioner may request reinstatement of privileges by submitting a written notice to Medical Staff Services along with a summary of relevant activities during the leave. The Practitioner's request, activity summary and verification, if applicable, shall be presented to the Medical Director. The Medical Director will review the documentation and provide a recommendation to the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be subject to quality review as determined by the Medical Executive Committee following recommendation by the Medical Director. If the practitioner is scheduled for reappointment during the approved leave, the practitioner's application for reappointment must be finalized in accordance with Article VII, Section 4 prior to the practitioner's return.

c. Failure to Request Reinstatement. Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall not give rise to the right to a fair hearing. A request for Medical Staff membership received from a practitioner

subsequent to termination shall be submitted and processed in the manner specified for applications for initial appointments.

d. Medical Leave of Absence. Following recommendation by the Medical Director, the Medical Executive Committee shall determine the circumstances under which a particular practitioner shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. Unless accompanied by a reportable restriction of privileges, the leave shall be deemed a voluntary medical leave of absence and will not be reported to the National Practitioner Data Bank.

e. Military Leave of Absence. Requests for leave of absence to fulfill military service obligations shall be granted upon appropriate notice to Medical Staff Services and will be provided to the Medical Executive Committee for information only.

ARTICLE IV — CATEGORIES OF THE MEDICAL STAFF

Section 1. The Active Staff

a. Qualifications. The Active staff shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 3;

(2) Meet the minimum case requirement by performing at least (50) cases during the prior (12) month period and performing at least one hundred (100) cases within the prior two (2) year appointment period; and

(3) Hold faculty appointments from Baylor College of Medicine or The University of Texas Health Science Center at Houston or are employed by Harris Health or are Contract Practitioners.

b. Prerogatives. Except as otherwise provided, the prerogatives of an Active staff member shall be:

(1) Exercise of all clinical privileges that are granted to the member pursuant to Article VII;

(2) Attend and vote on matters which are presented at general and special meetings of the Medical Staff or any meeting of any specialty or committee of the ASC of which such person is a member;

(3) Participate in Medical Staff Satisfaction surveys;

(4) Hold any office for which the member is qualified; and

(5) Serve as a voting member on any committee to which such person is duly appointed or elected.

c. Reclassification. Failure of an Active Staff member to meet the requirements of Article IV, Section 1(a) at the time of reappointment shall result in reclassification as Affiliate Staff.

Section 2. The Affiliate Staff

a. Qualifications. The Affiliate Staff shall consist of members who:

(1) Meet the general qualifications for membership set forth in Article III, Section 3;

(2) Meet the minimum case requirement by performing at least ten (10) cases during

the prior (12) month period and performing at least twenty (20) cases within the prior two (2) year appointment period; and

(3) Hold faculty appointments from Baylor College of Medicine or The University of Texas Health Science Center at Houston or are employed by Harris Health or are Contract Practitioners.

b. Prerogatives. Except as otherwise provided, the prerogatives of an Active staff member shall be:

(1) Exercise of all clinical privileges that are granted to the member pursuant to Article VII; and

(2) Attend, in a non-voting capacity, general and special meetings of the Medical Staff or any meeting of any specialty or committee of the ASC of which such person is a member.

Section 3. The Provisional Staff

a. All Practitioners and APPs who have been granted an initial appointment to the Medical Staff will be assigned to the Provisional Staff for a three (3) month period during the first year of his or her initial appointment. During the provisional period, the Practitioner or APP must perform or assist with at least ten (10) cases. At the end of the provisional period, the Medical Executive Committee will determine if they will or will not recommend placing the individual in the Active or Affiliate category of Medical Staff.

b. Membership on the Provisional Staff is probationary and does not create any right or expectation on the part of any such Practitioner or APP of continued membership on the Medical Staff or of advancement to any other category of Medical Staff.

c. The probationary period may be extended by the Medical Executive Committee for a period not to exceed twelve (12) months after the initial appointment of privileges.

d. The Medical Executive Board and Governing Body may required that a Practitioner be placed in this category of Medical Staff at any time, such as when privileges are granted between appointments or when privileges are granted for new procedures.

ARTICLE V — INTERNS, RESIDENTS, AND FELLOWS (HOUSESTAFF)

Housestaff are not members of the Medical Staff. Housestaff shall not be eligible for independent clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeals rights under these Bylaws. Housestaff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the ASC and the school or program; credentialing information shall be made available to the ASC upon request and as needed by the Medical Staff in making any training assignments and in performance of their supervisory function. In compliance with federal laws, the ASC shall not submit a query to the National Practitioner Data Bank prior to permitting Housestaff to provide services at ASC. All interns, residents, and fellows will be required to obtain a Texas Medical Board training license, if not otherwise licensed in Texas, and a National Provider Identifier (NPI), prior to beginning training at the ASC. Verification of this licensure will be accomplished through the Graduate Medical Education Offices at the respective Accreditation Council for Graduate Medical Education sponsoring institutions. Housestaff may render patient care services at ASC only pursuant to and limited by the following:

a. Applicable provisions of the professional licensure requirements of this State;

b. A written affiliation agreement between the ASC and the sponsoring medical school or training program; such agreement shall identify the individual or entity responsible for providing professional liability insurance coverage for a Housestaff Practitioner.

c. The protocols established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program regarding the scope of a Housestaff authority, mechanisms for the direction and supervision of Housestaff, and other conditions imposed upon Housestaff by the ASC.

d. While functioning in the ASC, Housestaff shall abide by all provisions of state and Federal law, rules and regulations; requirements of Accrediting Bodies; the ASC Medical Staff Bylaws, Rules and Regulations; and ASC and Medical Staff policies and procedures.

e. Housestaff may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or ASC policies, and to the extent approved by the Governing Body.

f. Housestaff shall be responsible and accountable at all times to an assigned member of the Medical Staff and shall be under the supervision and direction of that member of the Medical Staff. Housestaff may be invited or required to attend meetings of the Medical Staff, Medical Staff Services, Sections, or Committees, but shall have no voting rights.

g. The ASC will promptly notify Baylor College of Medicine or The University of Texas Health Science Center at Houston (sponsoring institutions) Graduate Medical Education (GME) Offices when or if the ASC becomes aware of potentially inappropriate action taken by Housestaff. Upon notification of such a request, the sponsoring institution will promptly investigate the inappropriate actions. The ASC will cooperate and consult with the sponsoring institution and will permit the sponsoring institution reasonable time to conduct its investigation prior to the ASC taking any adverse action against the Housestaff member, except as otherwise provided in this Section. Regardless, after consultation with the Medical Director and/or Program Director, Harris Health's CEO may in his or her sole discretion determine that the Housestaff member not continue his or her training at the ASC until the investigation is complete. At the conclusion of the sponsoring institution's investigation, the sponsoring institution will notify the ASC of the results of the investigation and proposed corrective or rehabilitative action, or reason(s) for inaction. If Harris Health's CEO is not satisfied with the sponsoring institution's investigation, proposed corrective or rehabilitative action, or reason(s) for inaction, and a mutually agreed resolution cannot be reached, Harris Health's CEO will notify the ASC's Governing Body and the ASC's Governing Body may, in its sole discretion, remove the Housestaff member's ability to continue his or her training at the ASC.

h. If a sponsoring institution requests to reinstate a Housestaff member who was previously removed from the ASC, the sponsoring institution will notify the ASC of the circumstances that warrant reinstatement. Harris Health's CEO will consult with the sponsoring institution that made the request, as well as with the Medical Director and the ASC's Governing Body. If Harris Health's CEO does not agree with the sponsoring institution's request to reinstate, Harris Health's CEO will notify the ASC's Governing Body and the ASC's Governing Body may, in its sole discretion, deny the request to reinstate.

i. Nothing in these Bylaws shall be interpreted to entitle Housestaff to the fair hearing rights as described in Article IX of these Bylaws.

ARTICLE VI — ADVANCED PRACTICE PROFESSIONALS

Section 1. Membership

Advanced Practice Professionals are not members of the Medical Staff, but provide clinical services to ASC patients.

Section 2. Qualifications

APPs include those non-Medical Staff members whose license or certificate permits, and the ASC authorizes, the individual provision of patient care services without direction or supervision within the scope of the APP's individually delineated clinical privileges. APPs must:

(1) Meet all applicable standards related to licensure, training and education, clinical competence and health status as described in these Bylaws, Medical Staff Rules and Regulations, and Medical Staff and ASC policies and procedures;

(2) Be assessed, credentialed, and monitored through existing ASC credentialing, quality assessment, and performance improvement functions;

(3) Maintain an active and current credential file and hold delineated clinical privileges approved by the Medical Executive Committee and Governing Body;

(4) Complete all proctoring requirements as may be established by the Medical Executive Committee; and

(5) Not admit patients or assume primary patient care responsibilities.

APPs include those categories of individuals identified in the Definitions Section of these Bylaws.

Section 3. Prerogatives

1. By virtue of their training, experience and professional licensure, APPs are allowed by the ASC to function within the scope of their licensure and delineated clinical privileges but may not admit patients. All APPs shall be under the supervision of a sponsoring physician, who is member of the Medical Staff and has clinical privileges in the same surgical specialty as the APP, who is responsible for delineating the applicant's clinical privileges. If the sponsoring physician's Medical Staff membership is terminated, then the APP's ability to perform clinical services shall be suspended for a period of up to ninety (90) days or until an alternative supervising physician can be secured. If the suspension lasts longer than ninety (90) days or if there is any change in the APP's privileges, then the APP shall complete the initial application procedure. Each APP must notify Medical Staff Services immediately upon loss of required sponsorship or supervision.
2. APPs holding clinical privileges shall have their privileges or practice prerogatives reviewed and approved through the same mechanism described in Article VII of these Bylaws unless otherwise determined by the Medical Executive Committee.
3. The clinical privileges and/or practice prerogatives which may be granted to specific APPs shall be defined by the Medical Staff. Such prerogatives may include:

   (a) The provision of specific patient care services pursuant to established protocols, either independently or under the supervision or direction of a physician or other member of the Medical Staff. The provision of such patient care services must be consistent with the APP's licensure or certification and delineated clinical privileges or job description;

(b) Participation by request on Medical Staff and/or administrative committees or teams; and

(c) Attendance by request at Medical Staff and/or administrative meetings.

4. Participating in quality assessment and performance improvement activities as requested by the Quality Review Council, Medical Executive Committee, or any other committee of the Medical Staff or Governing Body. Failure of an APP to participate in quality assessment or performance improvement activities when requested by the Medical Staff or Governing Body shall result in responsive action, including the possible revocation or suspension of all privileges or practice prerogatives.

Section 4. Review

Nothing in these Bylaws shall be interpreted to entitle APPs to the fair hearing rights as described in Article IX of these Bylaws. An APP shall, however, have the right to challenge any action that would adversely affect the APP's ability to provide patient care services in the ASC. Under such circumstances, the following procedures shall apply:

(1) Notice. Special Notice of the adverse recommendation or action and the right to a hearing shall be promptly given to the APP subject to the adverse recommendation or action. The notice shall state that the APP has thirty (30) days in which to request a hearing. If the APP does not request a hearing within thirty (30) days, the APP shall have waived the right to a hearing.

(2) Hearing Panel. The Medical Director shall appoint a hearing panel that will include at least three members. The panel members shall include the Medical Director, another member of the Medical Staff, and if possible, a peer of the APP, except that any peer review of a nurse shall meet the panel requirements of the Texas Nursing Practice Act. None of the panel members shall have had a role in the adverse recommendation or action.

(3) Rights. The APP subject to the adverse recommendation or action shall have the right to present information but cannot have legal representation or call witnesses.

