HARRISHEALTH SYSTEM

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, August 17, 2023
9:00 A.M.

BOARD ROOM
4800 Fournace Place, Bellaire, Texas 77401

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

Notice: Members of the Governing Body may participate by videoconference.

Mission

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

AGENDA

I.	**Call to Order and Record of Attendance**	**Ewan D. Johnson, MD, PhD**	**1 min**
II.	**Approval of the Minutes of Previous Meeting** • ASC at LBJ Governing Body Meeting – May 18, 2023	**Ewan D. Johnson, MD, PhD**	**1 min**
III.	**Executive Session**	**Ewan D. Johnson, MD, PhD**	**30 min**
A.	Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ, 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 Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Upon Return to Open Session ***– Dr. Scott Perry***		*(10 min)*
B.	Report by the Vice President, Compliance 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 ***– Mr. Anthony Williams***		*(10 min)*
C.	Report Regarding Quality of Medical and Healthcare, 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 Healthcare 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)*

IV.	**Reconvene**	**Ewan D. Johnson, MD, PhD**	**2 min**
V.	**General Action Item(s)**	**Ewan D. Johnson, MD, PhD**	**15 min**

A. General Action Item(s) Related to Quality *(5 min)*

1. Consideration of Approval of Credentialing Changes for Members of the Harris Health System Ambulatory Surgical Center at LBJ Medical Staff – ***Dr. Scott Perry***
2. Consideration of Approval of the Quality Assessment and Performance Improvement Plan for the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder***
   i. Quality Improvement Program
   ii. Infection Control Program

B. General Action Item(s) Related to Policy and Procedures *(10 min)*

1. Consideration of Approval of New and/or Amended Policies and Procedures for the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder***
   i. Policy ASC-P-1001
   ii. Policy ASC-P-6015 and 6016
2. Consideration of Approval of Medical Staff Bylaws for the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder***
3. Consideration of Approval of Revisions to Governing Body Bylaws of the Ambulatory Surgical Center at LBJ ***– Dr. Scott Perry and Mr. Matthew Reeder***
4. Discussion and Appropriate Action to Elect Officers of the ASC Governing Body in Accordance with Article V, Section 2 of Governing Body Bylaws of the Ambulatory Surgical Center (ASC) at LBJ ***– Dr. Scott Perry***
   - Vice Chair

VI.	**Ambulatory Surgical Center at LBJ Governing Body 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, Including Questions and Answers ***– Dr. Scott Perry and Mr. Matthew Reeder***

VII.	**Adjournment**	**Ewan D. Johnson, MD, PhD**	**1 min**

MINUTES OF THE HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
May 18, 2023
9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:00 a.m. by Ewan D. Johnson, MD, PhD, Chair. It was noted that a quorum present and the attendance was recorded. Dr. Johnson stated while some of Board members are in the room with us today, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. The meeting may be viewed online: http://harrishealthtx.swagit.com/live.	**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 Meeting: • ASC at LBJ Governing Body Meeting – February 16, 2023	**Motion No. 23.05-06** **Moved by Ms. Alicia Reyes, seconded by Dr. Arthur Bracey, and unanimously passed that the Governing Body approve the minutes of the previous meeting. Motion carried.**
III. Executive Session	At 9:17 a.m., Dr. Johnson stated that the ASC Governing Body would enter into Executive Session for Items "A through C" as permitted by law under Texas Health & Safety Code Ann. §161.032 and Texas Occupations Code Ann. §160.007.	
	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ Hospital, 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 Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Hospital Upon Return to Open Session.	**No Action Taken.**
	B. Report by the Vice President, Compliance 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 Healthcare, 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 Healthcare 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.**
IV. Reconvene	At 9:41 a.m., Dr. Johnson reconvened the meeting and stated that no action was taken in Executive Session.	
V. General Action Item(s)	**A.** General Action Item(s) Related to Quality: Ambulatory Surgical Center at LBJ Hospital Medical Staff 1. Approval of Credentialing Changes for Members of the Harris Health System Ambulatory Surgical Center at LBJ Hospital Medical Staff Dr. Scott Perry, Medical Director, ASC, presented the credentialing changes for members of the Harris Health System Ambulatory Surgical Center at LBJ Hospital Medical Staff. For May 2023, there were six (6) initial appointments, twelve (12) reappointments, and three (3) reappointments. A copy of the credentialing report is available in the permanent record.	**Motion No. 23.05-07** **Moved by Ms. Alicia Reyes, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Governing Body approve V.A. Motion carried.**
	B. Approval of the Governing Body Bylaws of the Ambulatory Surgical Center at LBJ Governing Body Mr. Matthew Reeder, R.N., Administrator, ASC at LBJ, requested to have the Governing Body Bylaws deferred to the next meeting.	**PULLED/DEFERRED**
	C. Approval to Appoint or Reappoint Key Positions to the Ambulatory Surgical Center at LBJ Governing Body 1. Administrator – Matthew Reeder 2. Clinical Manager(s) – Jessica Larson and Myles Matherne 3. Medical Director –Scott Perry, M.D. 4. Business Office Manager – Pollie Martinez 5. QA/PI Officer – Gina Taylor 6. Medical Staff Privileges Officer – Eunice Ambriz 7. Infection Control Coordinator – Maria Taylor 8. Pharmacy Officer – Alvin Nnabuife 9. Risk Manager – Scott Stanley	**Motion No. 23.05-08** **Moved by Ms. Alicia Reyes, seconded by Ms. Jennifer Tijerina, and unanimously passed that the Governing Body approve V.C. Motion carried.**

	10. Compliance Officer – Anthony Williams 11. Safety Officer – Harold Sias 12. Radiation Officer – Patricia Svolos 13. Privacy Officer – Carolynn Jones 14. Medical Records Officer – Veronica De Leon	
VI. 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 provided an update on the Ask My Nurse Hotline. He stated that the Ask My Nurse program has enabled physicians to prioritize their work while allowing nurses to triage patients. Copies of the MEC report are available in the permanent record.	**As reported.**
VII. Adjournment	Moved by Ms. Alicia Reyes, seconded by Dr. Arthur Bracey, and unanimously approved to adjourn the meeting. There being no further business to come before the Governing Body, the meeting adjourned at 9:46 a.m.	

I certify that the foregoing are the Minutes of the Harris Health System ASC at LBJ Governing Body Meeting held on May 18, 2023.

Respectfully Submitted,

Ewan D. Johnson, M.D., Ph.D., Chair

Minutes transcribed by Cherry Pierson

Thursday, May 18, 2023

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 D. Johnson *(Chair)*		
Dr. Arthur W. Bracey *(Ex-Officio)*		
Ms. Alicia Reyes		
Ms. Jennifer Tijerina		
Dr. Glorimar Medina-Rivera		
Dr. Scott Perry, Medical Director, ASC		
Mr. Matthew Reeder, Administrator, ASC		

EXECUTIVE LEADERSHIP
Dr. Esmaeil Porsa, President & Chief Executive Officer
Mr. Anthony Williams, Vice President, Compliance Officer
Dr. Jennifer Small, Executive Vice President, Ambulatory Care Services
Dr. Matasha Russell, Chief Medical Officer, Ambulatory Care Services
Mr. Michael Hill, Executive Vice President, Chief Strategy & Integration Officer
Ms. Olga Llamas Rodriguez, Vice President, Community Engagement & Corporate Communications
Dr. Sandeep Markan, Chief of Staff, Ben Taub Hospital
Dr. Steven Brass, Executive Vice President & Chief Medical Executive
Dr. Tien Ko, Chief of Staff, Lyndon B. Johnson Hospital

OTHERS PRESENT	
Cherry Pierson	Jerry Summers
Daniel Smith	John Matcek
Derek Curtis	Matthew Schlueter
Ebon Swofford	Nicholas Bell
Elizabeth Winn	Shawn DeCosta
Jennifer Zarate	

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

Executive Session

Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ, 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 Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Upon Return to Open Session

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BOARD OF TRUSTEES

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Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

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Report Regarding Quality of Medical and Healthcare, 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 Healthcare 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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BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

Consideration of Approval of Credentialing Changes for Members of the Harris Health System Ambulatory Surgical Center at LBJ Medical Staff

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Ambulatory Surgical Center Governing Body

August 2023 Medical Staff Credentials Report

HARRISHEALTH SYSTEM

Medical Staff Initial Appointments: 2

Medical Staff Reappointments: 7

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

Consideration of Approval of the Quality Assessment and Performance Improvement Plan for the Ambulatory Surgical Center at LBJ

ASC at LBJ
Quality Improvement Program
2022-2023

Introduction

- **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 fumished in the ASC.

- **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.

- **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:

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

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

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

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

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

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

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.

• Leadership and Organization

- **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 Quad A.

- **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.

- **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.

- **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.

- **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.

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.

• Quality Improvement Project Development

- **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.

- **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 efforts. The QRC will agree on a specific outcome for an improvement effort. 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 system processes to guide quality 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.

• 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.

- **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.

- **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.

- **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.

- **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 events.

- **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, Erythromycin, Gatifloxacin, Gentamicin, Levofloxacin, Metronidazole, Moxifloxacin, Neomycin and Vancomycin.

- **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):
   a. For each initiative, provide a brief description of what activities took place including the results on your indicator.
      i. What are the next steps?
      ii. How are the results sustained?
   b. Describe implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes at your program in the coming year.
5. 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 fr°m 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.

Selected References:

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University oflowa Gerontological Nursing Interventions Research Center (UIGN). (2004). Falls prevention for older adults. Iowa City, IA. University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core.

APPENDIXC:
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 Quad A 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 reporting period for a total of three cases, plus all adverse events.

B. If a surgeon has performed less than three cases during a reporting period, that must be reported to the Quad A 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:
   i. Adequacy and legibility of the history and physical exam;
   ii. Adequacy and appropriateness of the surgical consent form;
   iii. Presence of the appropriate laboratory, EKG, and radiographic reports;
   iv. Presence of a dictated or written operative report, or its equivalent;
   v. Anesthesia record;
   vi. Presence of instructions for post-operative and follow-up care; and
   vii. 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:
   i. An Unplanned hospital admission;
   ii. A return to the operating room due to a complication of a previous procedure;
   iii. Untoward result of procedure such as an infection, bleeding, wound dehiscence, or inadvertent injury to another bodily structure;
   iv. Cardiac or respiratory problems during a stay at the ASC at LBJ or within forty-eight (48) hours of discharge;

v. An allergic reaction to medication;
vi. An incorrect needle or sponge count;
vii. A patient or family complaint; and
viii. 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:
i. Identification of the problem;
ii. Immediate treatment or disposition of the case;
iii. The patient's outcome;
iv. An analysis of the reason for the problem; and
v. 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 Quad A within five (5) days of notification of the death.

To obtain a copy Quad A's Patient Safety Data Repotting exemption forms, please follow the below link:

PSDR Exemption Form-2.pdf (hubspotusercontent-na1.net)

APPENDIX "D"

QUAD A PATIENT SAFETY DATA REPORTING RANDOM CASE FORM

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

PSDR-Template-Oct2020.pdf (hubspotusercontent-na1.net)

HARRIS HEALTH
AMBULATORY SURGICAL CENTER AT LBJ

APPENDIX "E"

QUAD A PEER REVIEW ADVERSE EVENT FORM:

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

PSDR-Unanticipated-Sequela-Template-Oct2020.pdf (hubspotusercontent-na1.net)

The Ambulatory Surgical Center (ASC) at LBJ Infection Control Plan

Table of Contents

Statement of Adherence:

The Ambulatory Surgical Center (ASC) at LBJ's Infection Control Plan follows the standards set forth and prescribed by the following entities as applicable:

1. Centers for Disease Control (CDC)
2. Association of PeriOperative Registered Nurses (AORN)
3. Association for Professionals in Infection Control (APIC)

Please see the references in each specific section of the Infection Control Plan to determine which entity's standards the Ambulatory Surgical Center (ASC) at LBJ is adopting and following.

TITLE: SANITARY ENVIRONMENT PROTOCOL

PURPOSE: To establish the procedures and processes the Ambulatory Surgical Center (ASC) at LBJ will follow to maintain a sanitary environment for its patients and personnel to prevent the spread of infections and communicable diseases.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to creating and maintaining a sanitary environment to prevent the spread of infections and communicable diseases to its patients and Workforce members.

POLICY ELABORATIONS:

I. VENTILATION & WATER SYSTEMS

A. Ventilation Systems:

1. It is the policy of the ASC that all ventilation system(s) be evaluated on a routine basis to prevent the deployment of reservoirs of infection.
2. The following must be verified and documented in the evaluation of the ASC ventilation system(s):

   i. Negative pressure for isolation rooms with appropriate Air Changes per Hour ("ACH");
   ii. Positive pressure for operating rooms with appropriate ACH;
   iii. Use of biocide and routine cleaning of cooling towers; and
   iv. Appropriate filter efficiency.

3. In the event of an interruption or disruption of the ASC's ventilation systems, the following steps must be taken:

   i. Evaluate air handling systems for particle counts and bio aerosol
   ii. Assess ventilation system filters, ACH and pressure differentials;
   iii. Assess dust and debris and institute appropriate measures, including but not limited to the following:

      1. Wet mop or clean areas regularly with disinfectant to control dust;

2. Provide negative air pressure and/or partitions around the area of disruption to prevent dust movement to adjacent areas, if needed, or isolate HVAC system where the construction/work is being done;
3. Use walk off mats to prevent dust from spreading to adjacent areas;
4. Seal windows and/or air intakes;
5. Sanitize air handling duct, if necessary depending on the magnitude of the disruption;
6. Clean or sanitize cooling towers, if needed;
7. Cover debris for removal and transport debris during periods of low activity, if applicable.

iv. If the interruption or disruption of the ASC ventilation system involves biohazardous material, Workforce members must use personal protective equipment.

B. Water Systems:

1. It is the policy of the ASC that all components of the ASC's water supply system be evaluated on a routine basis to prevent the development of reservoirs of infection.

2. The routine evaluation of the ASC's water supply system includes at a minimum:

i. Verification of the appropriate hot water temperatures; and
ii. Periodic flushing of water system(s) and holding tank maintenance.

3. In the event of an interruption of water services, the following steps must be taken:

i. Identify and make provisions for waterless hand washing products;
ii. Identify and make provisions for products for patient use;
iii. Determine if toilets can be flushed;
iv. Identify sources of water for flushing if the water is off, but flushing can be done;
v. Provide alternate toilet sites, if indicated;

vi. Make provisions for environmental and/or equipment cleaning and sanitation;
vii. Evaluate the need for cleaning and chlorinating water system(s) and/or the need for culturing to assure acceptable water quality;
viii. Determine the communication process to be used for the restriction of water use and when water use can resume; and
ix. Test water for coliforms prior to clearing ASC water for use.

C. Prevention, Management, and Treatment of Legionella:

1. The following protocol must be followed to prevent the transmission of Legionella:

i. Maintain hot water in the ASC water system(s) at 140 degrees Fahrenheit with a minimum return of 120 degrees Fahrenheit.
ii. Maintain a continuous flow-adjusted injection of chlorine into the water system;
iii. Periodically flush all hot water tanks;
iv. Minimize the formation of biofilms and growth of organisms by appropriate ongoing maintenance and the continuous use of oxidizing biocide and an intermittent use of a non-oxidizing biocide;
v. Install drift eliminators on cooling towers and evaporative coolers; and
vi. Keep adequate maintenance records.

2. If a possible outbreak of Legionella is suspected, the following steps must be taken:

i. Review medical and microbiological records to verify diagnosis;
ii. Initiate active surveillance to identify other possible cases;
iii. Develop a line listing by person, place, and time;
iv. Form a multidisciplinary team, if indicated to guide remediation efforts;
v. Examine possible sources and collect water samples;
vi. Initiate water treatment;
vii. Consider restrictions from showering for high-risk patients if water is proven to contain legionella; and

viii. After water has been treated, continue surveillance to monitor the effectiveness of the treatment.

3. If Legionella is identified in the water system of the ASC, the following remediation measures may be taken:

i. Superheat and flush system with water temperature at 160-170 degrees Fahrenheit to disinfect system; and/or
ii. Hyper chlorinate water system with >10mg/L of chlorine and flush all outlets.

D. Treatment, Prevention and Management of Aspergillosis:

1. The following protocol should be followed to prevent the transmission of Aspergillosis:

i. Minimize dust generation in the ASC;
ii. Limit excess moisture and humidity in the ASC;
iii. Construction areas should have barriers to eliminate the dispersion of dust to the ASC. If barriers are not practical or not adequate, patient relocation may be necessary;
iv. Minimize traffic through the ASC;
v. Thoroughly clean newly occupied areas; and
vi. Check particle counts (>0.5 microns diameter) and/or bio aerosols.

HEPA filtered areas can be expected to have particle counts <1000 cubic foot of air and non HEPA areas with 30/90 progressive filtration can be expected to have <5000/cubic foot of air. These numbers are based on the assumption that the ASC's HVAC system has been running for at least 24 hours.

2. If a suspected outbreak of Aspergillosis is suspected, the following steps should be taken:

i. Review medical and microbiological records to verify diagnosis;
ii. Initiate active, prospective surveillance to identify other possible cases;

iii. If there is no evidence of a continuing transmission, continue routine maintenance procedures;
iv. If evidence of continuing infection is present, conduct environmental investigations to find the source;
v. Develop a line listing by person, place, and time;
vi. Form a multidisciplinary team, if indicated, to guide remediation efforts; and
vii. During and after remediation, continue surveillance to monitor effectiveness.

II. CLEANING AND DISINFECTING THE ASC:

A. It is the policy of the ASC to adequately disinfect and clean the ASC to prevent the risk of infection to patients, visitors, and employees of the ASC.

B. **General Disinfection:** The ASC will follow the general disinfection methods listed in Attachment A.

C. **General Cleaning of Perioperative and Postoperative Care Areas:** The ASC will adopt and follow the Association of Perioperative Registered Nurses (AORN) Guidelines for Environmental Cleaning when cleaning ASC operating rooms and perioperative and postoperative care areas.

D. **Surgical Instruments Sterilization:** The ASC will adopt and follow the Association of Perioperative Nurses (AORN) Guidelines for Cleaning and Care of Surgical Instruments and Guideline for Sterilization when sterilizing surgical instruments.

III. DISPOSAL OF WASTE:

A. Generally:

1. Per the Letter of Agreement between Harris Health and the ASC, Harris Health will manage the ASC's disposal of waste.
2. All waste at the ASC will be disposed of in accordance with the Waste Disposal Chart listed in Attachment B.

3. All medical and infectious/biohazardous waste will be segregated from ordinary trash and/or rubbish at the point of generation. Disposal containers will be lined with approved bags and liners and must be tied up prior to removing and transporting.
4. All Workforce members must follow universal precautions and wear personal protective equipment when disposing of medical waste, sharps, broken glass, debris, or trash.

B. Safe Handling and Disposal of Needles and Sharps:

1. Needles and other disposable sharps are discarded in puncture resistant containers.
2. Sharps containers should be placed where they are easily accessible in operating rooms.
3. Syringes should not be disconnected from needles to discard unless it is required for processing specimens.
4. Large bore reusable needles should be placed in a designated area for transport.
5. Needles and sharps may not be placed in wastebaskets.
6. A contaminated collection container may not be reused. When containers are three-fourths (3/4ths) full, the top must be secured and the container must be taken to an area designated in the ASC..
7. All contaminated broken glass and needles should be picked up with forceps, brush and dust pan, or another tool to avoid contact with hands.
8. When disposing of the sharp, it is important to keep hands behind the sharp tip.
9. Workforce members must maintain control of the tubing and the needle when disposing a sharp with the attached tubing, (e.g., winged steel needle) because the tubing can recoil and lead to injury.

IV. PEST CONTROL:

A. Pests will be controlled or eliminated from the ASC to provide a safe environment for patients, visitors, and staff.

B. Preventative Measures: The following preventative measures will be taken by the ASC to prevent and control pests:

1. Food:

   i. All food brought into the ASC must be kept in airtight containers; and
   ii. Food spillage should be promptly cleaned.

2. Waste:

   i. Waste should be stored in a manner that prevents access by pests and vermin; and
   ii. Waste containers should be regularly cleaned to prevent buildup of material that may attract flies or gnats.

3. Water:

   i. Drains should be covered
   ii. when possible with screens; and
   iii. Leaking pipes should be immediately repaired.

4. Building:

   i. Cracks in plaster or woodwork should be immediately repaired; and
   ii. Wall and firewall penetrations should be sealed.

C. Procedure to follow to control or eliminate pests from the ASC:

1. Insects: If insects are identified in the ASC, the ASC must remediate the source for their presence, e.g., closing propped exterior door, eliminating food or water that is drawing the insects into the ASC.
2. Vermin: If vermin are identified in the ASC, a pest control specialist must be contacted to control and eliminate the vermin.
3. Lice: If lice are identified on a patient in the ASC, all of the patient's linen must be laundered.
4. Bed Bugs: If bed bugs are identified in the ASC, a pest control specialist must be contacted to remediate the ASC. Please see Attachment C.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.)§416.51(a).

Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf

Guideline for Environmental **Cleaning** *DOI: 10.6015/psrp.15.01.009*

Guideline for **Cleaning** and Care of Surgical Instruments *DOI: 10.6015/psrp.15.01.615*

Guideline for Sterilization: *DOI: 10.6015/psrp.15.01.665*

42 Code of Federal Regulations (C.F.R.) §416.41(a)

42 Code of Federal Regulations (C.F.R.) §416.42

42 Code of Federal Regulations (C.F.R.) §416.51(a) and (b)

Quad A Version 8.2

Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007. http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised and Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT "A"

Table 1. Methods of sterilization and disinfection

	Sterilization			Disinfection	
	Critical items (will enter tissue or vascular system or blood will flow through them)		**High-level (semicritical items; [except dental] will come in contact with mucous membrane or nonintact skin)**	**Intermediate-level (some semicritical items[1] and noncritical items)**	**Low-level (noncritical items; will come in contact with intact skin)**
Object	**Procedure**	**Exposure time**	**Procedure (exposure time 12-30 min at ≥20°C)[2,3]**	**Procedure (exposure time ≥ 1 m) [9]**	**Procedure (exposure time ≥ 1 m) [9]**
Smooth, hard Surface[1,4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J	K L[5] M N	K L M N O
Rubber tubing and catheters[3,4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		
Polyethylene tubing and catheters[3,4,7]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		
Lensed instruments[4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H J		
Thermometers (oral and rectal)[8]					K[8]
Hinged instruments[4]	A B C D F G H	MR MR MR 10 h at 20-25°C 6 h 12 m at 50-56°C 3-8 h	D E F H I[6] J		

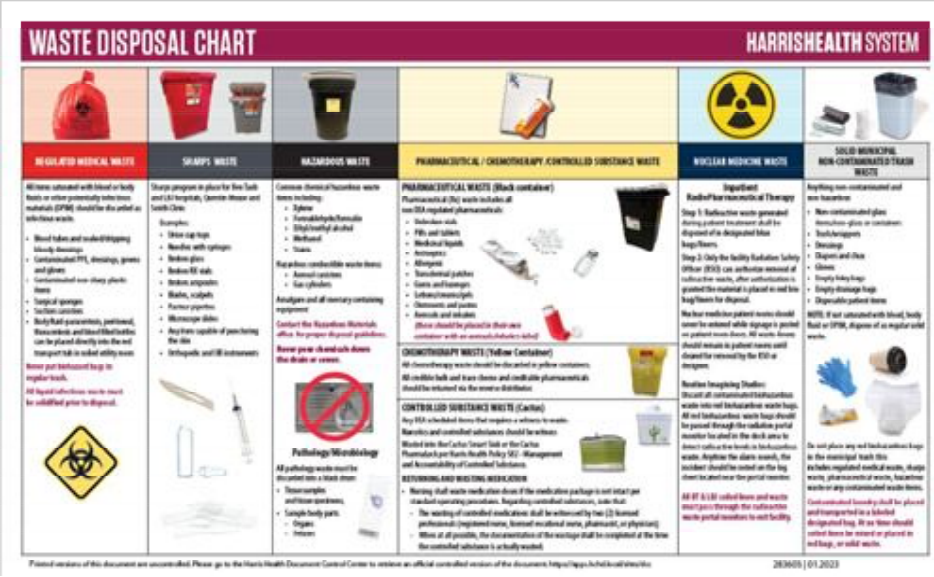
Modified from Rutala and Simmons. 15, 17, 18, 421 The selection and use of disinfectants in the healthcare field is dynamic, and products may become available that are not in existence when this guideline was written. As newer disinfectants become available, persons or committees responsible

for selecting disinfectants and sterilization processes should be guided by products cleared by the FDA and the EPA as well as information in the scientific literature.

A, Heat sterilization, including steam or hot air (see manufacturer's recommendations, steam sterilization processing time from 3-30 minutes)
B, Ethylene oxide gas (see manufacturer's recommendations, generally 1-6 hours processing time plus aeration time of 8-12 hours at 50-60ₒC)
C, Hydrogen peroxide gas plasma (see manufacturer's recommendations for internal diameter and length restrictions, processing time between 45-72 minutes).
D, Glutaraldehyde-based formulations (≥2% glutaraldehyde, caution should be exercised with all glutaraldehyde formulations when further in-use dilution is anticipated); glutaraldehyde (1.12%) and 1.93% phenol/phenate. One glutaraldehyde-based product has a high-level disinfection claim of 5 minutes at 35ₒC.
E, Ortho-phthalaldehyde (OPA) 0.55%
F, Hydrogen peroxide 7.5% (will corrode copper, zinc, and brass)
G, Peracetic acid, concentration variable but 0.2% or greater is sporicidal. Peracetic acid immersion system operates at 50-56ₒC.
H, Hydrogen peroxide (7.35%) and 0.23% peracetic acid; hydrogen peroxide 1% and peracetic acid 0.08% (will corrode metal instruments)
I, Wet pasteurization at 70ₒC for 30 minutes with detergent cleaning
J, Hypochlorite, single use chlorine generated on-site by electrolyzing saline containing >650-675 active free chlorine; (will corrode metal instruments)
K, Ethyl or isopropyl alcohol (70-90%)
L, Sodium hypochlorite (5.25-6.15% household bleach diluted 1:500 provides >100 ppm available chlorine)
M, Phenolic germicidal detergent solution (follow product label for use-dilution)
N, Iodophor germicidal detergent solution (follow product label for use-dilution)
O, Quaternary ammonium germicidal detergent solution (follow product label for use-dilution)
MR, Manufacturer's recommendations
NA, Not applicable

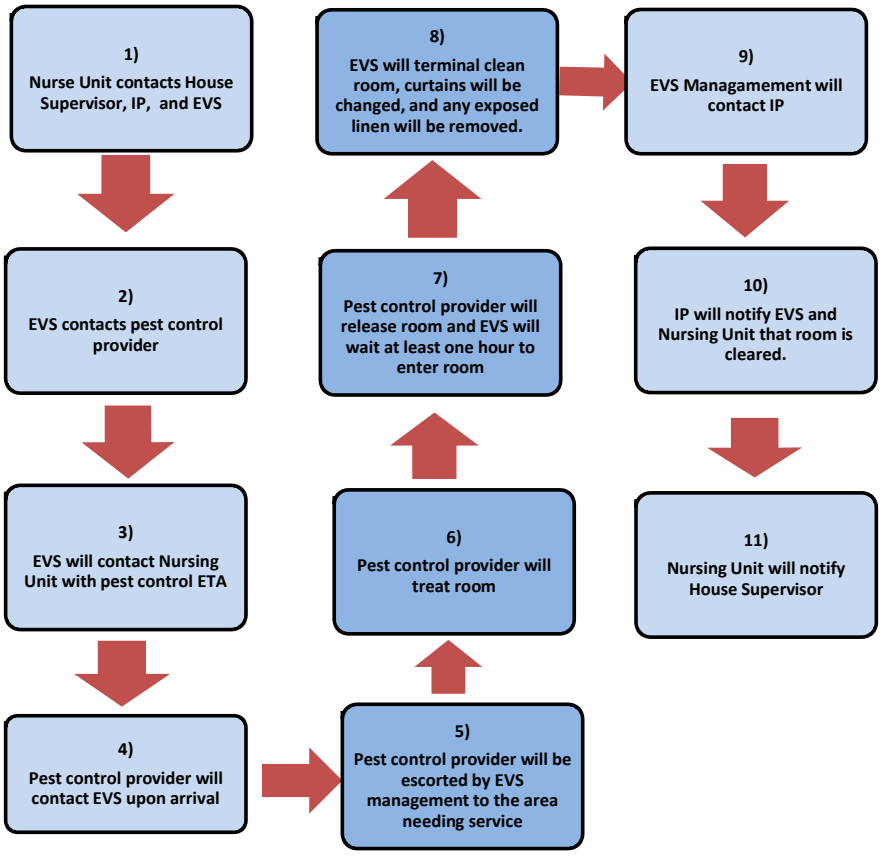
1 See text for discussion of hydrotherapy.
2 The longer the exposure to a disinfectant, the more likely it is that all microorganisms will be eliminated. Follow the FDA-cleared high-level disinfection claim. Ten-minute exposure is not adequate to disinfect many objects, especially those that are difficult to clean because they have narrow channels or other areas that can harbor organic material and bacteria. Twenty-minute exposure at 20ₒC is the minimum time needed to reliably kill *M. tuberculosis* and nontuberculous mycobacteria with a 2% glutaraldehyde. Some high-level disinfectants have a reduced exposure time (e.g., ortho-phthalaldehyde at 12 minutes at 20ₒC) because of their rapid activity against mycobacteria or reduced exposure time due to increased mycobactericidal activity at elevated temperature (e.g., 2.5% glutaraldehyde at 5 minutes at 35ₒC, 0.55% OPA at 5 min at 25ₒC in automated endoscope reprocessor).
3 Tubing must be completely filled for high-level disinfection and liquid chemical sterilization; care must be taken to avoid entrapment of air bubbles during immersion.
4 Material compatibility should be investigated when appropriate.
5 A concentration of 1000 ppm available chlorine should be considered where cultures or concentrated preparations of microorganisms have spilled (5.25% to 6.15% household bleach diluted 1:50 provides > 1000 ppm available chlorine). This solution may corrode some surfaces.
6 Pasteurization (washer-disinfector) of respiratory therapy or anesthesia equipment is a recognized alternative to high-level disinfection. Some data challenge the efficacy of some pasteurization units.
7 Thermostability should be investigated when appropriate.
8 Do not mix rectal and oral thermometers at any stage of handling or processing.
9 By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered products label, the user assumes liability from any injuries resulting from off-label use and is potentially subject to enforcement action under FIFRA.