(4) Hearing Panel Determination. Following presentation of information and panel deliberation, the panel shall make a determination:

i. A determination favorable to the APP shall be reported in writing to the body making the adverse recommendation or action.

ii. A determination adverse to the APP shall result in notice to the APP of a right to appeal the decision to the Chairperson of the Governing Body.

(5) Final Decision. The decision of the Chairperson of the Governing Body shall be the final appeal and represent the final action in the matter.

ARTICLE VII – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, to resolve any reasonable doubts about these matters, and to satisfy any request for such information. Failure of a Practitioner to produce required

information related to an authorized Medical Staff peer review, quality assessment, performance improvement, or credentialing activity in a timely manner shall result in automatic suspension of all clinical privileges until such time as the required information has been provided. Initial applicants who fail to produce all appropriate information and/or documents as requested may withdraw their application prior to review by the Medical Executive Committee.

Section 2. Application for Appointment

a. All applications for appointment to the Medical Staff shall be signed by the applicant, and shall be submitted on a form prescribed by the State of Texas. The application shall include the following detailed information:

- evidence of current licensure;
- evidence of current Board Certification or current Board Eligible status;
- evidence of current United States and Texas Controlled Substances Registration Certificates (DEA/DPS);
- evidence of current National Provider Identifier (NPI);
- evidence of appropriate professional liability insurance, as determined by the Governing Body;
- privileges requested;
- Evidence of appropriate Basic Life Support (BLS), except for those board certified or board eligible in Anesthesiology (ACLS is required);
- relevant training and/or experience;
- current competence;
- physical and mental health status attestation;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary decrease of privileges at any other hospital or institution;
- suspension or revocation of membership in any local, state or national medical society;
- suspension or revocation of license to practice any profession in any jurisdiction
- any claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, including consent to the release of information from the present and past malpractice insurance carrier(s);
- loss of clinical privileges;
- a clear, legible copy of a government-issued photo identification, e.g., valid driver's license or passport;
- three professional peer references; and
- evidence of continuing medical education satisfactory to the Medical Executive Committee.

b. The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

c. Upon the receipt of a Completed Application, Medical Staff Services shall verify the applicant's information on behalf of the Medical Executive Committee. Harris Health, on pursuant to the Letter of Agreement with the ASC, shall consult primary sources of information about the applicant's credentials. It is the applicant's responsibility to resolve any problems Harris Health may have in obtaining information from primary sources. Verifications of licensure, controlled substances registrations (state and federal), specialty board certification or eligibility, and professional liability claims history, query of the National Practitioner Data Bank, and queries to ensure the applicant is not an Ineligible Person shall be completed. Verification may be made by a letter or computer printout obtained from the primary source, verbally, if documented, or electronically if transmitted directly from the primary source to Harris Health. For new applicants, information about the applicant's membership status and/or work history shall be obtained from all organizations where the applicant currently has membership or privileges and/or is employed, and where the applicant has held membership or has been granted clinical privileges and/or has been employed during the previous five years. Associated details on the credentialing process are set forth in Harris Health's Credentialing Procedures Manual.

d. The application and verifications shall be forwarded to Medical Staff Services for review. After review by Medical Staff Services for completeness, the application and all supporting materials shall be transmitted to the Medical Executive Committee for evaluation.

e. By applying for appointment to the Medical Staff, applicants thereby signify their willingness to appear for interviews in regard to the application; authorize the ASC to consult with members of Medical Staffs of other health care organizations with which the applicant has been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on the applicant's competence, character and ethical qualification; consent to Harris Health and the ASC's inspection of all records and documents that, in the opinion of the Medical Executive Committee, may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, as well as moral and ethical qualifications for staff membership; releases from any liability all representatives of the ASC, Harris Health and its Medical Staff for their acts performed in good faith and without malice in connection with evaluation of the applicant and his or her credentials; and releases from any liability all individuals and organizations who provide information to Harris Health and the ASC in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

f. Each applicant shall sign and return a statement that he or she has received and read the ASC Medical Staff Bylaws and that he or she agrees to be bound by the terms thereof relating to consideration of the application and, if the applicant is appointed, to all terms thereof.

Section 3. Appointment Process

a. Medical Staff Services shall transmit Completed Applications to the Medical Executive Committee at its next regularly scheduled meeting following completion of verifications tasks and receipt of all relevant materials.

b. Within one hundred and twenty days (120) days after receipt of the Completed Application, the Medical Executive Committee shall report its review and recommendation to the Governing Body. Prior to making this report, the Medical Executive Committee shall

examine the evidence of the character, professional competence, physical and mental health status, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant, and from any other sources available to the committee, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested.

c. Within sixty (60) days of receipt of the recommendation from the Medical Executive Committee, the Governing Body shall determine whether to accept or reject the recommendation. The Governing Body may only make a decision contrary to the recommendation of the Medical Executive Committee if the applicant meets all of the requirements for Medical Staff membership and the Medical Executive Committee's recommendation is unreasonable or not based on sound judgment. If the Governing Body makes a decision contrary to the recommendation of the Medical Executive Committee, the Governing Body must document its rationale for doing so.

d. A decision by the Governing Body to accept a recommendation resulting in an applicant's appointment to the Medical Staff shall be considered a final action. Within twenty (20) days of the Governing Body's final action, the ASC shall provide notice of all appointments approved by the Governing Body by Special Notice to each new Medical Staff member. All such notices shall include a delineation of approved privileges and appointment dates.

e. The time periods specified in Section 3(b) and (c) above are for guidance only and do not create any right for for the applicant to have his or her application processed within those time periods.

f. When the recommendation of the Governing Body is adverse to the applicant, either in respect to appointment or clinical privileges, the Medical Director shall notify the applicant by Special Notice within fifteen (15) days, as described in Article IX of these Bylaws. No such adverse recommendation shall be forwarded to the Governing Body until after the applicant has exercised his or her right to a hearing as provided in Article IX of these Bylaws. If the applicant fails to act within thirty (30) days of receipt of the Special Notice, the applicant will have waived his or her right to a hearing as provided in Article IX of these Bylaws.

g. If, after the Medical Executive Committee has considered the report and recommendations of the hearing committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the applicant, it shall be processed in accordance with subparagraph "b" of this section. If such recommendation continues to be adverse, the Medical Director shall promptly so notify the applicant by Special Notice. The Medical Director shall so forward such recommendation and documentation to the Governing Body.

h. The Governing Body shall send notice of its final decision regarding any such review under Article IX of these Bylaws through the Medical Director to the applicant.

Section 4. Reappointment Process

a. It is the responsibility of Active and Affiliate members and Advanced Practice Professionals to request reappointment to the Medical Staff in accordance with the "Reappointment and Renewal of Clinical Privileges Procedure" in the Credentialing Procedures Manual. Reappointment to the Medical Staff shall be based on the applicant's maintaining qualifications for Medical Staff membership, as described in Section 2 of this Article, current competence, and consideration of the results of quality assessment activities as determined by the Medical Executive Committee. Failure to submit a completed reappointment application form with required supporting documentation no less than sixty (60) days prior to the expiration of the Practitioner's then current appointment shall constitute a resignation from

the Medical Staff and all privileges will terminate upon expiration of said appointment. Such termination shall not give rise to the right to a hearing pursuant to Article IX of these Bylaws.

Reappointment shall occur every two (2) years. Medical Staff Services will transmit the necessary reapplication materials to the Practitioner not less than 120 days prior to the expiration date of their then current appointment.

All claims, lawsuits, settlements, or judgments against the applicant in a professional liability action, either final or pending, since the last appointment or reappointment must be reported.

b. Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall take into consideration the following characteristics:

- the practitioner's ASC-specific case record, including measures employed in the ASC's quality assurance/performance improvement program, including but not limited to emergency transfers to hospitals, post-surgical infection rates, other surgical complications, etc.
- professional competence and clinical judgment in the treatment of patients;
- ethics and conduct;
- relations with other Medical Staff members;
- general attitude toward patients, the ASC, and the public;
- documented physical and mental health status;
- evidence of continuing medical education that is related, at least in part, to the Practitioner or APP's clinical privileges;;
- previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration);
- voluntary or involuntary relinquishment of such licensure or registration;
- voluntary or involuntary termination of Medical Staff membership; and
- voluntary or involuntary decrease of privileges at any other hospital.

c. Thereafter, the procedure provided in Sections 2 and 3 this Article relating to recommendations on applications for initial appointment shall be followed.

d. Members of the Medical Staff shall maintain current licensure and certifications, as described in Article III, Section 3 of these Bylaws. Members of the Medical Staff must notify the ASC whenever their license to practice in any jurisdiction has been voluntarily/involuntarily limited, suspended, revoked, denied, or subjected to probationary conditions, or when proceedings toward any of those ends have been instituted. Those without current licensure and certifications will be subject to loss of privileges as described in Article VIII, Sections 3 and 4 of these Bylaws.

e. The appointment of any Practitioner who fails to submit an application for reappointment, or who loses faculty appointment at Baylor College of Medicine and/or The University of Texas Health Science Center at Houston or ceases to be employed by or have a contractual relationship with the ASC shall automatically expire at the end of his or her faculty appointment or employment. A Practitioner whose appointment has expired must submit a new application, which shall be processed without preference as an application for initial appointment.

f. When the final action has been taken, the Medical Director shall give written notice of the reappointment decision to the Practitioner.

Section 5. Application for Clinical Privileges

Every initial application for staff appointment to the Medical Staff and each reappointment application must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, clinical training, experience, current competence, references, judgment, and other relevant information. The applicant shall have the burden of establishing his or her qualifications and competency to be granted the clinical privileges requested.

Section 6. Clinical Privileges

a. Every Medical Staff member practicing within the ASC by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, exercise only those clinical privileges specifically approved, ratified, and affirmed to him or her by the Governing Body.

b. Clinical privileges will be limited to those activities deemed the responsibility of the specialty area to which the applicant is appointed.

Section 7. Privileges in More Than One Specialty

Practitioners or APPs may be awarded clinical privileges in one or more specialty in accordance with their education, training, experience, and demonstrated competence.

Section 8. Temporary Privileges

a. Upon the basis of information then available, which may reasonably be relied upon as to the competence and ethical standing of the applicant, the Medical Executive Committee may grant temporary clinical privileges to the applicant. Temporary privileges of the applicant shall persist until the next meeting of the Governing Body (not to exceed 120 days) and shall cease at the time of official action upon his or her application for Medical Staff membership.

b. Termination. Temporary clinical privileges may be terminated by the Medical Director.

c. Neither termination of temporary clinical privileges nor failure to grant them shall constitute a Final Hearing Review Action and neither is an Adverse Recommendation or Action.

Section 9. Emergency Clinical Privileges

In the case of an emergency, any current Medical Staff member, to the degree permitted by his or her license and regardless of service or staff status, shall be permitted and assisted to do everything possible to save the life of a patient using the appropriate resources of the ASC, including the calling for any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which a patient is in immediate danger of serious permanent harm or loss of life, and any delay in administering treatment could add to that danger.

Section 10. Confidentiality of the Credentials File

A Medical Staff member or other individual exercising clinical privileges shall be granted access to his or her own credentials file, subject to the following provisions:

a. A request for access must be submitted in writing to the Chairperson of the Medical Executive Committee.

b. The individual may review, and receive a copy of, only those documents provided by or addressed personally to the individual. All other information, including peer review committee findings, letters of reference, proctoring reports, complaints, and other documents shall not be disclosed.

c. The review by the individual shall take place in Medical Staff Services during normal work hours with an officer or designee of the Medical Staff present.