ATTACHMENT "B"



LBJ Nursing, EVS, and ECOLAB

Bed Bug Protocol Process



1. Nurse Unit contacts EVS via email and via Phone at 713-566-6960 or 713-566-6961. Unit is required to leave all linen in the room contained in a plastic bag for extermination process. Bed linen should be contained in one linen bag, while the curtains in a second linen bag. Nursing staff of the department should attempt to capture the bed bug if able to do so via a container or tape to ensure proper extinction procedure and close the room until further notice. Point of contact for Infection Prevention is the Ambulatory Care Services (ACS) Infection Prevention Department which can be reached at 346-426-0144.

2. EVS contacts contracted Pest Control provider requesting service and ensuring to document who they spoke to, the time, the date, and the name of the service technician who will contact EVS for an estimated time of arrival (ETA). All documentation will be scanned and filed in the appropriate data storage location. Technicians will then be sent an email from management to inform them of the request.

3. A follow-up assessment must be performed by EVS Management by inspecting the location of the request and speaking to the requestor so that they are aware that pest control has been contacted and provide an ETA.

4. The pest control provider will contact EVS upon arrival to begin their service.

5. The pest control provider will then be escorted to the requested service area then proceed to inspect the room under EVS supervision.

6. The pest control provider will begin treatment based on their findings and guidelines.

7. The pest control provider will release room after treatment ends and instruct EVS to wait at least an hour before entering the room.

8. EVS will begin their procedures which will include a terminal clean, removal of any exposed linen, and the change of curtains to complete their protocol.

9. EVS Management will contact the ACS Infection Prevention (IP) Department at 346-426-0144to inform the department of the completion of the terminal clean. Upon speaking to the ACS IP Department the EVS Management will send an email to the ACS IP Department to maintain documentation of the process.

10. The ACS Infection Prevention Department will assess the area and inform EVS and the Nursing Unit when the room is cleared for further use.

TITLE: HAND HYGIENE GUIDELINES

PURPOSE: To prevent the transmission of infection to patients and healthcare workers.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ implements hand hygiene guidelines to reduce the transmission of infectious agents to patients and Workforce members.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **HAND HYGIENE**: A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

B. **DECONTAMINATE HANDS**: Means to reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic hand wash.

C. **OTHER POTENTIALLY INFECTIOUS MATERIALS (OPIM)**: Refers to:

a. The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;
b. Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
c. Human Immunodeficiency Virus (HIV) containing cell or tissue cultures, organ cultures, and HIV or Hepatitis B Virus (HBV) containing culture medium or other solutions; and blood, organs, or other tissues infected with HIV or HBV.

D. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. Hand washing stations shall be maintained with appropriate supplies and conveniently located throughout the ASC in accordance with state and federal requirements.

B. Hands must be cared for by washing with soap and water as follows:

1. When hands are visibly dirty or contaminated or are visibly soiled with blood or other bodily fluids;
2. If exposure to potential spore-forming organisms is strongly suspected or proven;
3. After using the restroom;
4. Before eating; and
5. Prior to starting work.

C. In all other clinical situations, it is preferred that Workforce members must Decontaminate their hands by using an alcohol-based hand rub, unless washing hands with soap and water is indicated. Specifically, hands must be Decontaminated with an alcohol-based hand rub in the following situations:

1. Decontaminate hands before and after having direct contact with patients.
2. Decontaminate hands before inserting indwelling catheters or other invasive devices that do not require a surgical procedure.
3. Decontaminate hands after contact with a patient's intact skin (e.g., taking a pulse or blood pressure, or lifting a patient).
4. Decontaminate hands after contact with bodily fluids or excretions, mucous membranes, non-intact skin, and wound dressings.
5. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care.
6. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
7. Decontaminate hands after removing gloves.

D. Areas that do not have immediate access to hand washing stations will have readily available an alcohol-based waterless antiseptic agent.

E. In the event of interruption of the ASC's water supply, alternative agents, such as detergent containing towelettes and alcohol-based hand rubs will be available.

F. Use of communal bar soap is prohibited in the ASC.

G. The ASC will follow and adopt all additional guidelines and recommendations of the Association of Perioperative Registered Nurses (AORN) regarding hand hygiene, available at: *DOI: 10.6015/psrp.15.01.097*.

III. OTHER ASPECTS OF HAND CARE AND PROTECTION:

A. Gloves should be used for hand-contaminating activities, but are not a substitute for hand washing.

B. When it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur, wear gloves.

1. Hands should be decontaminated before donning sterile gloves.
2. Gloves should be removed and hands washed when procedure task is completed.
3. Change gloves during patient care if moving from a contaminated body site to a clean body site.

IV. PROCEDURE:

The procedures that shall be used in the implementation of this policy may be found in Appendix "A" attached.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.50(b).

Quad A Version 8.2

Guideline for Hand Hygiene in Health-Care Settings, Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. CDC Morbidity and Mortality Weekly Report, Vol. 51. October 25, 2002.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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06/14/2016	1.0	06/14/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Revised / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

A. Hand Hygiene Techniques: Soap and Water:

1. Turn on Water: Keep water running continuously throughout hand washing procedure. Adjust water temperature comfortable to hands. Extremely hot or cold water tends to dry skin.
2. Wet Hands and Wrists with Water: If long sleeves are worn, raise sleeves before washing hands. Hold hands down toward sink. Water should drain from wrists to finger tips to carry away bacteria.
3. Apply sufficient amount of liquid soap or antiseptic agent sufficient to form a good lather and thoroughly distribute over hands.
4. Wash palms, wrists, and the back of each hand. Interlace hands, rub and massage in a rotary (circular) motion. Vigorously rub hands together for twenty (20) seconds covering all surfaces of the hands and fingers.
5. Hold hands slanted downward and rinse well under running water. Running water should flow from wrists down to fingers, thus carrying suds and germs down the drain.
6. Dry wrists then hands with paper towel, and turn off faucets with paper towel, and discard towels in wastebasket. Use of paper towels prevents contamination of clean hands by touching of faucet. All faucets must be considered contaminated.
7. Paper towels should be within easy reach of sink, but beyond splash contamination.
8. Lever-operated towel dispensers should be activated before beginning hand washing.

B. Hand Hygiene Techniques: Waterless Product:

1. Apply product to palm of one hand; and
2. Interlace hands and rub hands together covering all surfaces of hands and fingers until hands are dry.

C. Hand Hygiene Technique: Surgical Hand Scrub:

The ASC will follow the procedure and guidelines set forth by the Association of Perioperative Nurses (AORN) for surgical hand scrub for ORs and special procedure areas within the ASC performing diagnostic/invasive/ procedures, available at:

AORN eGuidelines +

ATTACHMENT B

Hand Hygiene Observations at the ASC

1. The ASC at LBJ will maintain 3 Secret Shoppers (SS) and Just-in-Time coaches (JITC)
2. The expectation of each SS is to document observations; totaling a combined number of 100 per month for the ASC. Half of these must be completed by the fifteenth of the month before close of business and the rest before the twenty fifth of the month before close of business.
3. There will also be Just-in-Time coaches who will be responsible for documenting 15 observations per month before the last day of the month. These coaches will give feedback to staff and providers noted to be in violation of our hand hygiene policy.

Commented [TG1]: Change to required 100 observations


Your 5 moments for
HAND HYGIENE
1 BEFORE PATIENT CONTACT
2 BEFORE ASEPTIC TASK
3 AFTER BODY FLUID EXPOSURE RISK
4 AFTER PATIENT CONTACT
5 AFTER CONTACT WITH PATIENT SURROUNDINGS

TITLE: PERSONAL PROTECTIVE EQUIPMENT

PURPOSE: To establish guidelines to follow to protect the workforce members of the Ambulatory Surgical Center (ASC) from exposure to or contact with infectious organisms or agents.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to assume that every person is potentially infected or colonized with an organism that could be transmitted and that all members of the ASC's workforce wear personal protective equipment to lower the risk of exposure or contact with those infectious organisms or agents.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. PERSONAL PROTECTIVE EQUIPMENT (PPE): A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents or organisms. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

B. STANDARD PRECAUTIONS: A group of Infection Prevention Practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes, but is not limited to, the use of gloves, gown, mask, eye protection, or face shield.

C. TRANSMISSION-BASED PRECAUTIONS:

a. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based Precautions:
   i. Contact Precautions;
   ii. Droplet Precautions; and
   iii. Airborne Precautions.

b. They may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

D. **WORKFORCE**: The employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways or at nursing stations.

B. Contact Transmission Precautions: Contact Transmission Precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be work to protect Workforce members against contact with bodily fluids or contaminated surfaces.

C. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach respiratory tracts of a susceptible host. The following Droplet Transmission Precautions must be taken:

1. A surgical face mask must be work within 3-6 feet of an individual with a respiratory infection; and
2. A gown and gloves should be worn if the Workforce member is touching surfaces where droplets may have landed.

D. Airborne: Airborne Transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable amounts of time. Therefore, N95 Respirators are required to be worn by ASC Workforce members if necessary to protect against Airborne Transmission.

E. Any visibly or knowingly contaminated protective equipment will be cleaned or discarded, if disposable, immediately after use.

III. PROCEDURES:

Please see Appendix "C" for procedures to follow regarding Personal Protective Equipment.

REFERENCES/BIBLIOGRAPHY:

Quad A Version 8.2

42 Code of Federal Regulations (C.F.R.) §416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT "C"

1. Gloves:

a. Disposable latex, nitrile, or vinyl gloves are available for use in the ASC. The gloves are not puncture-resistant; nor are the gloves one-hundred percent protective against infectious agents or organisms.
b. Gloves must be replaced as soon as practical when contaminated (at a minimum, after each patient). Torn or punctured gloves must be replaced as soon as feasible. Gloves must be removed prior to leaving the treatment area.
c. Gloves may not be washed for reuse.
d. Grossly contaminated gloves will be discarded appropriately.
e. Gloves must be used in the following circumstances:

i. During all surgical procedures;
ii. If a Workforce member's skin is cut, abraded or chapped;
iii. During an exam of a patient's mouth, oropharynx, gastrointestinal tract, or genitourinary tract;
iv. While examining abraded or non-intact skin or patients with active bleeding;
v. During invasive procedures;
vi. When performing phlebotomy, processing and/or testing blood, preparing pathology specimens, or other potentially infectious specimens; and
vii. During housekeeping and decontaminating procedures.

2. Eyewear:

a. Protective eyewear includes goggles, face shields, or glasses with solid side shields.
b. Protective eyewear must be worn when a procedure or surgery presents a danger of splashing or if a manufacturer recommends that protective eyewear be worn when using their product.
c. Protective eyewear must be removed prior to exiting the treatment area. Goggles and face shields will be cleaned and decontaminated after each use or disposed of properly, if disposable.

3. *Masks:*

a. Masks should be used when indicated and disposed of properly after use.

b. Contaminated masks will be replaced immediately or as soon as feasible. Contaminated masks must be disposed of properly.

4. Gowns, Aprons, Lab Coats:

a. Gowns are worn to protect clothing and the arm and neck areas of Workforce members from contamination.
b. Gowns may be worn until soiled, damaged, or made wet, at which time they must be immediately removed and replaced.
c. Protective laboratory coats, gowns, and aprons must be removed and replaced when they become visibly damaged or contaminated.

5. Donning and Removing Personal Protective Equipment:

a. ***Donning:*** The following order will be followed when donning PPE:

i. Gown;
ii. Mask;
iii. Goggles/face shield;
iv. Gloves

b. ***Removing:*** The following order will be followed when removing PPE:

i. Gloves;
ii. Goggles/face shield;
iii. Gown;
iv. Mask.

TITLE: STANDARD AND TRANSMISSION BASED PRECAUTIONS

PURPOSE: To prevent the transmission of healthcare associated or community acquired organisms and/or infections to patients, visitors, and members of the Ambulatory Surgical Center at LBJ's workforce.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ ("ASC") that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **AIRBORNE INFECTION ISOLATION ROOM (AIIR):** Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. AIIRs should provide negative pressure in the room so that air flows under the door gap into the room; and an air flow rate of 6-12 ACH and direct exhaust of the air from the room to the outside of the building or recirculation of air through a HEPA (high-efficiency particulate air) filter before returning to circulation.

B. **COHORTING**: Applies to the practice of grouping patients infected or colonized with the same infectious agent together to confine their care to one area and prevent contact with susceptible patients. Cohorting patients during outbreaks, Workforce members may be assigned to a cohort of patients to further limit opportunities for transmission to Cohorting staff.

C. **MULTI-DRUG RESISTANT ORGANISM (MDRO)**: In general, bacteria, excluding M. Tuberculosis, that are resistant to one or more classes of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents e.g, MRSA, VRE, Extended Spectrum Beta-Lactamse (ESBL) producing or intrinsically resistant gram negative bacilli, or Carbapenem Resistant Enterobacteriacae (CRE). In addition, organisms of clinical significance or that have special virulent properties such as *Clostridium difficile* will be considered in the same fashion.

D. **OTHER POTENTIAL INFECTIOUS ORGANISMS**: Human body fluids shall be treated as if they are known to be infectious for blood borne pathogens. These fluids include, but are not limited to:

a. Amniotic Fluid;
b. Pleural Fluid;
c. Blood;
d. Saliva (in dental procedures);
e. Cerebrospinal Fluid;
f. Semen;
g. Pericardial Fluid;
h. Synovial Fluid;
i. Peritoneal Fluid; and
j. Vaginal Secretions.

E. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**: A variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. PPE includes gloves, masks, respirators, goggles, face shields, and gowns.

F. **QUALIFIED LICENSE PRACTITIONER (QLP)**: Any individual permitted by law and by the ASC to provide care and services, without relevant direction or supervision within the scope of the individual's license and consistent with individually granted clinical privileges.

G. **REGULATED MEDICAL WASTE**:

a. A liquid or semi-liquid blood or Other Potentially Infectious Material (OPIM); contaminated items that would release blood in a liquid or semi-liquid state if compressed;
b. Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbial wastes containing blood or other potentially infectious materials.

H. **RESPIRATORY HYGIENE/COUGH ETIQUETTE**: A combination of measures designed to minimize the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.

I. **STANDARD PRECAUTIONS**: A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed diagnosis or presumed infection status. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes hand hygiene, and depending on anticipated exposure, the use of gloves, gowns, masks, eye protection, or face shields.

J. **TRANSMISSION-BASED PRECAUTIONS**:

a. Transmission-Based Precautions are used when the routes of transmission are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based Precautions:
   i. Contact Precautions;
   ii. Droplet Precautions; and
   iii. Airborne Precautions.

b. They may be combined together for diseases that have multiple routes of transmission. When used either singularly or in combination, they are to be used in addition to Standard Precautions.

K. **WORKFORCE:** Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. It is safer to "Over-Isolate" than to "Under-Isolate." If there is a question regarding isolation, then the more stringent Isolation Precaution should be used in until a definitive diagnosis is confirmed.

B. All QLPs, nurses, students, etc., are responsible for complying with Isolation Precautions.

C. Education and training on preventing transmission of infectious agents associated with healthcare will be provided during orientation to the ASC and thereafter, annually.

D. Identification of MDROs:

1. The ASC's pre-procedure screening clinic will aid in the coordination of patient care by identifying patients with MDROs so that those patients receive the appropriate level of care, i.e. care at either Lyndon B. Johnson Hospital or Ben Taub General Hospital.

2. Harris Health System's Laboratory will alert infection prevention and the nursing of a MDRO laboratory result pursuant to the Letter of Agreement between Harris Health System and the ASC.

3. Nursing will initiate the appropriate isolation immediately.

4. The patient will be placed in the isolation room. The appropriate signage must be placed on the isolation room door and the isolation type should be entered into the patient's medical record.

E. Categories of Standard and Transmission-Based Precautions:

1. Standard Precautions: This presumes that all body substances may carry infectious agents. PPE appropriate to the potential exposure should be worn. PPE may not be worn in hallways, nursing stations, other areas outside of the ASC, or in isolation rooms, when applicable.

2. Contact Transmission Precautions: These precautions are based on direct contact with an infected patient or contact with a contaminated environment. Gowns and gloves should be worn by ASC QLP or other personnel to protect against contact with body fluids or contaminated surfaces.

3. Droplet: Droplet Transmission Precautions are based on an infectious agent being transmitted from droplets that can reach the respiratory tract of a susceptible host; and

   i. Surgical face masks must be worn within 3-6 feet of an individual with a respiratory infection;

ii. Gowns and gloves should be worn if Workforce members or QLPs are touching surfaces where droplets may have landed.

4. Airborne Precautions: Airborne transmission occurs by the dissemination of small particles that can remain suspended in the air for considerable time. N95 Respirators are required to be worn by Workforce members and QLPs as an Airborne Precaution.

F. Workforce members will instruct visitors about precautions to be taken while visiting patients in the isolation room. PPE must be worn by all visitors in the isolation room.

Patients having the same pathogen may be cohorted in the absence of private rooms.

III. GUIDELINES FOR ISOLATION OF PATIENTS WITH MULTI-DRUG RESISTANT ORGANISMS:

A. Patients colonized or infected with any identified MDRO must be initially placed in the ASC isolation room. Appropriate signage must be placed on the door of the isolation room to alert Workforce members.

B. After the MDRO has been identified, the following steps will be followed:

1. TB Infection:
   i. If a patient has TB, that patient will remain in the ASC isolation room. The patient's surgery/procedure at the ASC will be cancelled.
2. Other MDROs:
   i. If a patient has another MDRO (e.g., MRSA, VRE, VIRE), the ASC Medical Director and Administrator and Infection Prevention Manager in consultation with the surgeon will make a determination as to whether that patient's scheduled surgery/procedure may continue as scheduled and what precautions, if any, need to be taken.

IV. MANAGEMENT OF THE ENVIRONMENT:

A. Environmental Services: All trash, linen, and cleaning of rooms in the ASC are the same for all patients regardless of whether that patient has been in the isolation room. Privacy curtains must be changed at the patient's discharge.

B. Patient Care Equipment: When possible, equipment should be dedicated. If common equipment is unavoidable, then that equipment must be cleaned and disinfected after each use with an ASC approved product.

C. Patient Supplies: Supplies that are kept in the isolation room should be kept to a minimum and any leftover supplies from the isolation room should be discarded when the patient is discharged.

V. SPECIAL CONSIDERATIONS:

A. Surgery and Procedure Rooms: In the event that patients with a communicable disease are scheduled for surgery at the ASC and who are placed in the ASC isolation room, those patient's surgeries and/or procedures should be done as the last case of the day with a terminal clean being completed after the procedure concludes. If it is not possible to perform this surgery as the last case of the day, then a terminal clean must be performed on the operating room before the next surgery is performed.

B. Guest Transportation: Patients transported outside of the ASC must be transported with appropriate barriers in place, such as surgical masks on patients with a respiratory illness. Workforce members must wear appropriate PPE during the transport.

REFERENCES/BIBLIOGRAPHY:

APIC Text On-Line, Chapter 29 Isolation Precautions-Recommendations.

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

42 Code of Federal Regulations (C.F.R.)§ 416.51.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: VACCINE PREVENTABLE DISEASE POLICY

PURPOSE: To reduce the transmission of infectious and communicable diseases.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ strives to protect the health and safety of its workforce, visitors, patients, patient and employee family members, and the community as a whole against the transmission of infectious and communicable diseases.

All individuals providing patient care and/or services or having direct patient contact in the ASC must utilize all appropriate measures to prevent the spread of infectious and communicable diseases through vaccination; by utilizing personal protective equipment, if applicable; or by utilizing a combination of these controls, where appropriate.

POLICY ELABORATIONS:

This policy is intended to protect patients, employees, visitors, and others affiliated with the ASC from the spread of vaccine preventable diseases. The goal is to maximize vaccination rates against vaccine preventable diseases among Workforce members.

I. DEFINITIONS:

A. **PATIENT**: Any individual undergoing medical assessment or active treatment at the ASC.

B. **PATIENT CARE OR CLINICAL CARE AREA**: Includes the physical or recognized borders of the ASC where patients may be seen, evaluated, treated, or waited to be seen.

C. **PUBLIC HEALTH DISASTER**: A declaration by the governor of a state of disaster and a determination by the commissioner that there exists an immediate threat from a communicable disease that: (i) poses a high risk of death or serious long-term disability to a large number of people and (ii) creates a substantial risk of public exposure because of the diseases high level of contagion or the method by which the disease is transmitted.

D. **QUALIFIED EXEMPTION**: Immunity from the imposed immunization requirements based on medical or religious reasons that have been approved by Harris Health System's Human Resources department for members of the ASC

workforce who are not part of the medical staff and by Medical Staff Services for members of the ASC Medical Staff.

E. **VACCINE PREVENTABLE DISEASES**: The diseases included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

F. **WORKFORCE:** The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GENERAL PROVISIONS:

A. As a condition of employment, appointment to the medical staff, or access to provide patient care and/or services covered by this policy, as appropriate to each covered person's circumstances and in accordance with patient safety standards, all Workforce members are required to have vaccinations for the following Vaccine Preventable Diseases, have proof of immunity, or obtain a Qualified Exemption for the Vaccine Preventable Disease(s):

1. Hepatitis B;
2. Influenza (received annually);
3. Measles;
4. Mumps;
5. Rubella;
6. Pertussis;
7. Varicella; and
8. Neisseria Meningitdis (Meningococcal).

B. Persons born prior to 1957 are considered immune for Measles, Mumps, and Rubella and are not required to have these immunizations.

III. PROCEDURES:

A. Harris Health System (Harris Health) Employee Health Services (EHS) may offer immunizations, and when appropriate, provide antibody or serologic testing to Workforce members at no cost, per the Letter of Agreement between Harris Health System and the ASC. EHS shall inform Workforce members about the following:

1. Requirements for vaccinations;
2. Procedures for receiving vaccination, including completion of the appropriate vaccine consent form;
3. Procedures for submitting written proof of vaccination(s) obtained outside of the EHS;
4. Procedures for declining vaccination(s) due to a Qualified Exemption; and
5. Effects of declining vaccination(s).

B. All Workforce members must:

1. Receive appropriate vaccination(s), when applicable;
2. Provide EHS with written proof of vaccination or immunity from vaccination for each of the Vaccine Preventable Diseases listed above if obtained from the Workforce member's physician, another health care facility, or other vaccination services available in the community. Acceptable proof of vaccination includes a physician note or immunization record, which includes date of vaccination and lot number, if available. Proof of vaccination must include the date of the vaccination; or
3. Obtain a Qualified Exemption.
4. Note: Workforce members are required to be immunized against influenza each year unless a specific exemption is requested and approved by the ASC. Proof of immunization of influenza obtained outside of Harris Health's EHS must be provided to the Harris Health's EHS on an annual basis.

IV. QUALIFIED EXEMPTIONS:

A. Medical Exemptions: Medical exemptions for required immunizations may be provided for certain conditions identified as medical contraindications or precautions by the most current recommendations of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (AICP).

1. Workforce members requesting a medical exemption because of medical contraindications must complete and submit to Harris Health's EHS within thirty (30) days of being notified of the required vaccination, the appropriate Request for Medical Exemption form.

2. The Request for Medical Exemption form must include an original signature, the date signed, and be completed by the Workforce member's private physician attesting to the medical contraindications.
3. If a medical exemption is provided for a temporary condition, the Workforce member must complete and submit the appropriate Request for Medical Exemption form annually.
4. If a medical exemption is provided for a permanent condition, a subsequent Request for Medical Exemption form need only be completed and submitted if vaccine technology changes eliminating the contraindication on which the medical exemption is based.
5. If a medical exemption request is denied for incompleteness, the Workforce member will be notified of the denial, including the basis for the denial, and will be required to be immunized pursuant to this policy unless the Workforce member resubmits a fully completed Request for Medical Exemption form.

B. Religious Exemptions:

1. If a Workforce member declines a vaccination because it conflicts with the Workforce member's religious beliefs, the Workforce member must complete and submit a Request for Religious Exemption form to Harris Health's Human Resources Department within thirty (30) days of being notified of the required vaccination.
2. The Request for Religious Exemption form must include an original signature, the date signed, and be completed by the Workforce member's clergy.
3. A request for religious exemption will be evaluated on a case-by-case basis by Harris Health's Human Resources Department, per the Letter of Agreement between Harris Health and the ASC, within twenty (20) business days of receipt of the request.
4. The Workforce member requesting the religious exemption will be notified in writing as to whether his or her request for a religious exemption has been granted. If a religious exemption request is denied, the Workforce member will be notified of the denial, including a basis for the denial, and will be required to be immunized pursuant to this policy.

C. The ASC shall not discriminate or retaliate against a Workforce member who is medically exempt from the required immunizations for Vaccine Preventable Diseases.

V. INFECTION CONTROL PROCEDURES:

A. All Workforce members are responsible for monitoring their health status and reporting to work only when they are not in a status that would put others at risk of contracting an infection, whether viral or bacterial.

B. All Workforce members are responsible for performing appropriate infection control standards to prevent risk to others and themselves. This includes, but is not limited to, frequent hand washing, masking, covering coughs, and sneezing, disinfecting equipment and work stations, and not reporting to work when ill.

VI. NON-VACCINATED WORKFORCE MEMBERS:

A. Seasonal flu activity can start as early as October and end as late as May. Proof of flu vaccination or exemption will be obtained from October 1st to November 15th. All Workforce members granted an exemption for the influenza vaccination must wear a surgical mask at all times while unvaccinated and while in any ASC patient care or clinical care areas from November 16th of each year through March 31st of the following calendar year. These dates may be modified depending on the circulation of influenza in the community.

B. Workforce members who do not receive vaccination for Measles, Mumps, Rubella, or Varicella will not be allowed to work with high-risk patients.

1. Workforce members who do not receive vaccinations for Measles, Mumps, Rubella, or Varicella will be relieved of their work duties and will be denied access to patient care or clinical care areas should an exposure occur outside or inside the ASC setting.

C. The time of any Workforce member relieved of work duties as set forth herein shall be handled in accordance with the Harris Health System Paid Time Off (PTO) Policy No. 6.03.

VII. COMPLIANCE:

A. Any Harris Health Workforce member who fails to comply with the requirements of this policy may be suspended without pay until the Workforce member complies. If the Workforce member fails to comply with the requirements of this policy after thirty (30) days, the Workforce member may be terminated.

B. Any ASC Medical Staff member who fails to comply with the requirements of this policy shall not be permitted to enter patient care or clinical care areas of the ASC.

VIII. RESPONSIBILITIES:

A. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's EHS shall:

a. Administer and track vaccinations of Workforce members;
b. Accept and review requests for medical exemptions of Workforce members;
c. Notify Harris Health's Human Resources Department of Workforce members receiving medical exemptions;
d. Notify Workforce members who require vaccination through the ASC Administrator;
e. Review the Workforce member's vaccination statuses, immunity statuses, and Qualified Exemptions annually and report annually to the ASC Infection Prevention Manager and to Harris Health's Human Resources Department of non-compliant Workforce members;
f. Evaluate organizational Workforce member vaccination rates and frequency and reasons for vaccine declinations;
g. Establish vaccination requirements; and
h. Maintain written or electronic records of vaccinations, proof of vaccinations, and medical exemptions for all of the Workforce members.

B. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's Human Resources Department shall:

a. Accept, evaluate, and approve requests for religious exemptions of Workforce members;

b. Coordinate with the ASC Administrator disciplinary procedures for Workforce members who do not comply with this policy; and
c. Maintain written or electronic records of religious exemptions for all Workforce members.

C. Medical Staff Services shall:

a. Ensure compliance with this policy by the ASC Medical Staff.
b. Evaluate annually vaccination rates and frequency and reasons for vaccine declinations of the ASC Medical Staff.
c. Review documentation annually of vaccination status, immunity status, and Qualified Exemptions for all ASC Medical Staff.
d. Initiate disciplinary procedures for ASC Medical Staff members who do not comply with this policy.
e. Maintain written or electronic records of vaccinations, proof of vaccinations, and religious and medical exemptions for all ASC Medical Staff.

D. Per the Letter of Agreement between Harris Health and the ASC, Harris Health's Materials Management shall:

a. Ensure compliance with this policy by vendor and supplier representatives;
b. Evaluate annually vendor and supplier representative's vaccination rates and frequency and reasons for vaccine declinations;
c. Review documentation annually of vaccination status, immunity status, and Qualified Exemptions for all vendor and supplier representatives;
d. Initiate disciplinary procedures for vendor and supplier representatives who do not comply with this policy; and
e. Maintain written or electronic records of vaccinations, proof of vaccinations, and religious and medical exemptions for all vendor and supplier representatives through the vendor credentialing system.