ARTICLE VIII - CORRECTIVE ACTION

Section 1. Procedure

a. Whenever the activities, professional conduct or health status of any Medical Staff member are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the ASC, corrective action against such Medical Staff member may be requested by the Medical Director or by the Governing Body. All such requests shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request. The Medical Director or designee must meet with the member to discuss the issues that are the basis for the request either prior to submission or no later than 72 hours after receipt of a copy of the request. In the event that the member who is the subject of the request for corrective action is the Medical Director, another voting member of the Medical Executive Committee must conduct the meeting. The party conducting the meeting shall send a letter to the staff member immediately following the meeting confirming that the meeting was held and the matters discussed. The letter must be sent to the staff member via Special Notice procedures with a copy to Medical Staff Services.

b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the Chairperson of the Medical Executive Committee shall immediately appoint an ad hoc committee to investigate the matter.

c. Within thirty (30) days after the ad hoc committee's receipt of the request for corrective action, it shall make a report of its investigation to the Medical Executive Committee. If in the reasonable view of the Medical Executive Committee more than thirty (30) days is needed to complete the investigation, the Medical Executive Committee shall grant an extension to the ad hoc committee. Prior to the making of a report, the Medical Staff member against whom corrective action has been requested shall have an opportunity for an interview with the ad hoc investigating committee. At such interview, the Medical Staff member shall be informed that the meeting shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto. A record of such interview shall be made by the ad hoc committee and included with its report to the Chairperson of the Medical Executive Committee.

d. Within thirty (30) days following the receipt of the report of the ad hoc investigating committee, the Medical Executive Committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected Medical Staff member shall be permitted to make an appearance before the Medical Executive Committee prior to its taking action on such request, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the Medical Executive Committee.

e. The Medical Executive Committee shall take such action as deemed justified as a result of these investigations.

f. Any recommendations by the Medical Executive Committee to the Governing Body for reduction or revocation of clinical privileges, or expulsion from the Medical Staff shall entitle the affected Medical Staff member to the procedural rights provided in Article IX.

g. All decisions resulting from investigations of a Medical Staff member in a medical administrative position shall be reviewed by the Governing Body following the process as outlined in Article IX.

h. When the Medical Executive Committee or Governing Body has reason to question the physical and/or mental status of a Medical Staff member, the latter shall be required to submit an evaluation of their physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee and the affected physician as a prerequisite to further consideration of: (1) their application for appointment or reappointment, (2) their exercise of previously granted privileges, or (3) their maintenance of a Medical Staff appointment.

Section 2. Summary Suspension

Whenever there is a reasonable belief that a Member's conduct or condition requires that immediate action be taken to protect life or to reduce the likelihood of injury or damage to the health or safety of patients, workforce members, or others, summary action must be taken as to all or any portion of the Member's clinical privileges, and such action shall become effective immediately upon imposition.

The Chairperson of the Medical Executive Committee, the Medical Executive Committee itself, the Medical Director, Harris Health's Chief Executive Officer, or the Governing Body shall have the authority, whenever action must be taken immediately in the best interest of patient care at the ASC, to suspend summarily all or any portion of the clinical privileges of a Medical Staff member, and such summary suspension shall become effective immediately upon imposition.

The Medical Staff member must be immediately notified by Special Notice from the Medical Director. A suspended member's patients in the ASC must be assigned to another member by the applicable specialty, considering the wishes of the patient, where feasible, in choosing a substitute practitioner.

As soon as possible, but within ten (10) working days after a summary suspension is imposed, the Medical Executive Committee shall convene to review and consider the action taken. In its sole discretion, the Medical Executive Committee may provide the member the opportunity to meet with the Medical Executive Committee, which may recommend modification, continuation or termination of the terms of the suspension. A Medical Executive Committee recommendation to continue the extension or to take any other adverse action as defined in Article IX entitles the Medical Staff member, upon timely and proper request, to the procedural rights contained in Article IX.

Section 3. Automatic Suspension

Occurrence of any of the following shall result in an automatic suspension as detailed. An automatic suspension is not considered a final action or an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article IX of these Bylaws.

(1) Suspension, limitation or placement of a condition on a member's professional license by the state licensing board shall result in automatic suspension of the member's privileges until the Medical Executive Committee can assess whether the suspension, limitation, or condition will be adopted by the medical staff. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(2) Indictment of a member for a felony or indictment of any other criminal charges

involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services shall result in automatic suspension of the member's privileges. As soon as possible, but no later than the tenth (10^{th}) working day after the automatic suspension, the Medical Executive Committee shall convene to review and consider appropriate action.

(3) Failure of the member to maintain current required licensure and certifications, as described in Article III, Section 3, shall result in automatic suspension of the member's privileges for up to thirty (30) days. The member's privileges will be reinstated once Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such actions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the actions as appropriate. Failure to satisfy this requirement in thirty (30) days will result in a voluntary resignation of the member's privileges and require the submission of an initial credentialing application, which will be processed without preference. In certain circumstances, the Medical Executive Committee may approve an exception to this requirement.

(4) A member's delinquency in completion of medical records shall result in automatic suspension of the member's privileges and medical staff membership until Medical Staff Services has confirmed that the issue has been resolved to the satisfaction of the Chair of the Medical Executive Committee, or designee. The Chair shall make a report of all such resolutions at the next regularly scheduled meeting of the Medical Executive Committee and the Medical Executive Committee shall ratify or modify the resolution as appropriate.

Section 4. Automatic Termination

Occurrence of any of the following shall result in an automatic termination as detailed. An Automatic termination is not considered an adverse recommendation or action but may be considered in any investigation or proceeding pursuant to Article IX of these Bylaws.

(1) Revocation of a physician's professional license by the Texas Medical Board shall cause all the member's clinical privileges and the medical staff membership to automatically terminate.

(2) Conviction of or a guilty or nolo contendere plea to (including deferred adjudication) for a felony or conviction of or a guilty or nolo contendere plea to any other criminal charges involving substance abuse, minors, assault, battery, fraud, dishonesty, moral turpitude, or the delivery of health care services by a member shall result in automatic termination of the member's privileges and medical staff membership.

(3) A member's privileges and staff membership shall automatically terminate if the member becomes an Ineligible Person as that term is defined in these Bylaws.

(4) Loss of employment with Baylor College of Medicine, the University of Texas Health Science Center at Houston, Harris Health, or another entity contracted to

provide clinical care at the ASC shall result in automatic termination of the Practitioner's privileges and staff membership. However, if the loss of employment is related to the member's professional competence or conduct, such action is considered an adverse action under Article IX, Section 1.

(5) The privileges and medical staff membership of a member who is suspended four times in a twelve (12) month period for delinquency in completion of medical records shall automatically terminate upon the first day of the fourth suspension within twelve months

(6) The privileges and medical staff membership of a member who remains suspended for six (6) continuous weeks for delinquency in completion of medical records shall automatically terminate upon the last day of the sixth week of continuous suspension.

(7) Failure to notify the Medical Staff Services of the occurrence of any of the events listed in Article VIII, Section 3 shall result in automatic termination of a member's privileges and medical staff membership.

a. Notice

The member must be immediately notified by Special Notice from the Medical Director.

Section 4. Medical Administrative Positions

A Medical Staff member shall not lose staff privileges if his or her medical administrative position is terminated without following the hearing and appellate procedures as outlined in Article IX.

ARTICLE IX — PROCEDURAL RIGHTS OF REVIEW

Section 1. Events Giving Rise to Hearing Rights

a. Actions or Recommended Actions

Subject to the exceptions set forth in Section 1.c of this Article IX, the following actions or recommended actions, if deemed adverse under Section 1.b below, entitle the member (for purposes of Article IX, the term "member" shall include an applicant to the Medical Staff whose application for Medical Staff appointment and clinical privileges has been denied) to a hearing upon timely and proper request as provided in Section 4:

(1) Denial of initial Medical Staff appointment;

(2) Denial of reappointment;

(3) Suspension of appointment, provided that summary suspension entitles the member to request a hearing only as specified in this section;

(4) Revocation of appointment;

(5) Special limitation of the right to admit patients not related to standard administrative or Medical Staff policies within the ASC;

(6) Denial or restriction of requested clinical privileges;

(7) Reduction in clinical privileges;

(8) Suspension of clinical privileges, provided that summary suspension entitles the member to request a hearing only as specified in this section,

(9) Revocation of clinical privileges;

(10) Individual application of, or individual changes in, mandatory consultation or supervision requirement; or

(11) Summary suspension of appointment or clinical privileges, if the recommendation of the Medical Executive Committee or action by the Governing Body is to continue the suspension or to take other action which would entitle the member to request a hearing under Section 4, provided that if the Medical Executive Committee initiates an investigation of the member in accordance with Article VIII, no hearing rights shall accrue until the Medical Executive Committee had acted upon the report of the ad hoc committee.

b. When Deemed Adverse

Except as provided below, any action or recommended action listed in Section 1.a above is deemed adverse to the member only when it has been:

(1) recommended by the Medical Executive Committee; or

(2) taken by the Governing Body under circumstances where no prior right to request a hearing exists.

c. Exceptions to Hearing Rights

(1) Certain Actions or Recommended Actions: Notwithstanding any provision in these ASC Medical Staff Bylaws, or in the Credentialing Procedures Manual to the contrary, the following actions or recommended actions do not entitle the member to a hearing:

(a) the issuance of a verbal warning or formal letter of reprimand;

(b) the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;

(c) the imposition of a probationary period involving review of cases;

(d) the imposition of a requirement for a proctor to be present at procedures performed by the member, provided that there is no requirement for the proctor to grant approval prior to provision of care;

(e) the removal of a Practitioner from a medical administrative office within the hospital unless a contract or employment arrangement provides otherwise; and

(f) any other action or recommended action not listed in Section 1.a above.

(2) Other Situations: An action or recommended action listed in Section 1.a above does not entitle the applicant or member to a hearing when it is:

(a) voluntarily imposed or accepted by the Practitioner;

(b) automatic pursuant to any provision of these ASC Medical Staff Bylaws and related manuals;

(c) taken or recommended with respect to temporary privileges, unless the action must be reported to the National Practitioner Data Bank.

Section 2. Notice of Adverse Action

a. The ASC shall, within fifteen (15) days of receiving written notice of an adverse action or recommended action under Section 1.a, give the Practitioner Special Notice thereof. The notice shall:

(1) advise the Practitioner of the nature of and reasons for the proposed action and of his or her right to mediation or a hearing upon timely and proper request pursuant to Section 3 and/or Section 4 of this Article IX;

(2) specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for mediation or a hearing and that the request must satisfy the conditions of Section 3 and/or Section 4;

(3) state that failure to request mediation or a hearing within that time period and in the proper manner constitutes a waiver of rights to mediation or a hearing and to an appellate review on the matter that is the subject of the notice;

(4) state that any higher authority required or permitted under this Article IX to act on the matter following a waiver is not bound by the adverse action or recommended action that the Practitioner has accepted by virtue of the waiver but may take whatever action, whether more or less severe, it deems warranted by the circumstances;

(5) state that upon receipt of his mediation or hearing request, the Practitioner will be notified of the date, time, and place of the hearing, and the grounds upon which the adverse recommendation or action is based; and

(6) provide a brief summary of the rights the Practitioner would have at a hearing, as set forth in Sections 12-14 of this Article.