IX VACCINE SHORTAGE CONTINGENCY:

A. In the event of a vaccine shortage, the ASC Infection Prevention Manager, Harris Health EHS, and Harris Health's pharmacy department will determine an appropriate distribution plan for the resources available. Required vaccinations

will be offered to Workforce members based on job function and risk of exposure to the Vaccine Preventable Diseases.

B. Priority for vaccinations will be given to Workforce who:

1. Provide direct patient care with prolonged face-to-face contact with patients;
2. Care for patients with high risk for complications from a Vaccine Preventable Disease;
3. Have the highest risk of exposure to patients with a Vaccine Preventable Disease; or
4. Are at high-risk for complications from a Vaccine Preventable Disease.

C. Workforce members who meet the requirements for priority for vaccinations during a vaccine shortage shall comply with the provisions of this policy.

D. Workforce members who are not given priority for vaccinations during a vaccine shortage will be required to follow procedures for non-vaccinated Workforce members under Section VI above.

X. PUBLIC HEALTH DISASTER:

In the event of a Public Disaster, Workforce members deemed non-immune or exempt from vaccination for a Vaccine Preventable Disease may not provide direct patient care or work in a patient care or clinical care area of the ASC and will be relieved of their work duties and/or denied access to patient care or clinical care areas. The time of any Workforce member relieved of work duties set forth herein shall be handled in accordance with the Harris Health System Paid Time Off (PTO) Policy 6.03.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Quad A Version 8.2

Tex. Health & Safety Code Ann. §81.003(7).

Tex. Health & Safety Code Ann. §224.002.

Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report, "*Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP),"* Vol. 60/No.7, November 25, 2011.

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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APPENDIX A:
WORKFORCE MEMBERS and ASC Medical Staff

Workforce members and ASC Medical Staff may include, but are not limited to, any of the following:

1. Individuals who primarily serve in a clinical support role and most often receive patients or provide equipment for patient use in the next site of care. Their role requires them to often work in patient care areas and/or provide assistance to or consult with patient care staff.
2. Individuals who serve primarily in a technical support role or product and service sales role. They may provide technical assistance, may occasionally assist with operation of equipment and be in a patient care environment that is not defined as a restricted or sterile area. Their role requires them to often work in patient care areas where other visitors may be present and/or provide assistance to or consult with patient care staff.
    a. This includes vendor and supplier sales representatives that interact with care providers for the purpose of sales, education, and technical support.
    b. Examples may include: DME providers, medical device sales, and pharmacy representatives, representatives calling on departments such as laboratory and radiology, and diagnostic representatives.
3. Individuals who serve primarily in a clinical support or product sales/service role while attending or observing patient procedures. These individuals often provide technical information and serve as a resource for the medical professional by responding to questions regarding the appropriate operation of their medical equipment.
4. Physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, and persons having direct patient contact who may be potentially exposed to infectious agents that can be transmitted to and from patients and others.
5. Examples of non-clinical personnel who may provide services in a patient care or clinical area include, but are not limited to:
    a. Patient Relations & Interpretation Services personnel;
    b. Facilities Management Personnel;
    c. Sterile Processing and Material Services technicians;
    d. Vendor's; and
    e. Environmental Services personnel;

APPENDIX B:
EXAMPLES OF PATIENT CARE OR CLINICAL CARE AREAS

1. Admissions and Registration;
2. Patient rooms/cubicles;
3. Patient exam rooms/areas;
4. Hallways of the ASC where patients are located;
5. Nursing stations;
6. Procedural/operating rooms and areas;
7. Hallways connecting waiting areas and exam areas or those connecting clinical areas; and
8. Waiting areas.

TITLE: SAFE HANDLING OF NEEDLES AND SHARPS

PURPOSE: To establish procedures for handling needles and sharps that reduces workforce member injuries and exposures to blood and body fluids.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ is committed to reducing the risk of infection to workforce members by safely handling needles and sharps.

POLICY ELABORATIONS:

I. DEFINITIONS:

WORKFORCE: Employees, medical staff, trainees, contractors, volunteers, and vendors.

II. GUIDELINES FOR PROPER HANDLING OF NEEDLES AND SHARPS

A. The following guidelines must be followed when handling needles and sharps in the ASC:

1. Disposable needles or sharps must be handled in a manner that will minimize the chance of a puncture, cut, or exposure to blood or bodily fluids.

2. Recapping should never be done by a two-handed method with a cap held in one hand and the needle inserted in the other hand. Rather, recapping should be done by following one of the following single-handed methods:

   i. Hemostat Method – Use a hemostat to pick up the cap and recap the stationary needle. The cap may then be tightened with the fingers.
   ii. Scoop Method – Place the cap on its side on a clean surface and carefully scoop it up with the needle. The cap may then be tightened with the fingers. The needle should always be considered contaminated by this procedure and should be replaced with a new sterile needle if needed.
   iii. Device Assisted Method – Place the cap in the well of a device to hold it for the purpose of recapping.

3. Available engineered safety devices must be activated and used to minimize sharp injuries and reduce exposures to blood and bodily fluids.

4. Contaminated sharps and needles are disposed of immediately in a puncture proof container.

5. All needle disposal boxes are replaced when the boxes are three-fourths (3/4ths) full. Workforce members should never use their hand to push protruding needles or syringes back into the box.

6. Assistance should be obtained when starting an IV, giving an injection, or drawing blood from a patient that is uncooperative, combative or confused.

7. Plastic blood tubes, syringes, and capillary tubes should always be used instead of glass when available

8. Ensure that equipment necessary for performing a procedure is available and accessible.

9. If multiple sharps will be used during a procedure, organize the work area so that the sharp is always pointed away from the Workforce member using the sharp.

10. Identify the location of the sharps container. If the sharps container is movable, place it as near the point of use as appropriate for immediate disposal. If the sharp is reusable, determine in advance where it will be placed for safe handling after use.

11. Do not pass exposed sharps from one person to another. Instead use a predetermined neutral zone or tray for placing and retrieving used sharps.

B. Disposal of sharps and needles should be in accordance with the Sanitary Environment Protocol.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

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TITLE: **COMMUNICABLE DISEASE WORK RESTRICTIONS FOR WORKFORCE MEMBERS**

PURPOSE: To provide guidance for work restrictions for Ambulatory Surgical Center (ASC) at LBJ workforce members with a communicable disease or special conditions.

POLICY STATEMENT:

Possible transmission of infection by an Ambulatory Surgical Center (ASC) at LBJ ("ASC") Workforce member poses a risk to patients, visitors, and other workforce members. The route of transmission and likelihood of transmission of infection varies with the specific agent and type of contact. As a result, Workforce members with a communicable disease or infection will be assessed for restrictions.

POLICY ELABORATIONS:

I. DEFINITIONS:

WORKFORCE: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. RESPONSIBILITY:

A. All Workforce members with a communicable disease should remain away from work until he or she is no longer contagious. Workforce members are responsible for notifying his or her supervisor if they are ill with a communicable disease. Supervisors are responsible for ensuring that Workforce members are compliant with work restrictions when appropriate.

B. Per the Letter of Agreement between Harris Health System (Harris Health) and the ASC, Harris Health's Employee Health Services is available for consultation when needed.

III. PROCEDURES:

A. Any Workforce members with a fever should stay home until he or she has no fever for twenty-four (24) hours without medication. See the table below for guidelines regarding when to stay home in the setting of an acute respiratory viral illness.

Symptoms	Stay At Home	Return to Work
FEVER • Fever (T38C or 100.4)	• T >38C or 100.4	• No fever for 24 hours(!)
RESPIRATORY SYMPTOMS WITHOUT FEVER • Cough • Sore throat • Nasal congestion / runny nose • Myalgia (body aches)	One or more symptoms on high risk units Two or more symptoms on all other units	• 24 hours after onset of symptoms AND • No fever AND • Symptoms have significantly improved
RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza) • Fever (T38C or 100.4F) • Cough • Sore throat • Nasal congestion/runny nose • Myalgia (body aches)	T> 38C or 100.4 and at least one symptom	No fever for 24 hours and symptoms have significantly improved

B. A Workforce member who provides patient care and who suspects or knows that he or she is infected with a potential communicable disease shall not engage in any activity that is known to be a risk to others in the ASC.

C. Workforce members who are linked epidemiologically to an increase in bacterial or viral infections caused by a pathogen associated with a carrier state may be advised to provide samples for microbiology testing, and, if positive, be excluded from patient contact until carriage is eradicated or the risk of disease transmission is eliminated.

D. Workforce members who are infected with a potential communicable pathogen should report their condition to their supervisor. Work restrictions are determined on a case by case basis.

E. For selected conditions, medical clearance by Harris Health Employee Health Services is required prior to return to work. These conditions are set out in Attachment D.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Bolyard, E.A., et al. The Hospital Infection Control Practices Advisory Committee (1998). *Guidelines for Infection Control in Health Care Personnel,* 1998. American Journal of Infection Control, 26(3), 289-354.

Infectious Disease Guidelines by Type of Infection (2003). Occupational Exposure and Health.

CDC Recommendations for the Amount of Time Persons with Influenza-Like Illness Should be Away from Others. (Oct. 23, 2009).

Henderson, O.K., et al., and the Society for Healthcare Epidemiology of America (2010). SHEA Guidelines for Management of Healthcare Workers Who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus. Infection Control and Hospital Epidemiology, 31(3), 203-232.

Updated CDV Recommendations for the Management of Hepatitis B Virus-Infected Health Care Providers and Students. MMWR Recommendations and Reports. Vol. 61, No. 3 (July 6, 2012).

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ATTACHMENT D

Disease Problem	Work Restriction	Duration
Conjunctivitis	Restrict from patient contact with patient care environment	Until discharge ceases.
Cytomegalovirus	None	
Diarrhea, acute stage	Restrict from patient contact, contact with patient's environment, or food handling	Until symptoms resolve.
Diarrhea, convalescent stage, Salmonella	Restrict from care of high risk patients*	Until symptoms resolve.
Diphtheria	Exclude from duty	Until antimicrobial therapy concluded and 2 cultures obtained greater or equal to 24 hours apart are negative. **EHS clearance required.**
Enteroviral Infections	Restrict from care of infants, neonates, and immunocompromised patients and their environments	Until symptoms resolve.
Hepatitis A	Restrict from patient contact, contact with patient's environment, or food handling	Until 7 days after jaundice. **EHS clearance required.**
Hepatitis B, acute or chronic surface antigenemia personnel who do not perform exposure prone procedures**	None	**EHS clearance required.**
Hepatitis B, acute or chronic surface antigenemia personnel who perform exposure prone procedures	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Hepatitis C, personnel who do not perform exposure prone procedures	None	**EHS clearance required.**
Hepatitis C, personnel who perform exposure prone procedures	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Herpes Simplex, Genital	None	

Herpes Simplex, HADS (Herpetic Whitlow)	Restrict from patient contact and contact with patient care environment	Until lesions heal.
Herpes Simplex, Orofacial	Restrict from care of high risk patients*	Until lesions heal.
Human Immunodeficiency virus, personnel who do not perform exposure prone procedures	None	**EHS clearance required.**
Human Immunodeficiency virus, personnel who do perform exposure prone procedurs	Expert Panel Review	Expert Panel Review. **EHS clearance required.**
Influenza	Exclude from duty	24 hours after resolution of symptoms. **EHS clearance required.**
Measles, active	Exclude from duty	Until 7 days after rash appears.
Measles, post-exposure (susceptible person)	Exclude from duty	From the 5th day after 1st exposure through the 31st day after last exposure and/or 7 days after rash appears. **EHS clearance required.**
Meningococcal	Exclude from duty	Until 24 hours after start of effective therapy.
Mumps, active	Exclude from duty	Until 9 days after onset of parotitis. **EHS clearance required.**
Mumps, post-exposure (susceptible person)	Exclude from duty	From 12th day after 1st exposure through 26th day after last exposure or until 9 days after onset of parotitis. **EHS clearance required.**
Pediculosis (lice)	Restrict from patient contact	Until after one does of effective treatment.
Pertussis, active	Exclude from duty	Until 5 days after start of effective antimicrobial therapy.
Pertussis, post-exposure, asymptomatic	No restrictions, prophylaxis recommended	
Pertussis, post-exposure, symptomatic	Exclude from duty	Until 5 days after start of effective antimicrobial therapy.

Rubella, active	Exclude from duty	Until 5 days after rash appears.
Rubella, post-exposure (susceptible personnel)	Exclude from duty	From 7th day after 1st exposure through 21st day after last exposure. **EHS clearance required.**
Scabies	Restrict from patient contact	Until treated.
Skin lesions that cannot be covered precludes hand washing	Restrict from patient contact	
Staphylococcus aureus infection, active draining skin lesions	Restrict from patient contact with patent care environment or food handling	Until lesions have healed.
Staphylococcus aureus infection, carrier state	No restrictions unless personnel are epidemiologically linked to transmission of organism	
Streptococcal Infection, Group A	Exclude from duty	Until 24 hours after start of effective therapy.
Tuberculosis, active disease	Exclude from duty	Until proved noninfectious. **EHS clearance required.**
Tuberculosis, PPD converter	No restriction	
Varicella, active disease	Exclude from duty	Until all lesions dry and crust.
Varicella, post-exposure (susceptible personnel)	Exclude from duty	From 10th day after 1st exposure through 21st day (28th day if VZIG given after last exposure). **EHS clearance required.**
Zoster, localized in healthy person	Cover lesions; restrict from care of high risk patients*	Until all lesions dry and crust.
Zoster, generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust.

Zoster, post-exposure (susceptible person)	Restrict from patient contact	From 10th day after 1st exposure through 21st day (28hth day if VZIG given after last exposure). **EHS clearance required.**
Viral upper respiratory infection	Restrict from care of high risk patients*	Until 24 hours after symptoms resolve.

TITLE: COMMUNICABLE DISEASE EXPOSURE EVAULATION

PURPOSE: To prevent the acquisition and/or transfer of a communicable disease to a member of the workforce of the Ambulatory Surgical Center (ASC) at LBJ after exposure by outlining the process for evaluation post exposure.

POLICY STATEMENT:

Center for Disease Control guidelines will be followed for the evaluation and/or treatment of Ambulatory Surgical Center (ASC) at LBJ Workforce members after their occupational exposure to a known communicable disease.

POLICY ELABORATIONS:

I. DEFINITIONS:

WORKFORCE: The members of the governing body of the Ambulatory Surgical Center (ASC) at LBJ, employees, Medical Staff, trainees, contractors, volunteers, and vendors.

I. RESPONSIBILITIES AND PROCEDURES:

A. The ASC Infection Prevention Manager will be responsible for notifying Harris Health System's ("Harris Health") Employee Health Services of any potential Workforce member exposures related to communicable diseases for events that occur in the ASC. Per the Letter of Agreement between Harris Health and the ASC, Employee Health Services ("EHS") is responsible for contacting the Workforce members, evaluating Workforce members, and treating Workforce members with prophylaxis, if necessary.