Section 3. Request for Mediation

a. Within ten (10) days of receipt of the notice of adverse recommendations giving rise to

hearing rights, an affected member may file a written request for mediation. The request must be delivered by Special Notice to the Medical Director and state the reason the member believes mediation is desirable. If a hearing has already been scheduled, mediation must be completed prior to the date of the hearing. If no hearing has been scheduled, the mediation must take place within 45 days of receipt of the request. Under no circumstances will a hearing be delayed beyond the originally scheduled date unless both parties agree to a continuance to a date certain.

b. The mediator shall be selected by the Chairperson of the Medical Executive Committee and must have the qualifications required by state law and experience in medical staff privileging and disputes.

c. The fee of the mediator shall be shared equally among the parties.

d. An individual shall be appointed by the Chairperson of the Medical Executive Committee to participate in the mediation and represent the Medical Executive Committee. The affected member and the representative of the Medical Executive Committee may each be accompanied in the mediation by counsel of their choice.

e. Under no circumstances may the mediation delay the filing of any report required by law, or result in an agreement to take any action not permitted by law. No agreement arising out of the mediation may permit or require the Medical Executive Committee, the Governing Body, or the ASC to violate any legal requirement, accreditation requirement or any requirement of the ASC Medical Staff Bylaws.

f. If no resolution is reached through the mediation, a hearing must be scheduled no later than forty-five (45) days following the mediation, unless otherwise agreed by the parties.

Section 4. Request for Hearing

The Practitioner shall have thirty (30) days after receiving the above notice to file a written request for a hearing. The request must be delivered to the Medical Director by Special Notice.

Section 5. Waiver by Failure to Request a Hearing

A member who fails to request a hearing within the time and in the manner specified in Section 4 above waives his or her right to any hearing and appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommended action triggering the Section 2 notice. The Medical Director shall as soon as reasonably practicable send the member Special Notice of each action taken under any of the following Sections and shall notify the Chairperson of the Medical Executive Committee of each such action. The effect of a waiver is as follows:

a. Adverse Action by the Governing Body

A waiver constitutes acceptance of the adverse action, which immediately becomes the final decision of the Governing Body.

b. Adverse Recommendation by the Medical Executive Committee

A waiver constitutes acceptance of the adverse recommendation, which becomes effective immediately and remains so pending the decision of the Governing Body. The Governing Body shall consider the adverse recommendation as soon as practicable following the waiver but at least at its next regularly scheduled meeting. Its action has the following effect:

(1) If the Governing Body's action accords in all respects with the Medical Executive Committee recommendation, the Governing Body decision becomes effective immediately.

(2) If, on the basis of the same information and material considered by the Medical Executive Committee in formulating its recommendation, the Governing Body proposes a more severe adverse action, the member shall be entitled to a hearing.

Section 6. Additional Information Obtained Following Waiver

When, in considering an adverse Medical Executive Committee recommendation transmitted to it under Section 5.b of this Article IX, the Governing Body acquires or is informed of additional relevant information not available to or considered by the Medical Executive Committee, the Governing Body shall refer the matter back to the Medical Executive Committee for reconsideration within a set time limit. If the source of the additional information referred to in this Section is the member or an individual or group functioning, directly or indirectly, on his or her behalf, the provisions of this Section shall not apply unless the member demonstrates to the satisfaction of the Medical Executive Committee that the information was not reasonably discoverable in time for presentation to and consideration by the party taking the initial adverse action.

a. If the Medical Executive Committee's recommendation following reconsideration is unchanged, the Governing Body shall act on the matter as provided in Section 5.b. of this Article IX.

b. If the Medical Executive Committee's recommendation following reconsideration is still adverse but is more severe than the action originally recommended, it is deemed a new adverse recommendation under Section 1.a of this Article IX and the matter proceeds as such.

c. A favorable Medical Executive Committee recommendation following reconsideration shall be forwarded as soon as reasonably practicable to the Governing Body by the Medical Director. The effect of the Governing Body action is as follows:

(1) Favorable: Favorable Governing Body action on a favorable Medical Executive Committee recommendation becomes effective immediately.

(2) Adverse: If the Governing Body's action is adverse, the member shall be entitled to a hearing.

Section 7. Notice of Time and Place for Hearing

The Medical Director shall deliver a timely and proper request for a hearing to the Chair of the Medical Executive Committee or Chairperson of the Governing Body, depending on whose

recommendation or action prompted the hearing request. The Chairperson of the Medical Executive Committee or the Chairperson of the Governing Body, as appropriate, shall then schedule a hearing. Hearings held by the Governing Body or any committee of the Governing Body under this Article IX of the ASC Medical Staff Bylaws will be closed meetings pursuant to Chapter 151 of the Texas Occupations Code and Section 161.032 of the Texas Health & Safety Code. The hearing date shall be set for as soon as practicable after the Medical Director received the request but in any event no more than forty-five (45) days thereafter. The Medical Director shall send the member Special Notice of the time, place, and date of the hearing, and the identity of the hearing committee members or hearing officer not less than thirty (30) days from the date of the hearing. The notice provided to the member shall contain a list of the witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee or Governing Body, whichever is appropriate. The member must provide a list of the witnesses expected to testify on his behalf within ten (10) days of this notice. If the member is under suspension, he or she may request that the hearing be held not later than twenty (20) days after the Medical Director has received the hearing request. The Medical Director may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Chairperson of the Governing Body. If the member does not in good faith cooperate in scheduling a hearing date, and as a result, a hearing has not been scheduled within ninety (90) days from the date of the first proposal for a hearing date by the Medical Executive Committee or Chairperson of the Governing Body, the member shall be deemed to have waived the member's right to a hearing in accordance with Article IX, Section 5, unless both parties agree to a delayed hearing date.

The notice of hearing shall contain a concise statement of the member's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

Section 8. Appointment of Hearing Committee or Hearing Officer

a. By Medical Staff

A hearing occasioned by an adverse Medical Executive Committee recommendation shall be conducted by a hearing committee appointed by the Chairperson of the Medical Executive Committee and composed of at least three (3) members of the Medical Staff. The Chairperson of the Medical Executive Committee shall designate one of the appointees as Chairperson of the committee.

b. By the Governing Body

A hearing occasioned by an adverse action of the Governing Body shall be conducted by a hearing committee appointed by the Chairperson of the Governing Body and composed of at least three (3) persons, including at least two (2) medical staff members when feasible. The Chairperson of the Governing Body shall designate one appointee as Chairperson of the committee.

c. Service on Hearing Committee

An individual shall not be disqualified from serving on a hearing committee merely because he or she has heard the case or has knowledge of the facts involved or what he or she supposes the facts to be. Any member of the Hearing Committee shall not be in direct economic competition with the member involved. Direct economic

competition may not be shown based solely on the member's medical school affiliation. Within ten (10) days of receipt of the Notice of Hearing, the member under review may submit a written challenge to a member of the hearing panel, specifying the manner in which the hearing committee member is deemed to be disqualified along with supporting facts and circumstances. The Medical Executive Committee or Governing Body, as appropriate, shall consider and rule on the challenge.

d. Hearing Officer in Lieu of Hearing Committee

Subject to the approval of the Governing Body, the Medical Executive Committee may determine that the hearing will be conducted in front of a hearing officer to be appointed by the Medical Executive Committee. This officer shall not be in direct economic competition with the member involved. The term "hearing officer" as used in this Section 8.d shall be used to refer to a hearing officer who is appointed in lieu of a Hearing Committee and shall not refer to an appointed presiding officer of a Hearing Committee, provided, however, that a presiding officer still may be appointed. The decision of a Hearing Officer appointed in lieu of a Hearing Committee shall have the same force and effect as a decision by the Hearing Committee.

Section 9. Final List of Witnesses

The witness lists required in Section 7 of this Article IX shall be amended as soon as possible by the appropriate party when additional witnesses are identified. The final list of witnesses must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the testimony of witnesses not disclosed within the required timeframe.

Section 10. Documents

All documents the parties plan to introduce into evidence at the hearing must be submitted to the Presiding Officer and exchanged by the member and the Medical Executive Committee or the Governing Body, as appropriate, no later than seven (7) days prior to the hearing. Failure of a party to comply with this requirement shall constitute good cause for the Presiding Officer to grant a continuance or otherwise limit the introduction into evidence of documents not produced within the required timeframe.

Section 11. Personal Presence

The personal presence of the member is required throughout the hearing, unless the member's presence is excused for any specified time by the hearing committee. The presence of the member's representative does not substitute for the personal presence of the member. A member who fails, without good cause, to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with Article IX of these ASC Medical Staff Bylaws shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Sections 4 and 5 of this Article IX, if applicable.

Section 12. Presiding Officer

The hearing officer, if appointed pursuant to Article IX Section 37 of these ASC Medical Staff Bylaws, or if not appointed, the hearing committee Chairperson, shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed, he or she shall not be entitled to vote. If the Chairperson of the hearing committee serves as the presiding officer, he or she shall be entitled to vote.

Section 13. Representation

The member may be represented at the hearing by a member of the Medical Staff in good standing, a member of his or her local professional society, or an attorney of his or her choice. The Medical Executive Committee or Governing Body, depending on whose recommendation or action prompted the hearing, shall designate a medical staff member to support its recommendation or action and, in addition, may appoint an attorney to represent it.

Section 14. Rights of Parties

During the hearing, each party shall have the following rights, which shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

(1) provide an opening statement no longer than 5 minutes each;
(2) call and examine witnesses;
(3) introduce exhibits;
(4) cross-examine any witness on any matter relevant to the issues;
(5) impeach any witness; and
(6) rebut any evidence.

If the member does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

Section 15. Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding officer, and a copy must be provided to the other party. The hearing committee may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it is appropriate.

Section 16. Official Notice

In reaching a decision, the hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Texas. Participants in the hearing shall be informed of the matters to be

noticed and those matters shall be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute the officially noticed matters by written or oral presentation of authority, in a manner to be determined by the hearing committee. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 17. Burden of Proof

The body whose adverse action or recommended action occasioned the hearing shall have the burden of coming forward with evidence in support thereof. Thereafter, the member shall have the burden of coming forward with evidence and proving by clear and convincing evidence that the adverse action or recommended action lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Section 18. Hearing Record

A court reporter shall be used to record the hearing, although those giving testimony need not be sworn by said reporter. The court reporter shall transcribe the hearing and submit a written copy to the presiding officer within 10 business days after adjournment of the hearing for his/her review. The presiding officer shall return any noted corrections to the court reporter within 7 days. The member may within ten days after the hearing's adjournment also request a copy of the hearing report upon payment of any reasonable costs associated with the preparation of said report and in such event may review the hearing report and return any noted corrections to the court reporter within 7 days. If the member fails to request a copy of the hearing report or if the hearing report is not returned in 7 days, the right to make any changes is waived.

Section 19. Postponement

Requests for postponement or continuance of a hearing may be granted by the presiding officer or hearing committee only upon a timely showing of good cause.

Section 20. Presence of Hearing Committee Members and Vote

A majority of the hearing committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the hearing committee.

Section 21. Recesses and Adjournment

The hearing committee may recess and reconvene the hearing without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 22. Hearing Committee Report

Within twenty (20) days after adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations with such reference to the hearing record and other considered documentation as it deems appropriate. The hearing committee shall forward the report to the body whose adverse action or recommended action occasioned the hearing. The

member shall also be given a copy of the report by Special Notice. The hearing record and other documentation shall be transmitted to the Medical Staff Office for safekeeping as official records and minutes of the Medical Staff and shall be made available for review by any party between the hours of 8:00 a.m. and 4:30 p.m. Monday through Friday, excluding holidays.

Section 23. Action on Hearing Committee Report

Within thirty (30) days after receiving the hearing committee report, the body whose adverse action or recommended action occasioned the hearing shall consider said report and affirm, modify, or reverse its action or recommended action. It shall transmit the result to the Medical Director.

Section 24. Notice and Effect of Result

a. Notice

As soon as is reasonably practicable, the Medical Director shall send a copy of the result to the member by Special Notice and to the Chairperson of the Medical Executive Committee.

b. Effect of Favorable Result

(1) Adopted by the Governing Body: If the Governing Body's determination is favorable to the member, it shall become effective immediately.

(2) Adopted by the Medical Executive Committee: If the Medical Executive Committee result is favorable to the member, the Medical Director shall, as soon as is reasonably practicable, forward it to the Governing Body which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further reconsideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Governing Body shall take action. Favorable action by the Governing Body shall become effective immediately.

c. Effect of Adverse Result

If the hearing results in an adverse recommendation, the member shall receive Special Notice of his or her right to request appellate review.

Section 25. Request for Appellate Review

A member shall have thirty (30) days after receiving Special Notice of an adverse result to file a written request for an appellate review. The request must be delivered to the Medical Director by Special Notice.

Section 26. Waiver by Failure to Request Appellate Review

A member who fails to request an appellate review within the time and in the manner specified in Section 24 of this Article IX shall have waived any right to a review. The waiver has the same force and effect as provided in Sections 5 and 6 of this Article IX, if applicable.

Section 27. Notice of Time and Place for Appellate Review

The Medical Director shall deliver a timely and proper request for appellate review to the Chairperson of the Governing Body. As soon as practicable, said Chairperson shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the Medical Director received the request. If the member is under suspension, he or she may request that the appellate review be held not later than twenty (20) days after the Medical Director has received the appellate review request. The Medical Director may grant the member's request after consultation with the Chairperson of the Medical Executive Committee or Governing Body. At least thirty (30) days prior to the appellate review, the Medical Director shall send the member Special Notice of the time, place, and date of the review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause.

Section 28. Appellate Review Body

The appellate review may be conducted by the Governing Body. The Chairperson of the Governing Body will appoint a committee consisting of three (3) to nine (9) members of the Governing Body to hear the appeal, including at least one (1) physician. The Chairperson shall designate one of the members as Chairperson.

Section 29. Nature of Proceedings

The proceedings by the review body are a review based upon the hearing record, the hearing committee's report, all subsequent results and actions, the written statements, if any, provided below, and any other material that may be presented and accepted. The presiding officer shall direct the Medical Staff Office to make the hearing record and hearing committee report available at the appellate review for use by any party. The review body shall determine whether the foregoing evidence demonstrates that the member has met the applicable burden of proof as required under Section 16 of this Article IX.

Section 30. Written Statements

The member may submit a written statement detailing the findings of fact, conclusions, and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the appellate review body and to the group whose adverse action or recommended action occasioned the review through the Medical Director at least five (5) days prior to the scheduled date of the review, except if the time limit is waived by the review body or its presiding officer. A similar statement may be submitted by the body whose adverse action or recommended action occasioned the review, and if submitted, the Medical Director shall provide a copy to the member and to the appellate review body at least ten (10) days prior to the scheduled date of the appellate review.

Section 31. Presiding Officer

The Chairperson of the appellate review body is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

Section 32. Oral Statement

The appellate review body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or

representative appearing shall be required to answer questions put by any member of the review body.

Section 33. Consideration of New or Additional Matters

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the review body and only if the party requesting consideration of the matter or evidence demonstrates to the satisfaction of the review body that it could not have been discovered in time for the initial hearing. The requesting party shall provide, through the Medical Director, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced at the review. Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment, and rebuttal provided at the hearing pursuant to Section 13 of this Article IX.

Section 34. Powers

The appellate review body has all the powers granted to the hearing committee, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.

Section 35. Presence of Members and Vote

A majority of the members of the review body must be present throughout the appellate review and deliberations. If a member is absent from any part of the proceedings, the presiding officer of the appellate review may, in his discretion, rule that said member shall not be permitted to participate further in the review or deliberations or in the decision of the review body.

Section 36. Recesses and Adjournments

The review body may recess and reconvene the proceedings without Special Notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The review body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

Section 37. Action Taken

Within thirty (30) days after adjournment pursuant to Section 21 of this Article IX, the review body shall prepare its report and conclusion with the result as provided below. The Medical Director shall send notice of each action taken under Section 22 of this Article IX below to the Chairperson of the Medical Executive Committee for transmittal to the appropriate Staff authorities and to the member by Special Notice.

a. Governing Body Decision

(1) Within fifteen (15) days after adjournment, appellate review body shall make its decision, including a statement of the basis of the decision. The appellate review body may decide:

(a) that the adverse recommendation be affirmed;

(b) that the adverse recommendation be denied;

(c) that the matter be the subject of further hearing or other appropriate procedures within a specified time period; or

(d) that modification of the adverse recommendation be made so that it is no longer unreasonable, arbitrary, capricious, or discriminatory.

If the appellate review body finds that the procedures were substantially complied with and that the adverse recommendation which is the subject of the appeal was not unreasonable, arbitrary, capricious, discriminatory, or lacking in basis, it shall affirm the adverse recommendation in its decision.

(2) A majority vote of the members of the appellate review body authorized to vote is required for an adverse decision.

(3) The decision of the appellate review body on behalf of the Governing Body shall be effective upon the date of such decision, unless reversed or modified by the Governing Body within thirty (30) days.

(4) A copy of the appellate review body's decision shall be sent to the member by Special Notice within five (5) days following its decision.

Section 38. Hearing Officer Appointment and Duties

The use of a hearing officer to preside at the evidentiary hearing is optional and is to be determined by, and the actual officer if any to be used is to be selected by the Chairperson of the Medical Executive Committee in conjunction with the Medical Director. A hearing officer may or may not be an attorney at law, but must be experienced in and recognized for conducting Medical Staff hearings in an orderly, efficient, and non-partisan manner.

Section 39. Number of Hearings and Reviews

Notwithstanding any other provision of these ASC Medical Staff Bylaws, no member shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse action or recommended action giving use to the right.

Section 40. Release

By requesting a hearing or appellate review under this Article IX, a member agrees to be bound by the provisions of Article VIII of these ASC Medical Staff Bylaws.

ARTICLE X – MEDICAL DIRECTOR

Section 1. Appointment

The Medical Director shall be appointed and approved by the ASC Governing Body. The Medical Director appointment may be cancelled by either the Governing Body or the Medical Director by providing thirty (30) days written notice to either party. The Medical Director shall perform the duties assigned by the ASC's Governing Body and by the Governing Body Bylaws and the ASC Medical Staff Bylaws.

Section 2. Responsibilities

The Medical Director is invested with the following duties and prerogatives:

1. Call and preside over Quality Improvement (QI) meetings.
2. Facilitate adherence of the Medical Staff of the ASC to the ASC Bylaws.
3. Be chief spokesperson and enunciator of policy for the Medical Staff.
4. Monitor adherence to policies with respect to patient rights.
5. Assist the Administrator in arranging for an appropriately trained, professional staff capable of providing safe, efficient, quality patient care.
6. Assist the Administrator in developing a structure that clearly delineates the authority and responsibility of the Medical Staff within the organization.
7. Take the initiative in developing, on behalf of the Medical Staff, appropriate policies and procedures for the safe, effective conduct of business and provision of patient care; and review all clinical policies and procedures of the ASC. The Medical Director shall be specifically authorized to approve (after consultation with the appropriate QI specialty representatives) and implement policies and procedures (subject to such subsequent QI review and ASC Governing Body ratification).
8. Take the initiative in developing, on behalf of the Medical Staff, Quality Improvement, Risk Management, and Peer Review programs in accordance with applicable standards.
9. Advise the Administrator in arranging for ancillary services including laboratory, radiology, and pathology services.
10. Carry out all other duties specifically entrusted to him/her by the QI, ASC Governing Body or any other provision of these Bylaws.

ARTICLE XI — COMMITTEES

The Governing Body, or Medical Director with the approval of the Governing Body, may establish such committees as are necessary to fulfill the functions of the ASC. Membership of the Medical Executive Committee and other committees established under this Article of the Bylaws will be by appointment of the Governing Body, with the advice of the Medical Director, unless otherwise specified.

Unless otherwise specified in these Bylaws or at the time of selection or appointment of a Committee, non-Medical staff members of a committee shall serve in an ex-officio capacity without a vote.

Committees of the Medical Staff described in the ASC Medical Staff Bylaws all function as "medical committees" and/or "medical peer review committees" pursuant to state law. Each committee's records and proceedings are, therefore, confidential, legally privileged, and protected from discovery under certain circumstances.

The function that the committee 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 committee, the committee's 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, committee meetings must be limited to only the committee members and invited guests who need to attend the meetings. The committee 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 committee 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 committee meetings, without prior approval from the Chair of the committee. Documents prepared by or considered by committee in the committee meetings must clearly indicate that they are not to be copied, are solely for use by the committee, and are privileged and confidential.

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

Section 1. The Medical Executive Committee

a. Membership
All Active Medical Staff members are eligible for membership on the Medical Executive Committee. The Medical Director shall act as the Chair of the Medical Executive Committee.

b. Voting Members

The Medical Executive Committee shall consist of five (5) members of the Active Medical Staff, including the Medical Director. There shall be no more than one (1) committee member per specialty and there must be a committee member from anesthesiology.

c. Election of Voting Members

Voting members of the Medical Executive Committee will be elected every two (2) years. Nominations and voting will occur at the beginning of the first Medical Executive Committee meeting of the new term. In the event a voting member is unable to complete his or her term, a special election will occur at the next Medical Executive Committee to fill the position.

d. Ex-officio Non-Voting Members:

(1) The Administrator of the ASC at LBJ.

e. Invited Guests

At the request of a committee member, non-voting guests may attend meetings of the Medical Executive Committee.

f. Duties

(1) Report to the Governing Body on all evaluation, monitoring and recommendations regarding the appropriateness and quality of health care services rendered to the patients at the ASC;

(2) Review, investigate, and make recommendations on matters relating to the professional competence and conduct of Practitioners and APPs, including the merits of complaints and appropriate corrective action;

(3) Represent and act on behalf of the Medical Staff and APPs between meetings, subject to such limitations imposed by these Bylaws;

(4) Coordinate the activities of and initiate and implement general policies applicable to the Medical Staff;

(5) Receive and act upon committee reports;

(6) Act as the liaison between the Medical Staff and the Governing Body;

(7) Periodically review all information available concerning the performance and clinical competence of Practitioners and APPs with clinical priviliges and make recommendations for reappointment or changes in clinical privileges;

(8) Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of the Practitioners and APPs with clinical privileges in the ASC;

(9) Review credentials of all applicants to the Medical Staff, as well as APPs, make recommendations on initial appointment and reappointment to the medical staff, and delineate clinical privileges;

(10) Perform appropriate functions related to quality assessment and improvement, medical records, surgery, infection control and antibiotic usage, tissue review, medical staff utilization, pharmacy and therapeutics, anesthesiology, and other such functions; and

(11) Perform other duties as requested by the Governing Body.

ARTICLE XII— IMMUNITY FROM LIABILITY

The following shall be express conditions to any Medical Staff member's application for clinical privileges within the ASC at LBJ:

Condition 1.

Any act, communication, report, recommendation, or disclosure, with respect to any such Medical Staff member performed, or made in good faith and without malice, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and immune from liability to the fullest extent permitted by law.

Condition 2.

All such privileges and immunities shall extend to members of The ASC at LBJ's Medical Staff and of its Governing Body, its other Practitioners, its Medical Director and his or her representatives, the Administrator of the ASC at LBJ, and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVII, the term

"third parties" means both individuals and organizations who provide information to an authorized representative of the Governing Body or of the Medical Staff.

Condition 3.

There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Condition 4.