B. Procedures:

1. Upon notification of a potential exposure, EHS will validate that the source case is a laboratory confirmed case. Non-laboratory confirmed communicable disease exposure cases will be evaluated on a case-by-case basis using CDC clinical case guidelines, EHS Medical Director review, or Harris Health's Chief of Infection Prevention review.

2. Depending upon the recommendations for the individual communicable disease, the EHS nurse will investigate potential Workforce member exposures. This investigation may include some or all of the following:

   a. Review of Workforce member records for the presence of vaccinations or antibody titers; and
   b. Interviewing the Workforce member for the nature of exposure and the presence of any symptoms.

3. Depending upon the recommendations for the individual communicable disease, the EHS nurse will follow the order of the EHS Medical Director or Harris Health's Chief of Infection Prevention regarding vaccination, prophylaxis, diagnostic evaluation and treatment, or no additional intervention. Workforce members should be counseled appropriately regarding the exposure and his or her treatment.
4. Depending upon the recommendations for the individual communicable disease, the EHS nurse will consult with the EHS Medical Director to determine if the Workforce member should have any work restrictions or be excluded from duty. Workforce members excluded from duty cannot work in the ASC.
5. Workforce members excluded from duty by EHS for a confirmed occupational exposure will receive pay.
6. All Workforce members excluded from duty require clearance from EHS to return to work.

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).
Bolyard, E.A., et al., The Hospital Infection Control Practices Advisory Committee (1998). American Journal of Infection Control, 26(3), 289-354.

OFFICE OF PRIMARY RESPONSIBILITY:

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TITLE: DETECTION AND MANAGEMENT OF OUTBREAKS

PURPOSE: To delineate the process to verify the existence of an outbreak and initiate infection control practices to interrupt the transmission of disease-causing agents.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ will use the processes and practices contained in this policy for the detection and management of outbreaks and the transmission of disease causing agents.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **OUTBREAK**: An excess over the expected level of disease within a specified period of time or in a geographic area, however one case of disease may constitute an outbreak.

B. **WORKFORCE**: Employees, Medical Staff, trainees, contractors, volunteers, and vendors.

II. CONDUCTING AN OUTBREAK INVESTIGATION

A. Initial Investigation: the following steps will be taken during the initial investigation of a possible outbreak:

1. Confirm the presence of an outbreak;
2. Alert key stakeholders about the investigation;
3. Perform a literature review;
4. Establish a preliminary case definition;
5. Develop a methodology for case finding;
6. Prepare an initial line list and epidemic curve;
7. Observe and review potentially implicated patient care activities;
8. Consider environmental sampling; and
9. Implement initial control measures.

B. Follow-up Investigation: the following steps will be taken during the follow-up investigation of an outbreak:

1. Refine the case definition;
2. Continue case finding and surveillance;
3. Review regular control measures; and
4. Perform an analytic study.

III. PROCEDURES:

A. Establish Diagnosis of Reported Cases:

1. Develop specific criteria for definition of a case. Initially, this may be a broad definition which is refined as the investigation proceeds (e.g., diarrhea in pediatric patients);
2. Write case definition that includes information regarding who, what, when, and where;
3. Characterize the nature of the disease, including signs and symptoms, person, place, and time;
4. Obtain laboratory specimens to identify specific causative agent;
5. Develop an outbreak log-listing of patients, location, culture results, procedures, and clinical findings;
6. Compare current incidence with usual or baseline incidents (calculate rates);
7. Review existing data to determine if an on-going problem exists; and
8. Document findings at each investigative step.

B. Institute Appropriate Early Control Measures:

1. Control measures should be based on the magnitude and nature of the problem;
2. List all patients in the ASC and their location before moving a single patient;
3. Divide patients into two categories for isolation and bed assignments:

    a. Affected and probable affected; and
    b. Exposed

4. Designate an area for cohorting patients and staff; and

5. Communicate findings and recommendations frequently to key stakeholders through written reports.

C. Report Additional Cases of the Disease:

1. Immediately report new cases to the Infection Prevention Manager through the following:

   a. Laboratory reports;
   b. Medical staff;
   c. Nursing staff; and
   d. Others as appropriate.

2. Investigate cases that may have occurred retrospectively or concurrently:

   a. Laboratory reports;
   b. Medical reports;
   c. Patient charts;
   d. Physicians and nursing staff;
   e. Public health data; and
   f. Discharged patients.

D. Investigate Sources of Infection:

1. Consult Infectious Disease Physician and the ASC Medical Director for treatment options for exposed patients. Consult Harris Health System's Employee Health Services, per the Letter of Agreement between Harris Health System and the ASC, for treatment options for exposed Workforce members.
2. Identify practices that are potentially related to the occurrence of the outbreak; and
3. Institute surveillance cultures as stipulated per the Infection Prevention.

E. Evaluate Efficacy of Control Measures:

1. Continue monitoring and surveillance activities to identify new cases;
2. Prepare written Performance Improvement reports; and

3. Distribute final summary reports to Infection Prevention, the Medical Director of the ASC, and the Administrator of the ASC.

Commented [TG2]: Remove Attachment A

REFERENCES/BIBLIOGRAPHY:

42 Code of Federal Regulations (C.F.R.) §416.51(b).

Association for Practitioners in Infection Control, APIC Text, Online 2014.

Mayhall, Glen C., Hospital Epidemiology and Infection Control, 4th Edition, 2012.

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OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
6/14/16	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Reviewed / Approved 02/15/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
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		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

The ASC at LBJ will follow current guidelines from the Centers for Disease Control (CDC) regarding the COVID-19 pandemic and operational safety.

- **Reduce facility risk.** Reduce elective procedures, limit points of entry and manage visitors, screen everyone entering the facility for COVID-19 symptoms, implement source control for everyone entering the facility, regardless of symptoms.
- **Identify symptomatic persons as soon as possible.** Communicate with patients preoperatively to prevent scheduling symptomatic patient. Set up separate screening areas to prevent admission of symptomatic patients, staff and providers to the ASC.
- **Protect healthcare personnel.** Emphasize hand hygiene, install barriers to limit contact with patients at check in, encourage social distancing and prioritize N95 masks for aerosol generating procedures.

This interim guidance has been updated based on currently available information about COVID-19 and the current situation in the United States, which includes community transmission, infections identified in healthcare personnel (HCP), and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (N95 respirators), eye protection, gloves, and gowns.

Please consult the link below for the most up to date guidance from the CDC on these key concepts.
Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic

Implement Telehealth and Nurse-Directed Triage Protocols

When scheduling appointments for routine medical care (e.g., annual physical, elective surgery):

- Advise patients that they should put on their own cloth mask before entering the facility.
- Instruct patients to call ahead and discuss the need to reschedule their appointment if they have symptoms of COVID-19 within the 10 days prior to their appointment, if they have been diagnosed with SARS-CoV-2 infection within the 10 days prior to their appointment, or if they have had close contact with someone with suspected or confirmed SARS-CoV-2 infection within 14 days prior to their scheduled appointment.

Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19

- Take steps to ensure that everyone adheres to source control measures and hand hygiene practices while in a healthcare facility

- Post visual alerts pdf icon (e.g., signs, posters pdf icon) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about wearing a cloth face covering or facemask for source control and how and when to perform hand hygiene.
- Provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand sanitizer (ABHS) with 60-95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins

- Limit and monitor points of entry to the facility.
- Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are practicing source control.
  - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days.
    - Fever can be either measured temperature ≥100.4°F or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.
    - Obtaining reliable temperature readings is affected by multiple factors, including:
      - The ambient environment in which the temperature is measured: If the environment is extremely hot or cold, body temperature readings may be affected, regardless of the temperature-taking device that is used.
      - Proper calibration of the thermometers per manufacturer standards: Improper calibration can lead to incorrect temperature readings.
      - Proper usage and reading of the thermometers: Non-contact infrared thermometers frequently used for health screening must be held at an established distance from the temporal artery in the forehead to take the temperature correctly. Holding the device too far from or too close to the temporal artery affects the reading.
- Properly manage anyone with suspected or confirmed SARS-CoV-2 infection or who has had contact with someone with suspected or confirmed SARS-CoV-2 infection:
  - Healthcare personnel (HCP) should be excluded from work and should notify occupational health services to arrange for further evaluation.
  - Visitors should be restricted from entering the facility and be referred for proper evaluation.
- Patients should be isolated in an examination room with the door closed.
- If an examination room is not immediately available, such patients should not wait among other patients seeking care.
  - Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies.
  - In some settings, patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

- Depending on the level of transmission in the community, facilities might also consider designating a separate area at the facility (e.g., an ancillary building or temporary structure) or nearby location as an evaluation area where patients
- with symptoms of COVID-19 can seek evaluation and care.

Implement Universal Source Control Measures

Source control refers to use of well-fitting cloth face masks or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.

- Patients and visitors should wear their own cloth mask (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth mask
  - Patients may remove their cloth mask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.
  - Facemasks and cloth masks should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
  - Visitors who are not able to wear a cloth mask or facemask should be encouraged to use alternatives to on-site visits with patients (e.g., telephone or internet communication), particularly if the patient is at increased risk for severe illness from SARS-CoV-2 infection.
- HCP should wear a facemask at all times while they are in the healthcare facility, **including in breakrooms or other spaces where they might encounter co-workers**.
  - When available, facemasks are preferred over cloth face masks for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
    - Cloth masks should NOT be worn instead of a respirator or facemask if more than source control is needed.
  - To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or facemask (extended use) throughout their entire work shift, instead of intermittently switching back to their cloth mask.
  - HCP should remove their respirator or facemask, perform hand hygiene, and put on their cloth mask when leaving the facility at the end of their shift.
- Educate patients, visitors, and HCP about the importance of performing hand hygiene immediately before and after any contact with their facemask or cloth mask.

Encourage Physical Distancing

Healthcare delivery requires close physical contact between patients and HCP. However, when possible, physical distancing (maintaining at least 6 feet between people) is an important strategy to prevent SARS-CoV-2 transmission.

Examples of how physical distancing can be implemented for patients include:

- Limiting visitors to the facility to those essential for the patient's physical or emotional well-being and care (e.g., care partner, parent).
    - Encourage use of alternative mechanisms for patient and visitor interactions such as video-call applications on cell phones or tablets.
- Scheduling appointments to limit the number of patients in waiting rooms, or creating a process so that patients can wait outside or in their vehicle while waiting for their appointment.
- Arranging seating in waiting rooms so patients can sit at least 6 feet apart.
- Modifying in-person group healthcare activities (e.g., group therapy, recreational activities) by implementing virtual methods (e.g., video format for group therapy) or scheduling smaller in-person group sessions while having patients sit at least 6 feet apart.
    - In some circumstances, such as higher levels of community transmission or numbers of patients with COVID-19 being cared for at the facility, and when healthcare-associated transmission is occurring, facilities might cancel in-person group activities in favor of an exclusively virtual format.

For HCP, the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas. Examples of how physical distancing can be implemented for HCP include:

- Reminding HCP that the potential for exposure to SARS-CoV-2 is not limited to direct patient care interactions.
- Emphasizing the importance of source control and physical distancing in non-patient care areas.
- Providing family meeting areas where all individuals (e.g., visitors, HCP) can remain at least 6 feet apart from each other.
- Designating areas and staggered schedules for HCP to take breaks, eat, and drink that allow them to remain at least 6 feet apart from each other, especially when they must be unmasked.

Implement Universal Use of Personal Protective Equipment

- **HCP working in facilities located in areas with moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic patients with SARS-CoV-2 infection. If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

They should also:

- Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.
- Wear an N95 or equivalent or higher-level respirator, instead of a facemask, for:
    - Aerosol generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings FAQ) and
    - Surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) (refer to Surgical FAQ).

- **For HCP working in areas with minimal to no community transmission**, HCP should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other personal protective equipment (PPE). In addition, universal use of a facemask for source control is recommended for HCP if not otherwise wearing a respirator.
- **Consider Performing Targeted SARS-CoV-2 Testing of Patients Without Signs or Symptoms of COVID-19**
- In addition to the use of universal PPE and source control in healthcare settings, targeted SARS-CoV-2 testing of patients without signs or symptoms of COVID-19 might be used to identify those with asymptomatic or pre-symptomatic SARS-CoV-2 infection and further reduce risk for exposures in some healthcare settings. Depending on guidance from local and state health departments, testing availability, and how rapidly results are available, facilities can consider implementing pre-admission or pre-procedure diagnostic testing with authorized nucleic acid or antigen detection assays for SARS-CoV-2. Testing results might inform decisions about rescheduling elective procedures or about the need for additional Transmission-Based Precautions when caring for the patient. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.
- **Consider if elective procedures, surgeries, and non-urgent outpatient visits should be postponed in certain circumstances.**
- Facilities must balance the need to provide necessary services while minimizing risk to patients and HCP. Facilities should consider the potential for patient harm if care is deferred when making decisions about providing elective procedures, surgeries, and non-urgent outpatient visits. Refer to the Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic for additional guidance.

Optimize the Use of Engineering Controls and Indoor Air Quality

- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals. Examples of engineering controls include:
  - Physical barriers and dedicated pathways to guide symptomatic patients through triage areas.
  - Remote triage facilities for patient intake areas.
  - If climate permits, outdoor assessment and triage stations for patients with respiratory symptoms.
  - Vacuum shrouds for surgical procedures likely to generate aerosols.
  - Reassess the use of open bay recovery areas.
- Explore options, in consultation with facility engineers, to improve indoor air quality in all shared spaces.
  - Optimize air-handling systems (ensuring appropriate directionality, filtration, exchange rate, proper installation, and up to date maintenance).
  - Consider the addition of portable solutions (e.g., portable HEPA filtration units) to augment air quality in areas when permanent air-handling systems are not a feasible option.
  - Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
    - Guidelines for Environmental Infection Control in Health-Care Facilities

- American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities external icon, which also provides COVID-19 technical resources for healthcare facilities external icon

Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others

Healthcare facilities should have a process for notifying the health department about suspected or confirmed cases of SARS-CoV-2 infection, and should establish a plan, in consultation with local public health authorities, for how exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. The plan should address the following:

- Who is responsible for identifying contacts (e.g., HCP, patients, visitors) and notifying potentially exposed individuals?
- How will such notifications occur?
- What actions and follow-up are recommended for those who were exposed?

Contact tracing should be carried out in a way that protects the confidentiality of affected individuals and is consistent with applicable laws and regulations. HCP and patients who are currently admitted to the facility or were transferred to another healthcare facility should be prioritized for notification. These groups, if infected, have the potential to expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, are at higher risk for severe illness themselves.
Information about when HCP with suspected or confirmed SARS-CoV-2 infection may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19.

Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 (COVID-19).

Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.

Please consult the link below for the most up to date guidance from the CDC on these key concepts.

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

Consideration of Approval of New and/or Amended Policies and Procedures for the Ambulatory Surgical Center at LBJ

Please find a summary of the new and/or amended policies reviewed.