All such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities, including, but not limited to:

a. Applications for appointment or clinical privileges;

b. Periodic reappraisals for reappointment or clinical privileges;

c. Corrective action, including summary suspension;

d. Hearings and appellate reviews;

e. Medical care evaluations;

f. Utilization reviews; and

g. Other ASC, department, service or committee activities related to quality patient care and inter-professional conduct.

Condition 5.

The acts, communications, reports, recommendations and disclosures referred to in this Article XII may relate to a Medical Staff member's professional qualifications, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Condition 6.

Each Medical Staff member shall, upon request of the ASC at LBJ, execute a release in favor of the entities identified in the Second paragraph of this Section and consistent with the provisions of this Article XII.

ARTICLE X111 — CONFLICTS OF INTEREST

Section 1. Definitions

Conflicts of Interest – A conflict of interest potentially exists when a Medical Staff member, or a relative, has direct or indirect interests, including financial and personal interests, or business transactions or professional activities, that may compromise or appear to compromise: (1) the Medical Staff member's clinical judgment; (2) the delivery of patient care; or (3) the Medical Staff member's ability to fulfill his or her Medical Staff obligations.

Section 2. Compliance

Medical Staff members must comply with the Conflict of Interest policies of their affiliated organization (e.g. Baylor College of Medicine, The University of Texas Health Science Center at Houston, or Harris Health for Contract Practitioners and Medical Staff members employed by Harris Health).

Section 3. Disclosure of Potential Conflict of Interest

a. A Medical Staff member shall have a duty to disclose any conflict of interest when such interest is relevant to a matter of action (including a recommendation to Harris Health Administration or the Governing Body) being considered by a committee, department or other body of the Medical Staff. In a Medical Staff member's dealings with and on behalf of the ASC, the Medical Staff member shall be held to a strict rule of honest and fair dealing with the ASC. The Medical Staff member shall not use his or her position, or knowledge gained there from, so that a conflict might arise between the interests of the ASC and those of the Medical Staff member.

b. As a matter of procedure, the Chairperson of the Medical Staff committee or other body designated to consider a matter that may lead to the provision of items, services or facilities to the ASC by a third party or the establishment of a business relationship between a third party and the ASC shall inquire, prior to any discussion of the matter, whether any Medical Staff member has a conflict of interest. The existence of a potential conflict of interest on the part of any committee member may be called to the attention of the committee Chairperson by any Medical Staff member with knowledge of the matter.

c. Any Medical Staff member with a conflict of interest on any matter should not vote or use his or her personal influence regarding the matter, and he or she should not be counted in determining the quorum for the body taking action or making a recommendation to the Governing Body. The minutes of that meeting should reflect that a disclosure was made, the abstention from voting, and the quorum situation.

d. The foregoing requirements should not be construed as preventing the Medical Staff member from briefly stating his or her position in the matter, nor from answering pertinent questions by the Governing Body or other Medical Staff members since his or her knowledge may be of great assistance.

ARTICLE XIV — RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed without previous notice at any general Medical Staff meeting, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A two-thirds affirmative vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

If the voting members of the Medical Staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they shall communicate the proposal to the Medical Executive Committee prior to submission of the proposal to the Governing Body. If the Medical Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff. When the Medical Executive Committee proposes a policy or an amendment thereto, it shall thereafter report the change to the Medical Staff.

If the Medical Executive Committee or Medical Director identifies an urgent need for amendment to Rules and Regulations to comply with laws or regulations, the Medical Executive Committee may provisionally adopt, and the Governing Body may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff shall be immediately notified by the Medical Executive Committee. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment shall remain in place. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Medical Executive Committee shall be implemented. If necessary, a revised amendment may be submitted to the Governing Body for action.

If there is a conflict between these Bylaws and the Rules and Regulations, the Bylaws shall prevail.

ARTICLE XV— PHYSICIAN/PRACTITIONER HEALTH ISSUES POLICY

The Medical Staff shall adopt such Physician/Practitioner Health Issues. Policy as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Physician/Practitioner Health Issues Policy shall be a part of these Bylaws, except that the Policy may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A two-thirds affirmative vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVI — CREDENTIALING POLICIES AND PROCEDURES

The Medical Staff shall adopt a Medical Staff Credentialing Procedures Manual as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is to be required of each Practitioner in the ASC. Such Medical Staff Credentialing Procedures Manual shall be a part of these Bylaws, except that the Manual may be amended or repealed without previous notice at any general meeting of Medical Staff, or by the Medical Executive Committee or at any special Medical Staff meeting on notice, provided a quorum is present. A majority vote of those present shall be required for amendment or repeal. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVII — AMENDMENTS

Section 1. Amendment Process

a. Amendment(s) to the Bylaws may be proposed at any meeting of the Medical Executive Committee.

b. All proposed amendments to the Bylaws approved by the Medical Executive Committee shall be submitted to the members of the Active Medical Staff for approval. The proposed

amendment(s) to be adopted shall require a majority vote of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws may be voted on at any regular or special meeting of the Medical Staff or submitted to the members of the Active Medical Staff for vote by written or electronic ballot, as approved by the Medical Executive Committee. Notice of such regular or special meeting shall be made at least fifteen (15) days in advance and shall include the Bylaws amendment(s) to be voted upon.

c. Bylaws Amendment(s) approved by the Medical Executive Committee and the Medical Staff shall be forwarded to the Governing Body, which shall approve, disapprove or approve with modifications. If the Governing Body modifies any Bylaw amendments approved by the Medical Executive Committee and the Medical Staff, such amendments, as modified, shall be returned to the Medical Executive Committee, which may accept or reject the modifications. If the Medical Executive Committee accepts the modifications, the amendment shall be submitted to the members of the Active Medical Staff for approval or disapproval as described in Section (b) above. If the Medical Executive Committee rejects the modification, the amendment shall be submitted again to the Governing Body, which may either approve or disapprove the amendment. Any disputes regarding proposed bylaws amendments shall be referred to the Joint Conference Committee for discussion and further recommendation to the Medical Executive Committee and the Governing Body.

d. Bylaws Amendments may also be proposed to the Governing Body by the Medical Staff by majority vote of the members of the Active Medical Staff voting on the proposed amendment. Proposed Bylaws shall be brought before the Active Medical Staff by petition signed by 20% of the members of the Active Staff. Any such proposed Bylaw amendment shall be submitted to the Medical Executive Committee for review and comment before it is submitted to the voting members of the Active Medical Staff. Any Bylaw amendment approved by a majority of the Active Medical Staff shall be presented to the Governing Body for final action along with any comments from the Medical Executive Committee.

e. These Bylaws, and all amendments thereto, shall be effective when approved by the Governing Body, unless otherwise stated in the Bylaw provision or amendment approved by the Governing Body, and shall apply to all pending matters to the extent practical, unless the Governing Body directs otherwise.

f. These Bylaws shall not be unilaterally amended by the Governing Body or the Medical Staff.

Section 2. Editorial Amendments

Notwithstanding Section 1 of this Article XVIII, the Medical Staff Services shall have the authority to make non-substantive editorial changes to the Bylaws and to correct any typographical, formatting, and inadvertent errors.

Section 3. Review Process

These Bylaws shall be reviewed at least annually and amendments made according to the described amendment procedure.

ARTICLE XVIII — PARLIAMENTARY PROCEDURES

Where these Bylaws do not conflict, *Robert's Rules of Order* shall be used in the conduct of Medical Staff meetings.

ARTICLE XIX — CONFLICT MANAGEMENT

A conflict management process shall be developed and implemented when a conflict arises between the Medical Executive Committee and Medical Staff on issues including, but not limited to, proposals to adopt provisions of, or amendments to, the Rules and Regulations or these Bylaws. The conflict management process shall include a meeting between the involved parties as early as possible to identify the conflict, gathering information about the conflict, working with all parties to manage and, to the extent possible, resolve the conflict, and ultimately protect patient safety and quality of care. As necessary, the Medical Director shall appoint an individual to act as mediator between the groups in an effort to resolve the conflict. The Governing Body shall have the ultimate discretion to determine an effective resolution to any conflict between the Medical Staff and the Medical Executive Committee, should the parties not be able to come to a resolution. The Governing Body shall regularly review whether the process is effective at managing conflict and shall revise the process as necessary.

ARTICLE XX - ADOPTION

These Bylaws shall be adopted at any regular or special meeting of the Active Staff, shall replace any previous Bylaws, and shall become immediately effective when approved by the Governing Body of The Ambulatory Surgical Center (ASC) at LBJ.

Accepted and adopted by the Medical Director and Chair of the Medical Executive Committee of the Ambulatory Surgical Center (ASC) at LBJ and the ASC Governing Body on March 29, 2018.

_____

Scott Perry, MD
Medical Director, Chair of Medicial Executive Committee
ASC at LBJ

_____

Ewan D. Johnson, MD
Chair, ASC Governing Body

Thursday, August 18, 2022

Ambulatory Surgical Center at LBJ Medical Director and Administrator Reports

Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the ASC at LBJ, Including Questions and Answers.

1. Implementation of Block Guidelines and Committee
2. Ask My Nurse Emergency Center Visit Mitigation Process

MINUTES OF THE AMBULATORY SURGERY CENTER MEDICAL EXECUTIVE COMMITTEE
Harris Health System
April 26, 2022 7:00 am

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
CALL TO ORDER	The meeting was called to order at 7:00 a.m. by Scott Perry, MD, Chairperson.	
MINUTES OF THE PREVIOUS MEETING	The March 29, 2022 minutes of the Ambulatory Surgery Center (ASC) Medical Executive Committee were approved as presented.	
ANNOUNCEMENTS/INFORMATION	**Staffing at the ASC & OR Block Schedule** Dr. Perry stated that we have been able to run 4 rooms on most days over the last week. There are no more days in the foreseeable future where we are going to only be able to run 2 rooms and there will be days where we can run 5. We will consistently run 3-4 rooms per day over the next few weeks. We also have some new hires coming in. Matt Reeder gave a staffing update, stating that we are currently looking at bringing two registry staff to the ASC to help maintain that 5th room on a more regular basis. We continue to interview as many candidates as reasonably possible. We have one agency nurse coming in May but have one of our own nurses going out on maternity leave that same week.	
UNFINISHED BUSINESS	**Hand Hygiene Provider Feedback** Dr. Perry stated that this is an initiative we had discussed with Amy Kimes and Dr. Brass about sending feedback to our fall-outs in real time. We started sending those letters to providers in real time last week as another component of our continuing hand hygiene initiative here at ASC.	
NEW BUSINESS	**Block Utilization** Dr. Perry stated that we have been meeting individually with the Chiefs and going over where each service stands in terms of utilizing their block time We are getting feedback from each provider and individual services on ways we can help and work together to help maximize their utilization. We have had a lot of helpful and constructive discussions to help us address any identified issues related to scheduling and cancellations. Discussion ensued regarding possible processes in the business office that could be contributing to any current issues. Dr. McAlister stated that one thing reported in the past for Medicaid patients is that they are able to change their Medicaid carrier on a monthly basis. They try not to pre-authorize Medicaid patients in a different month. Dr. Small stated that she was unsure if it was done at Harris Health but there is a process called batch authorization where they go through the schedules and do a batch run to the insurance carriers. A report is being requested so we can get more details on the cancellations. She stated that they can take the discussion offline and bring it back to the committee. **1st Quarter Cancellation Report** Matt Reeder presented the Day Of Cancellation Report. These are the day of cancellations and the reasons behind them. The highest category is patient condition change. The breakdown of this category shows most of the reasons are due to COVID positive patients, uncontrolled blood pressure and glucose changes. It is hoped that the COVID positive occurrences go down as we move through the pandemic. We have historically had challenges around blood pressure control and glucose control. Other reasons include the	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	number of rooms running which doesn't happen often but there have been some. As we are able to staff ASC fully, that challenge will be minimized. There are also cancellations due to patient changing their mind and transportation problems. Amy Smith's area is working on an agreement with Lyft and/or Uber. Dr. Brass asked if there were inclusion/exclusion criteria for preoperative blood pressure and glucose. Dr. Perry stated yes, the ASC guidelines for exclusion from surgery include controlled diabetes and controlled hypertension. There are specific numbers around it that the pre-op screening clinic uses. Those guidelines are used to determine if the patient can move forward with surgery. Discussion ensued regarding those same day cancellations due to blood pressure or glucose control. It was asked if additional FTEs would help with this. Dr. Perry stated yes, another FTE or half FTE for that particular role would help us out immensely. Mr. Reeder thanked Dr. Small for helping out with that process as well. **Block Committee** Dr. Perry stated that this is a proposed guideline that we wanted to share with the MEC. We have sent this to all the Chiefs and have been meeting with the chiefs individually to review utilization and what that current utilization would mean under the proposed block committee guideline. The block committee guideline was presented for review. The committee guideline just puts in writing what we have been trying to do since the ASC opened. We try to reward those block holders with high utilization with more block time. We try to help those with low utilization rates. The Block Committee would consist of Dr. Perry, Administrator of ASC, EVP of ACS, a member of the ASC MEC and the Manager of the ASC OR. Dr. Ko stated that the proposed committee and ASC OR block utilization decisions have a lot of administrative involvement, whereas the main OR does not have that level of administrator involvement. Dr. Ko will meet with Dr. Small and Mr. Smith offline. Dr. Hanna stated that holding services to a tight guideline becomes counterintuitive until we can fix the issues of getting cases booked into the ASC. He asked if these guidelines were going to help them get back to where they were. Dr. Perry stated that he understood the concerns. The goal of this is to provide a little structure and to help the services recognize when they are having difficulty. The purpose of the Block Committee and guideline is not punitive in any way and is there to help when needed. Discussion ensued regarding details of the guidelines. Dr. McAlister stated that having the committee is helpful because physicians have the opportunity to explain any extenuating circumstances. He stated that Dr. Ko's point is important - that we should have more physician involvement on the committee. Dr. Perry stated that the guidelines will come back to the committee for a vote at a future meeting. **Same Day Surgical Consent** Dr. Perry stated that some of the services have been participating in a pilot to do as much of the surgical consents they could but finishing them on the day of surgery. The reason was to try to minimize delays due to having to completely redo consents. We have had some issues with this practice with certain services including delays. He asked for input from the chiefs on the consent process related to their services. Dr. McCarty stated that things are going generally well. She stated that she has addressed those issues being experienced by various services. She stated that she believed all discussions should take place in the clinic in the day of in addition to signatures. She stated that she was unsure of the status of the interpreter	

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION/RECOMMENDATIONS</th></tr>
<tr><td></td><td>issues. Discussion ensued regarding interpreters in the ASC. Catherine Walther stated that the key is that we are using an interpreter for patients that don't speak English. The interpreters do keep records of all the interpretations they do and can pull that if there ever is a question</td><td></td></tr>
<tr><td>STANDING BUSINESS</td><td>Medical Staff Services Report
Credentialing
One initial appointment was presented for approval. The applicant has a clean file.

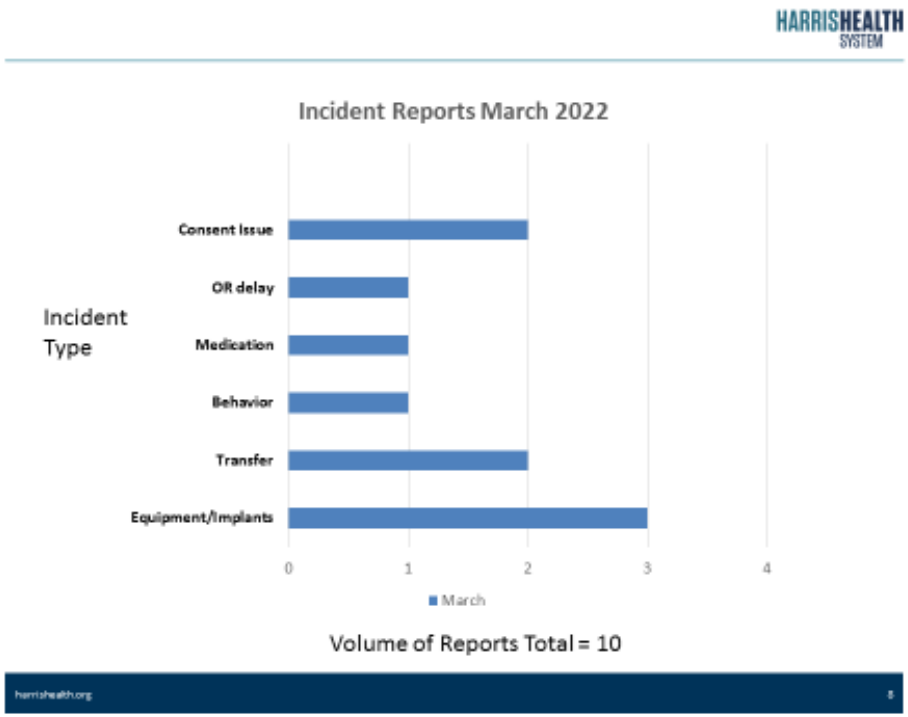
Initial Appointments
<table>
<tr><th>Last Name</th><th>First Name</th><th>Degree</th><th>Service</th></tr>
<tr><td>Movahedan</td><td>Asadolah</td><td>MD</td><td>Ophthalmology</td></tr>
</table>
It was moved and seconded to approve the one (1) initial appointment as presented. Motion carried.
It was moved and seconded to approve temporary privileges for the one (1) initial appointment. Motion carried.

Three reappointments were presented for approval. All applicants have a clean file.

Reappointments
<table>
<tr><th>Last Name</th><th>First Name</th><th>Degree</th><th>Service</th></tr>
<tr><td>Feldman</td><td>Robert</td><td>MD</td><td>Ophthalmology</td></tr>
<tr><td>LaPointe</td><td>Janet</td><td>CRNA</td><td>Anesthesiology</td></tr>
<tr><td>Mitchell</td><td>Scott</td><td>MD</td><td>Orthopedic Surgery</td></tr>
</table>
It was moved and seconded to approve three (3) reappointments as presented. Motion carried.
The resignations were presented for information.
Adriana Barron asked those on the call to encourage their services to complete the mandatory education by the deadline of May 31.

Quality Presentation
AAAASF Patient Safety Data Reporting
Amy Kimes presented the Quality Report for March. The hand hygiene data was not available for the</td><td>Two (2) credentialing files (initial appointments) were approved. Temporary Privileges were approved for two (2) initial appointments.</td></tr>
</table>

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	meeting. She addressed the QR code for the medical students and residents training. We were able to get our data for the attestation on this project. For the first two weeks in April, we have 2 dental students, 1 anesthesia resident and 2 medical students that have attested to the training. The next step is to increase use of this code. here. The 5 Moments for Hand Hygiene was reviewed. She also reviewed pictures of the preop area and PACU bays showing the location of dispensers and patient zones for each. Pictures of the ASC OR were also presented and reviewed. She presented the EC Visits after ASC volume for March. There were 7 visits - 2 ortho, 2 ophthalmology, 2 general surgery and 1 urology. Dr. Brass asked if we have implemented our residents Ask my Nurse program yet. Ms. Kimes stated that it is in progress. Matt Reeder stated that we continue to run into challenges and it hasn't been implemented yet. There is ongoing communication with the Epic group. We continue to wait for feedback in regards to Epic communicating with outside pharmacies. We continue to work on the spok process and the Ask My Nurse staff getting trained by the PARC team. We are also waiting for feedback from our physician partners to come up with a timeframe for their specific services. Dr. Brass stated that it would be helpful to get communication on the timeframe to get the physician aspect. He asked Mr. Reeder to contact him on the other things that he could help support and move forward. He asked Matt to set up a meeting and he would attend and support them. All the key players will be invited and we will go through the list of barriers and address those in one meeting. Amy Kimes presented Incident Reports for March.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	 She addressed the VTE Risk Assessment data, stating that we are doing well. There was one fall out on a urology case. Urology was at 94% and all other services were at 100%. She reviewed reminders for patient safety data reporting and preop documentation requirements.	
ADMINISTRATIVE REPORT	**ASC Scorecard** Matt Reeder presented the ASC Scorecard Report for March. He presented an overview of block utilization, 1st case starts, turnover time and cancellations for March.	
ADJOURNMENT	There being no further business to come before the committee, the meeting was adjourned at 7:56 a.m.	

Scott Perry, M.D., Chairperson

Minutes recorded by Medical Staff Services (CR)

MINUTES OF THE AMBULATORY SURGERY CENTER MEDICAL EXECUTIVE COMMITTEE
Harris Health System
May 24, 2022 7:00 am

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
CALL TO ORDER	The meeting was called to order at 7:00 a.m. by Scott Perry, MD, Chairperson.	
MINUTES OF THE PREVIOUS MEETING	The April 26, 2022 minutes of the Ambulatory Surgery Center (ASC) Medical Executive Committee were approved as presented.	
ANNOUNCEMENTS/INFORMATION	**Staffing at the ASC** Dr. Perry stated that we are consistently at 3-4 rooms per day for the past month. Matt Reeder gave the ASC staffing update. We are interviewing for a second peri-operative clinical coordinator to partner with Stephanie and the nurse navigator that we continue to recruit. We are moving the PCC position through the approval process and it should be complete this week and posted for recruitment. We continue to recruit to our nurse navigator position which is more difficult than anticipated. We are recruiting scrub techs through our supplemental staffing in regards to our scrub techs. We are one scrub tech short on some days and continue to recruit to that position and some nursing positions that are vacant. We currently have an agency nurse in the ASC OR. We will be having a recruitment fair specific to ASC on July 2. We also continue to recruit to the NC1 position which should be seen soon.	
UNFINISHED BUSINESS	**Block Guidelines** Dr. Perry stated that we have been discussing block guidelines for the past couple of months and there have been some updates since the group last met. The biggest change is related to the makeup of the Block Committee. We have spoken with several stakeholders and the proposed makeup of the block committee would be the Medical Director of ASC, Medical Director of OC, ASC Administrator, OR Manager and one member of the MEC. He asked that any member interested contact him or Matt. The committee will meet quarterly. **Ask My Nurse (AMN) Process** Dr. Perry stated that this is a process where a pilot will be done with BT Ortho and LBJ Ortho where patients will speak with a member of the surgical team when calling Ask My Nurse after leaving ASC. The pilot started on Monday of last week. We met with Dr. Saunders and Dr. McAlister yesterday to discuss issues that have come up. He thanked the Ask My Nurse team for their engagement and their willingness to be. Dr. Brass asked how many calls have been received that Ask My Nurse was able to send to the residents to get an idea of the volume. Mr. Reeder stated that we are aware of 3. Dr. Brass asked if there were any identified barriers with those 3 calls. Mr. Reeder stated that the schedule we had identifying what resident to call was a barrier. We did work through that yesterday. We will continue to meet every two weeks or even weekly until we feel the process is solid. Dr. Brass asked if AMN had access to SPOK. Mr. Reeder stated yes, they pulled up SPOK while we were on the call to determine who was on call. Dr. Perry thanked Dr. McAlister and Dr. Saunders for all of their help in getting the process off the ground.	