- Policy ASC-P-1001
- Policy ASC-P-6015
- Policy ASC-P-6016

TITLE: BLOOD/BLOOD COMPONENT ADMINISTRATION

PURPOSE: To provide the guidelines for administering blood and blood products, including the process of identifying those patients who should receive blood or a blood product transfusion.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to ensure that blood and blood products are available for administration to patients when necessary and to administer blood and blood products to patients in a safe manner consistent with applicable guidelines.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **BLOOD:** Whole blood collected from a single donor and processed either for transfusion or further manufacturing.

B. **BLOOD COMPONENT:** That part of a single-donor's blood separated by physical or mechanical means. This includes:

1. Plasma Products (Fresh Frozen Plasma (FFP); liquid plasma, cryo-poor plasma);
2. Platelets;
3. Red Blood Cells;
4. Cryoprecipitate;
5. Granulocytes; and
6. Pooled product from multiple donors.

C. **BLOOD DERIVATIVES:** Licensed pharmaceutical medications manufactured from in vitro recombinant DNA methods or human plasma donations pooled from large donor populations which have undergone multiple pathogen inactivation steps and fractionation regulated by the FDA to remove impurities, stabilize product, inactivate and or remove pathogens to ensure sterility. Blood derivatives may be administered following the appropriate order by a physician and

distribution of the derivative by the pharmacy department. Blood Derivatives include:

1. Albumin;
2. Immunoglobulins; and
3. Factor concentrates.

D. **WORKFORCE**: The employees, medical staff, trainees, contractors, volunteers, and vendors.

II. MEDICAL DISCLOSURE AND REFUSAL TO CONSENT:

A. A physician must disclose to the patient, or the individual authorized to give consent for medical care on behalf of the patient, the risks and hazards involved in the administration or refusal of blood or blood products as defined by the Texas Medical Disclosure Panel.

B. It is the policy of the ASC to not perform surgery on patients who refuse to consent to the administration of blood or blood products for the procedures listed in Appendix A. If a patient refuses to consent to the administration of blood or blood products, the ASC will refer the patient to Lyndon B. Johnson Hospital (LBJ) or Ben Taub Hospital to reschedule his or her surgery.

C. Pursuant to the Letter of Agreement between Harris Health and the ASC, Harris Health will utilize coolers to transport blood products to the ASC from LBJ, when necessary.

III. EMERGENCY RELEASE PROCEDURE:

A. When a determination has been made to utilize blood and/or blood products the following procedure must be followed:

1. The individual requesting the blood and/or blood products will call the Nurse Manager (NM) or his or her designee.

The NM or his or her designee will call the LBJ Blood Bank at 713-566-5293 to request that the Blood Bank immediately release the blood and/or blood products. The NM or his or her designee will send an available ASC Workforce member to the Blood Bank with the patient's label to obtain the blood and/or blood products.

2. The Harris Health Blood Bank will supply the ASC Workforce member with a transport cooler and blood and/or blood products.

3. This process will repeat until blood and/or blood products are no longer requested or needed.

B. When blood or blood products are used, a type and screen or type and cross will be conducted by the LBJ Hospital Laboratory.

IV. ADMINISTRATION:

A. Only physicians, dentists, or registered nurses may administer blood or blood products to patients.

CLIA MEDICAL DIRECTOR(S)			
CLIA Expiration Date: 04/11/2024	**CLIA Medical Director – ASC at LBJ: Dr. Scott Perry**	**License No.: 45D2111689**	**Signature:**

REFERENCES/BIBLIOGRAPHY:

Harris Health System Policy and Procedures 4170 Administration of Blood and Blood Components and Blood Derivatives

42 Code of Federal Regulations (C.F.R.) 416.48(a) (2)

Quad A Version 8.2

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
8/5/16	1.0	Reviewed / Approved 08/15/2016	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	1.1	Reviewed / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) Governing Body
		Revised / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) Governing Body

APPENDIX A
BLOOD COMPONENT

Purpose:

To delineate procedures that require consent for blood administration at the ASC

Procedure:

1. Dilation and Curettage (both non-obstetric and obstetric)
2. Facial Fracture repair and immobilization
3. Mandibular fractures: open reduction, with or without inter-dental wiring
4. All intra-abdominal procedures ~~(open or laparoscopic)~~
5. All intra pelvic procedures ~~(open and laparoscopic)~~

APPENDIX B
TRANSFUSION REACTIONS

A. Transfusion Reaction Procedure: If signs /symptoms of transfusion reaction are noted at any time during the transfusion, immediately stop the transfusion and:

1. Immediately take a full set of vital signs. Repeat the vital signs at a minimum of every 15 minutes, and additionally as needed until reaction is abated.
2. Notify the physician and blood bank.
3. Administer medications/treatments as ordered.
4. Physician to order the Transfusion Reaction Protocol which includes:

    a. Collect one pink top tube of patients' blood and a urine specimen, which is the 1st post transfusion being started. Collect one pink top tube of patients' blood and a urine specimen which is the 1st post transfusion being started.
    b. Sends collected specimens and un-transfused portion of blood component with attached tubing and IV fluid to blood bank.

5. Leave the IV site intact or maintain IV

B. Recognition of an Acute Transfusion Reaction

Common physical signs/symptoms of an acute transfusion reaction may include the signs and symptoms on the following list. However, bear in mind the patient's underlying clinical condition as none of these manifestations are unique to transfusion reactions. **If these signs/symptoms occur for the first time or worsen in severity during or after transfusion, consider transfusion reaction**:

- Chills/Fever
- Vital sign changes/shock
- Flushing
- Chest pain
- Dark/red urine or hemoglobinuria
- Generalized, abdominal, or flank pain
- Pain at infusion site
- Unexplained mucosa hemorrhage

- Dyspnea/Hypoxia
- Fainting or dizziness
- Itching, hives, rash, facial flushing or skin reactions
- New acute complaints of generalized discomfort or "impending sense of doom"

The following vital sign changes (from either pre-transfusion baseline or if representative of a new degree of fluctuation in vital signs) could be indicative of a transfusion reaction, and should be appropriately evaluated by a physician:

1. Fever:

   a. +1.0^{o}C/+2^{o}F increase in temperature to above 38^{o}C or 100.4^{o}F;

   or

   b. If new chills/rigors are noted without previously stated temperature elevations.

2. Hypoxemia:

   a. 90% or less on pulse-oximetry on room air
   b. PaO2/FiO2 less than or equal to 300 mmHg

3. Blood Pressure:

   Greater than or equal to +/-30 mmHg change in systolic blood pressure

4. The absence of these vital sign changes does not necessarily exclude a transfusion reaction.

New or worsening manifestations of these signs/symptoms within 24 hours of starting a transfusion **should be reported to a physician AND the blood bank via phone call for evaluation** of potential transfusion reaction. A "transfusion reaction evaluation" order in EPIC should be submitted to initiate the laboratory workup.

C. Management of a Potential Transfusion Reaction:

If a transfusion reaction is suspected, based on above signs/symptoms, at any time during the transfusion or within 24hrs following a completed transfusion:

1. Immediately stop the transfusion (if reaction occurred during transfusion).
2. Take a full set of vital signs. Repeat the vital signs at a minimum of every 15 minutes, and additionally as needed until reaction is abated.
3. Notify a treating physician, and notify the blood bank (phone call and through "transfusion reaction evaluation" order.
4. Administer medications/treatments as appropriate:

    a. Antihistamines is appropriate for most hives/rash
    b. Antipyretics as appropriate

5. DO NOT restart a transfusion, except in the case of a resolved mild allergic transfusion reaction (ONLY Hives/rash that resolves with or without antihistamines.)

To initiate blood bank investigation of transfusion reaction, perform the following steps:

1. Order "Transfusion Reaction Evaluation" in EPIC (LAB893).
2. Collect one pink top tube of patients' blood and a urine specimen (if available) as part of that order.
3. Send collected specimens and remaining bag/tubing of blood components to the blood bank; include any IV fluids attached to the same circuit as the blood component.
4. Nursing should document first-hand reaction details events via the transfusion flowsheet (aka BPAM, Blood Product Administration Module). Pertinent details of transfusion reaction may also be entered in a separate nursing note if insufficient space to document events in the flowsheet.
5. Leave the IV site intact and/or maintain IV fluids.
4. Expect pathology physicians to contact the bedside nurse and notified provider for an account of the transfusion reaction and response.

HARRISHEALTH SYSTEM

ASC Disaster Preparedness Plan

2023

TITLE: DISASTER PREPAREDNESS PLAN

PURPOSE: To provide a safe environment for patients, visitors, and workforce members at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ has a disaster preparedness plan in place to care for patients, workforce members, and other individuals who are on the ASC's premises when a major disruptive event occurs.

The governing body of the ASC is responsible for the development of this plan.

I. OBJECTIVE

To establish and maintain a program at the ASC that ensures an effective response to probable disasters or emergencies that may affect the ASC physical environment.

II. ELEMENTS OF DISASTER PREPAREDNESS PLAN:

The four phases of the ASC's emergency management activities are:
Mitigation - Measures taken to lessen the severity and impact of a disaster or emergency at the ASC.
Preparedness - Measures taken to ensure readiness and to identify resources that may be used should a disaster occur.
Response - Measures taken during a disaster to ensure the safety of patients, visitors, and Workforce members.
Recovery - Measures taken following a disaster or emergency to return the ASC to normal operations as quickly as possible.

III. HAZARD VULNERABILITY ANALYSIS:

The ASC has identified disaster situations that could affect the operations of the ASC in the Hazard Vulnerability Analysis, *see* Attachment A. Specific procedures are implemented in response to disasters which have been identified as "high probability."

IV. NIMS and HICS

The National Incident Management System (NIMS) guides all levels of government, nongovernmental organizations and the private sector to work together to prevent, protect against, mitigate, respond to and recover from incidents.

NIMS provides stakeholders across the whole community with the shared vocabulary, systems and processes to successfully deliver the capabilities described

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in the National Preparedness System. NIMS defines operational systems that guide how personnel work together during incidents.

- Local, state, territorial, and tribal nation jurisdictions are required to adopt NIMS in order to receive federal Preparedness grants.

HICS team charts depict the hospital command functions that have been identified and represent how authority and responsibility are distributed within the incident command team. The Incident Commander, who has overall responsibility for all activities within the Hospital Command Center (HCC), directs the activities at the Hospital Command Center (HCC). The Incident Commander may appoint other Command Staff personnel to assist. The Command staff generally includes a Liaison, Safety Officer, Public Information Officer, and other specialty appointed position (e.g., Medical Specialist). Many incidents that likely will occur involve injured or ill patients. Figure II-3 below shows a Hospital Incident Command System.

V. DISASTER PREPAREDNESS PLAN:

A. Activation of Plan:

1. As appropriate, the plan may be activated by the ASC Administrator. The centralized command post will be the nursing station between the pre-op and PACU areas.

2. The ASC command post will have a direct line of communication with LBJ's Incident Command Center (713-566-5105) and the Corporate Incident Command Center during a community or campus-wide disaster that may affect the operations of the ASC.

B. Authority & Responsibilities:

1. The ASC Administrator will serve as the coordinator of all disaster-related activities. If the ASC Administrator is not available, the person of highest authority at the ASC shall assume the role of coordinator, followed by the next person of highest authority.

2. The ASC command post will serve as a central resource for information and assignments regarding the disaster. Supply, space, security, and patient management will be directed from the command post by the ASC Administrator, or person of next highest authority, as appropriate, based on the size, type, and complexity of the emergency or disaster.

3. The ASC Administrator or his or her designee will notify Harris Health System's (Harris Health) Corporate Communications to handle all interactions with the news media regarding the disaster as well as the release of any information to the families of patients and/or victims, pursuant to the Letter of Agreement between Harris Health and the ASC.

(Media On-Call: 713-566-6430).

C. Communications:

1. As with the notification of external authorities, each emergency response procedure, as appropriate, has a method of notifying ASC Workforce members. Alternate methods of communication have been identified in the event there is a loss of telephone service.

- These include, but are not limited to, the use of back-up phones, email, digital pagers, cellular telephones, VOIP phones, hand held radio, Send Word Now, GETS (Government Emergency Telecommunication System), and Corporate Communications ~~etc~~.

2. In the case of an actual disaster affecting the operations of the ASC, each emergency response procedure, as appropriate, has a method of notifying Harris Health response personnel (e.g., Emergency Alerts & Codes) and external authorities of emergencies. This is done by calling Harris Health Security Dispatcher (713-566-9001) who will notify 911.

3. At the discretion of the ASC Administrator or designee, off-duty Workforce members will be notified to report to the facility as needed. A Disaster Call List will be maintained by the ASC Administrator and designees for the purposes of notifying off-duty Workforce members should their assistance be necessary. The disaster call list will be kept in the emergency preparedness binder in the PreOP and PACU station.

D. Staff Identification:

1. For security purposes, (e.g., vehicular access, etc.), all ASC Workforce members will be identified as Essential Employees on the back of their ID badges in order to access any Harris Health facility (if safe to do so) during a community disaster. Employees will show their "Essential Personnel" logo on the back of their ID badge to law enforcement.

2. Each ASC Workforce will be designated as a "Recovery" team member at the time of hire.

3. ASC Workforce members will call the Employee Staffing Hotline Number (888-305-2979) to verify the necessity to return to the ASC if they have not been contacted or instructed to return to work by their supervisor.

4. Post-disaster, all Recovery Workforce members will report to the ASC command post for specific assignments.

E. Discontinuation of Services:

In the event of a disaster, the ASC Administrator or designee in consultation with the ASC Medical Director and Harris Health leadership will make the determination as to whether services will be continued, modified, or discontinued as appropriate.

F. Emergency Assets & Resources:

1. Emergency assets and resources are available If specialty items are needed the ASC will contact Harris Health Supply Chain Management department. Harris Health support departments maintain a ninety-six (96) hour supply of assets, including: pharmaceuticals, medical and non-medical supplies, drinking water, and food.

2. In the event of a city-wide disaster, Harris Health's System Incident Command Team will announce steps to be taken to allocate resources.

G. Emergency Response:

1. The ASC response to disasters or emergencies follows an "All Hazards Approach" and is not designed to be all inclusive. If ASC Management can maintain the following "Critical Six" elements of an all hazard approach, the ASC can handle most likely any emergency. The "Critical Six" elements are:

i. Maintain communications;
ii. Maintain safety and security;
iii. Maintain utilities;
iv. Maintain assets and resources;
v. Manage patients; and
vi. Manage staff.

2. Security Threats:

In the event of a civil disturbance or security threat during normal business hours, the Administrator or designee will notify Harris Health's Department of Public Safety who will respond and notify the Houston Police Department. Patients, visitors, and Workforce members will be discouraged from leaving the ASC until the situation is deemed safe by law enforcement. Please see Harris Health System's*, Active Shooter / Armed Intruder Procedures*, attached.