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>ACTION/RECOMMENDATIONS</th></tr>
<tr><td></td><td>Block Utilization
Mr. Reeder presented the Block Utilization Report. The ASC reviews block utilization that matches up with what is seen on the inpatient side. The report showed block utilization by day and time and focused on Monday. He explained the reports and how utilization is being measured. He noted that the committee will look at quarterly reports. He reviewed the reports for Tuesday-Friday. Dr. Chung asked if we had expected variation by day of week. Dr. Perry stated that we do expect a variation by day of week. Moving forward, we will try to provide this feedback for the previous month. The Block Committee will provide that feedback and that will be part of the block committee as well as to provide that feedback and go over where each service stands with their individual block utilization.</td><td></td></tr>
<tr><td>NEW BUSINESS</td><td>First Case Delays
Dr. Perry stated that we have been trying to provide feedback to the providers related to the various reasons for our first case delays. He asked members to please let their teams know how important it is for them to be on time in order to get all the preoperative work done. We do not have a 5-minute grace period like the main OR. Physicians being late is not the only reason for first case delays but we can work to prevent the delays that are. Any delay in start is reflected on the block utilization report that Mr. Reeder presented earlier in the meeting. The most recent first case on time start report with reasons was reviewed with the committee. Dr. Perry stated that the majority of them fell into the other issue category. The volume of delays has gotten better.
Dr. Hanna stated that they don't often know what attributed to a late start. He asked if they could start getting that data. They receive that information in the main OR and can work through it to determine what happened. He stated that the service is getting penalized for any late start in block utilization but asked why the service would get penalized if the reason for the delay is not them. Mr. Reeder stated that we have a daily email that goes out about first case delays. It goes out to a group but we can start including the service chiefs. He addressed how first case start factors into block utilization. He stated that it is multifactorial - it's first case starts, day of cancellations, going beyond your block in late afternoon and overall utilization of that block. Dr. Perry stated that they would make sure the report is shared with the service chiefs and provider. Dr. Ko thanked Dr. Perry and Mr. Reeder for their leadership and this initiative. We want accountability to make sure we have maximal utilization of a very important resource but we know there are other mitigating factors.</td><td></td></tr>
<tr><td>STANDING BUSINESS</td><td>Medical Staff Services Report
Credentialing
One initial appointment was presented for approval. The applicant has a clean file.

Initial Appointments
<table>
<tr><th>Last Name</th><th>First Name</th><th>Degree</th><th>Service</th></tr>
<tr><td>Ranganathan</td><td>Govindaraj</td><td>MD</td><td>Anesthesiology</td></tr>
</table></td><td>One (1) credentialing files (initial appointments) was approved. Temporary Privileges were approved for one (1) initial appointments.</td></tr>
</table>

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	It was moved and seconded to approve the one (1) initial appointment as presented. Motion carried. It was moved and seconded to approve temporary privileges for the one (1) initial appointment. Motion carried. Ms. Barron stated that she will schedule time to meet with Dr. Perry about the categories of providers and activity. Dr. Perry stated that they should be able to put case minimums on the June agenda. **Quality Presentation** **AAAASF Patient Safety Data Reporting** Amy Kimes presented the Quality Report. She presented the hand hygiene data and it shows the compliance is much higher than before. We are in transition to another reporting platform for hand hygiene. She has met with Infection Prevention because the raw data has not been reviewed. She noted that she was cautiously optimistic about the accuracy of the report. She addressed the QR code for medical students and residents training. She has not received an update and has requested access to the reports. The 5 Moments for Hand Hygiene was reviewed. She also reviewed pictures of the preop area and PACU bays showing the location of dispensers and patient zones for each. Pictures of the ASC OR were also presented and reviewed. Dr. Brass asked if she was able to reach anyone about having access to the information. Ms. Kimes stated that she spoke with Kimberly Cooper and was told that we are in a blackout period. I was told that we were in a blackout period until June. Ms. Kimes presented the April report for EC visits after ASC. There were a total of 13 EC visits - 6 ortho, 6 general surgery and one gyn case. She reviewed the reasons for those visits with the committee. There were 8 electronic incident reports for April. She reviewed the reports with the group. Ms. Kimes presented VTE Risk Assessment data for April. We only had one fallout with Orthopedics - their compliance remains high at 97% out of 33 cases. She reviewed reminders for patient safety data reporting and preop documentation requirements. Dr. Brass asked her to send him the DVT audit sheet. She gave background information on the DVT audit sheet used at ASC.	
ADMINISTRATIVE REPORT	**ASC Scorecard** Matt Reeder presented the ASC Scorecard Report for April. He presented an overview of block utilization, 1st case starts, turnover time and cancellations for the month.	
ADJOURNMENT	There being no further business to come before the committee, the meeting was adjourned at 7:49 a.m.	

Scott Perry, M.D., Chairperson

Minutes recorded by Medical Staff Services (CR)

MINUTES OF THE AMBULATORY SURGERY CENTER MEDICAL EXECUTIVE COMMITTEE
Harris Health System
June 28, 2022 7:00 am

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
CALL TO ORDER	The meeting was called to order at 7:00 a.m. by Scott Perry, MD, Chairperson.	
MINUTES OF THE PREVIOUS MEETING	The May 24, 2022 minutes of the Ambulatory Surgery Center (ASC) Medical Executive Committee were approved as presented.	
ANNOUNCEMENTS/INFORMATION	**Staffing at the ASC** Matt Reeder stated that we have filled positions in our pre-operative and recovery areas. We are anticipating filling our nurse navigator position which is a preoperative position. We are currently interviewing for our perioperative clerical coordinator - that is a second scheduler that will help with our patients pre-operatively to make sure they are prepared for surgery. It also helps our surgeons to manage our waitlist. We are working on our OR staffing. We currently have an agency nurse and are reviewing his contract for a couple more weeks. We continue to engage with our nursing education department to bring one nurse graduate to train internally. Dr. Perry asked what the timeline was for running at full capacity - 5 rooms - continuously. Mr. Reeder stated that it is contingent upon obtaining a registered nurse. We continue to meet with HR every other week to discuss and work through how we can recruit more nurses. We continually run into a monetary challenge. **Accreditation Update** Dr. Perry stated that this year was our self-survey with AAAASF. There was a deficiency around an environmental issue with our cardboard management in the hallways. A CAP was developed which is now being monitored. Amy Kimes stated that we were cited when they were onsite two years ago. The CAP was for EVS and monitoring of the bin by the employee elevator.	
UNFINISHED BUSINESS	**Revised Block Guidelines** Dr. Perry stated that we will have our first Block Committee meeting tomorrow. We will be doing an initial look at our current utilization. **Same Day Surgical Consent** Dr. Perry stated that we have had discussion around the same day surgical consent. Many services are doing part of the consent prior to and part of the consent the day of surgery. We talked about the process at the LBJ OR Committee meeting from an efficiency and compliance standpoint. Issues that were brought up included interpretation documentation and having different physicians doing part of the same consent. Carolynn Jones stated that services work as a team so an individual physician member on that team can disclose the risks and hazards to the patient as part of the initial visit and another physician can collect the signature on the day of procedure/surgery. However, any physician can choose to have an additional, full conversation with the patient. The other issue discussed was related to interpreters. There has been an ask to put multiple fields on the consent form for more than one interpreter with a space for each interpreter to note what portion they interpreted for. We are looking at that with IT and believe we will be	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	able to accommodate that. Her recommendation for the interim is to document this in the medical record if there are no fields on the form.	
NEW BUSINESS	**Case Minimums** Dr. Perry stated that the ASC Bylaws have case minimums for the ASC. We suspended that requirement during COVID and while we had our staffing issues. We were going to propose reinstating those minimums when our capacity gets to a certain level. The level proposed is when half of our days are at a 5-room capacity. **Block Committee** The Block Committee will meet for the first time tomorrow. The members are Dr. Perry, Matt Reeder, Dr. Alava, Rebecca Lee and Dr. Hanna. **New ASC Residents Checking In** Myles Matherne addressed the new residents checking in. We have been working on a packet similar to ones given in the past. He asked that the Chiefs of Service let them know how they want those packets distributed. **Pharmacy Task Force** Mr. Matherne stated that physicians have been struggling with prescriptions getting over to various pharmacies, specifically for narcotics. Most of the problems come from Walgreens and CVS. We have appointed a task force to investigate Epic SureScripts and end user interfaces. We are seeing that some prescriptions are going through but it is not consistent. We are having much more success with those pharmacies in grocery stores. We are working to identify those errors and nursing is trained. They will ask the resident to switch over pharmacies if needed. Harris Health pharmacies are not eligible for these prescriptions so we do have to send to a third party pharmacy and the perioperative nurses are trained. Dr. McAlister stated that he has some faculty that don't come to ASC often and find that their Imprivata has been deactivated or they need to reregister for another reason. The only way they have been able to do that is to physically come to LBJ. Ms. Barron stated that they are registering physicians for Imprivata virtually. She will email Dr. McAlister and Myles Matherne that information.	
STANDING BUSINESS	**Medical Staff Services Report** *Credentialing* No files.	

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
	Quality Presentation **AAAASF Patient Safety Data Reporting** Amy Kimes presented the Quality Report. She stated that she was able to get April and May hand hygiene data which showed that our compliance has increased. We were 100% compliant in May with 52 observations. The new QR code for medical student and resident training has moved into the collection phase to view usage. We did put in a ticket for support from the quality analyst to get a platform where we can see this data on our own. She reviewed the April and May participation report for those that participated. There were 6 residents and/or medical students that attested to the training in April and 7 in May. A meeting is also scheduled with LRC to develop a short video to go along with it. The 5 Moments for Hand Hygiene was reviewed. She also reviewed pictures of the preop area and PACU bays showing the location of dispensers and patient zones for each. Pictures of the ASC OR were also presented and reviewed. There were a total of 9 EC visits after ASC in May - 4 general surgery, 3 ortho, 1 ENT and 1 Urology. Three of the 9 contacted Ask my Nurse. She reviewed the reasons for those visits with the committee. There were 14 electronic incident reports for May. She reviewed the reports with the group. There was one lost specimen in May. She reviewed VTE risk assessment data for the month. We had 246 cases for the month and 9 fall-outs which is higher than previous months. Four were in ortho, 1 was ophthalmology, 3 Gyn and 1 general surgery. An RCA will be done to address the lost specimen. She reviewed reminders for patient safety data reporting and preop documentation requirements.	
ADMINISTRATIVE REPORT	**ASC Scorecard** Matt Reeder presented the ASC Scorecard Report for May. He presented an overview of block utilization, 1st cast starts, turnover time and cancellations for the month. Dr. Brass stated that it would be helpful to review the readmissions (to EC) within 24 hours to see if there's any opportunities among them. He asked if they could drill down on those cases to determine if they could identify any opportunities. Matt Reeder stated that they have this data in a different report but we can bring it to the next MEC. .	
ADJOURNMENT	There being no further business to come before the committee, the meeting was adjourned at 7:47 a.m.	

Scott Perry, M.D., Chairperson

Minutes recorded by Medical Staff Services (CR)

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Executive Session

Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ Governing Body, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Possible Action Upon Return to Open Session, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ

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BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

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 Including a Status of Fraud and Abuse Investigations, Pursuant to Texas Health & Safety Code §161.032, and Possible Action Regarding This Matter Upon Return to Open Session.

This information is being presented for informational purposes only.

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 18, 2022

Executive Session

Report Regarding Quality of Medical and Health Care, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including ASC at LBJ Quality Scorecard Report, Quality Review Committee Report and Medical Executive Committee Report, Including Possible Action Upon Return to Open Session

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