3. Utility/Power Failure:

In the event of a utility/power failure, the ASC is equipped with an auxiliary generator, which is activated by a power failure. Should the auxiliary generator fail, ASC Workforce members should be aware that equipment requiring electricity in the ASC will not be functional except those items on battery back-up. ASC Workforce members will be responsible for reporting the power failure. LBJ Facility Engineering staff will respond and be responsible for repair and notifying and requesting emergency service from utility vendors. Please see Harris Health System's *Facility Alert, Utilities Failure Procedure,* attached. During a power failure staff will safely complete or stop any procedure they have currently started if the physician deems it is safe to do so. No additional procedures will begin until ASC has returned to normal power. In the event of a power failure emergency, the ASC will implement the Electronic Medical Record Downtime procedure. (Reference policy 4616)

4. Hurricanes:

The ASC will not be operational during a hurricane. Cancellation of procedures will be the responsibility of the Administrator or designee in conjunction with the Harris Health's Incident Command. Generally, services should be stopped twenty-four (24) to forty-eight (48) hours prior to tropical winds (39 mph) reaching the Houston area. In addition, ASC Workforce members will be given adequate time to be released to their homes and families.

5. Tornados / Severe Weather:

The areas of concern during severe weather are the waiting area and/or areas that have exposed glass. Once alerted (overhead page, phone call, e-mail), ASC Workforce members shall move all visitors, patients, and fellow Workforce members away from windows and towards interior corridors or protected areas (stairwells). Workforce members will communicate with visitors and patients, lower patient beds to its lowest position, and clear

pathways by moving emergency carts and equipment to interior rooms. Please see Harris Health System's, *Weather Alert Procedures, attached.*

6. Pandemic:

Harris Health's Quality department(s) will provide the ASC with continued recommendations in regards to the COVID-19 pandemic (see Attachment B).

H. Shelter-in-Place:

Shelter-in-Place is not intended to be a stand-alone response to an emergency. The ASC Administrator or designee should consider sheltering in place based on the emergent situation. Emergency situations likely to threaten the ASC are external threats such as a chemical release, tornado, ice storm, or severe weather event. All situations could warrant a sheltering place response inside the ASC.

I. Evacuation:

1. When it is determined that the environment cannot support adequate patient care and treatment, after consultation with the ASC Medical Director and Harris Health leadership the ASC will be evacuated.

2. In the event the ASC is evacuated, the Outpatient Center Administration and LBJ Administration will be notified of the evacuation.

3. Types Of Events Requiring Evacuation:

i. Fire/Explosion;
ii. Hazardous Material Incidents;
iii. Structural Damage/Failure;
iv. Extended Utility Failure;
v. Medical Gases Failure;
vi. Infectious Outbreak; and
vii. Tornado/Hurricane.

4. The ASC Evacuation Plan addresses specific procedures to be followed if an evacuation of the ASC is deemed appropriate, as well as alternate roles and responsibilities of key Workforce members.

i. External Requests for Information

- ASC Incident Command will maintain a directory of evacuated patients and may share information such as whether an individual is at the facility, his or her location

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within the facility, and general condition to those making inquiries about patients, staff, or other building occupants.

- During the course of the incident, requests for detailed patient information may be received from external sources (e.g., staff and patient families, media, public, emergency management, law enforcement, health department, insurance carriers).
    - Any person receiving such a request shall take the requestor's name, agency, telephone number, and nature of the inquiry and refer the matter to the ASC Incident Command Center.
    - Consolidated information (e.g., number of patients evacuated, receiving hospitals) may be shared with local EOC or other coordinating agencies.
    - No information shall be released without authorization from the ASC Incident Command.
- Information released to the public needs to be consistent and accurate. All information released to the general public or media will be released through the unified command Joint Information Center (JIC), if activated, or the ASC Incident Command Center.
    - Media relations will be accomplished in accordance with the Harris Health communications plan.

J. Reoccupation of the ASC after an Event:

1. Harris Health's Engineering/Planning department(s) will provide the ASC Administrator/Medical Director an assessment of damages and status of service operations.

2. Harris Health's Engineering/Planning department(s) will determine the overall readiness and/or operational limitations of the ASC and coordinate with the city of Houston and other appropriate agencies regarding the restoration of utilities and the type of services, if any, that the ASC can provide to the community.

3. All reports of property damage should be directed to Harris Health's Facilities Planning and Development department.

4. Evacuated areas of the ASC can be reoccupied only after thorough inspection and certification by Harris Health's Engineering/Facilities Planning and Development department deems areas safe to occupy.

5. Following an emergency event/disaster, workforce members will be contacted by the ASC Administrator or designee to advise a return-to-work status.

K. Alternate Care Sites:

1. An alternative care site will be identified and utilized when the ASC cannot adequately support patient care and treatment.

2. The specific type of disaster and the conditions in and around the ASC will dictate whether the evacuation, transfer, or relocation of patients to an alternate case site will be necessary.

3. The transfer of patients, staff, equipment, and any patient necessities will be coordinated between the ASC Administrator or his or her designee, the Harris Health Transfer Center, Medical Staff, and Harris Health Leadership. The ASC will follow ASC-P-1007 in regards to patient transfer.

L. Staffing During a Disaster and Volunteers:

1. The ASC staff will follow Harris Health policy 6.22 Staffing During Disasters Emergency Events and Service Disruptions.

2. The ASC will not utilize volunteers. ~~However, if Harris Health System begins to accept volunteer practitioners and volunteer advanced practice professionals they will be compliant with CMS requirements for participation.~~

M~~L~~. Training:

An orientation program has been established to familiarize ASC Workforce members with the components of the Disaster Preparedness Plan. Orientation is completed by Workforce members upon hire at Harris Health's New Employee Orientation. Additionally, Workforce members must complete annual training on the Disaster Preparedness Plan. Additional training will be completed by Workforce members on an as needed basis and based on reviews of data collected during drills and audits.

N~~M~~. Drills: Testing, Evaluating, and Updating the Plan:

1. At least once every year the ASC will conduct an exercise to test the effectiveness of the Disaster Preparedness Plan. An exercise that is conducted in concert with State or local authorities qualifies as an annual test. While the exercise drill does not

have to test the response to every identified hazard, the drill must test a significant portion of the Disaster Preparedness Plan.

Note: A real disaster event may be used for an exercise.

2. The following table includes the data evaluated in determining the effectiveness of the Emergency Management Plan.

Data	Source	When and Where Reported
Drill Hazard Vulnerability Analysis	Internal OEM	Annually (Quality Council & Gov. Body)
Drill Minutes and Critiques	Internal	Annually (Quality Council and Gov. Body)
Staff Education and Competency	Internal	Quarterly (Quality Council and Gov. Body)
Annual Evaluation of the EM Program	Internal	Annually (Quality Council and Gov. Body)

1. The ASC Administrator must prepare a written evaluation of each annual exercise. The evaluation must address issues identified during the exercise, propose resolutions to those issues, and update the Disaster Preparedness Plan accordingly. Specifically, the following must be evaluated:

i. Emergency preparedness knowledge among Workforce members;
ii. Workforce members' emergency preparedness skills;
iii. Workforce members' participation levels;
iv. Inspection activities;
v. Emergency and incident reporting procedures; and
vi. Testing applicable equipment.

O~~N~~. Coordination of the Plan:

Because the Southeast Texas Regional Advisory Council (SETRAC) has determined that the ASC will not be integrated into the city-wide disaster response program, the ASC's role in the event of a community-side disaster will be minimal.

REFERENCES/BIBLIOGRAPHY:

American Association for Accreditation of Ambulatory Surgery Facilities Version 7 §400.20

Harris Health Emergency Operations Plan (EOP)

Emergency Alerts, Codes, and Response Policy No. 7100

Harris Health Civil Disturbance Response Plan No. 7112

Emergency Preparedness Guide

LBJGH Fire Safety Plan Policy FP

HCHD Fire Safety Risks Procedures Policy 7404

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
			The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

2023 HAZARD VULNERABILITY ANALYSIS RISK RATING

Top 10 ASC Scored Events (Average)

Updated 1/16/2023

	Type Of Event	Risk
Rank	Top Rated Events from ACS HVAs	Relative Threat 0 – 100%
1	Hurricane / Tropical Storm	40%
2	Water Disruption / Contamination	30
3	Epidemic / Pandemic	29%
4	Flood, External	28%
5	Communication / Telephony Failure	27%
6	HVAC Failure	25%
7	Power Outage	24%
8	Information's Systems Failure	23%
9	Temperature Extremes	21%
10	Severe Thunderstorm	21%

TITLE: EVACUATION PLAN AND PROCEDURES

PURPOSE: To establish the protocol to be followed in the event of an evacuation of the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

In the event of an emergency requiring a complete or partial evacuation of the Ambulatory Surgical Center (ASC) at LBJ, the ASC will follow this protocol to ensure safe and appropriate patient safety during the evacuation.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **COMPLETE EVACUATION:** The movement of all Workforce members, patients, and visitors from the ASC when the ASC becomes unsafe or a threat poses a danger to all Workforce members, patients, and visitors (e.g., fire, flooding, structural damage). Complete Evacuation usually involves facility shutdown actions.

B. **PARTIAL EVACUATION OR RELOCATION:** The movement of Workforce members, patients, and visitors to either:

1. An area of relative safety in response to a given threat.
2. Staging areas in preparation for evacuation (close proximity to exits).

C. **HORIZONTAL EVACUATION:** The movement of Workforce members, patients, and visitors to a safe location on the same floor (preferably close to an emergency exit and in a different smoke compartment).

D. **VERTICAL EVACUATION:** The movement of Workforce members, patients, and visitors to a safe location on a lower floor when a Horizontal Evacuation is unsafe or cannot meet the safety needs of Workforce members, patients, and visitors.

E. **EVACUATION DEVICES:** Devices used to assist non-ambulatory patients during an evacuation, such as OR tables, beds, stretchers, blanket carriers, Stryker® chair, Paraslyde®*, or MedSled*®.

F. **PRE-EVENT EVACUATION:** An evacuation of Workforce members, patients, and visitors in advance of an impending disaster or when the ASC structure and surrounding environment is not immediately compromised. A Pre-Event Evacuation is appropriate when the ASC Administrator and Harris Health leadership believes the effects of an impending disaster may place Workforce members, patients, and visitors at unacceptable level of risk or when an evacuation after the event is likely to be extremely dangerous or impossible.

G. **POST-EVENT EVACUATION:** The evacuation of Workforce members, patients, and visitors of the ASC when there is no advance warning regarding an event requiring evacuation or after a decision was made to shelter-in-place, but damages or danger has made evacuation necessary.

H. **SEQUENCE OF EVACUATION:** The process of prioritizing the evacuation of patients, visitors, and Workforce members. In an emergent evacuation, priority should be given to those patients, visitors, and Workforce members who are in immediate danger. During a planned or urgent evacuation (<4 hours), evacuate those who need the least resources first (e.g., ambulatory).

I. **SHELTER-IN-PLACE:** The process of securing patients, visitors, and Workforce members from a threat and does not involve evacuation. The decision to Shelter-In-Place is circumstance specific and must be made in relation to the risk to the patient(s), visitor(s), and/or Workforce member(s). It is appropriate to Shelter-In-Place in the following circumstances:

1. When the threat does not permit safe relocation or evacuation;
2. When the movement poses a greater danger than the threat; and
3. When it is not possible to move within a reasonable time frame.

II. EVACUATION PROCEDURES:

A. **In General:**

In the event of an internal or external disaster that requires either the Complete Evacuation or Partial Evacuation of the ASC or requires Workforce members, patients, and visitors to Shelter-in-Place, the following steps will be followed by all Workforce members:

a. All Workforce members who are not involved in direct patient care will report to the designated area of the ASC to receive instructions from the ASC Administrator or designee regarding the internal or external disaster. The designated area of the ASC that Workforce members must always report to during a disaster is the Pre-Op/PACU nursing station in the ASC.

b. The ASC Administrator will determine, with the assistance of Harris Health leadership and/or the Houston Fire Department, whether a Complete Evacuation, Partial Evacuation, or Sheltering-In-Place is necessary.

c. Once it is has been determined that the ASC needs to be evacuated or that Workforce members, patients, and visitors need to Shelter-In-Place, the ASC Administrator must report that information to all Workforce members present at the Pre-Op/PACU nursing station.

d. Workforce members will begin executing the ASC Administrator's directions regarding the evacuation of the ASC.

~~d.~~ The ASC will follow ~~Harris Health Policy 4600 in regards to patient~~ASC-P-1007 in regards to patient transfer.~~ transfer.~~

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B. **Horizontal Evacuation:**

1. **Lobby:**

The Health Unit Coordinator ("HUC") or the Patient Care Coordinator is responsible for receiving instructions from the ASC Administrator regarding the evacuation. The HUC or the Patient Care Coordinator will escort the patients and visitors to the designated area that the ASC Administrator, in consultation with the Houston Fire Department or other proper authorities, has deemed appropriate for Horizontal Evacuation.

2. **Operating Room:**

a. In the event of a fire, tornado, or other environmental disaster requiring Horizontal Evacuation, the following steps must be followed:

1) The surgeon must close and/or pack wound(s).

2) After the wound is closed, the surgical technician will remove the drapes from the patient.
3) The anesthesia provider must secure the patient's airway and ventilate with an Ambu® bag.
4) The circulating nurse will obtain a stretcher for the patient and move the patient to the designated area for Horizontal Evacuation.

b. In the event of a non-environmental disaster (e.g., active shooter):

1) The surgeon and the anesthesia provider must secure the patient to the best of his or her ability with consideration given to the specific threat posed.
2) All Workforce members involved in the patient's care should either (1) Shelter-In-Place or evacuate to a safe area.

3. **Pre-Op/PACU:**

In the event of a fire, tornado, or other environmental disaster requiring Horizontal Evacuation:

1) All pending surgeries will be suspended.
2) All patients will be transported to the area designated as discharge for Horizontal Transfer.

4. **Discharge Points:**

a. Discharge points in are the areas where patients will either be discharged home or discharged to a hospital during an evacuation of the ASC.
b. During a Horizontal Evacuation, the ASC Administrator will report to Workforce members the specific locations to discharge "homebound" patients and to discharge patients requiring further care.

C. **Vertical Evacuation:**

1. **Lobby:**

The HUC or the Patient Care Coordinator is responsible for receiving instructions from the ASC Administrator regarding the evacuation. The HUC or Patient Care Coordinator will escort the patients and visitors to the designated areas that the ASC Administrator, in consultation with the Houston Fire Department or other proper authorities has deemed appropriate for the Vertical Evacuation. The ASC will utilize the Disaster Management Systems EVAC 123 which is Hospital Incident Command System (HICS) 255 compliant for patient tracking.

- Primary Staging for the ASC will Pre-Op/PACU area. Patients will be labeled and will be vertically evacuated to the second staging area for transportation.
- Secondary Staging area, the ASC staff will utilize the 1st floor conference room, and the patient information will be logged in the transportation log.
- Patients' information will be sent following policy ASC-P-1007.

2. **Operating Room:**

a. In the event of a fire, tornado, or other environmental disaster requiring a Vertical Evacuation, the following steps must be followed:

1) The surgeon must close and/or pack the wound(s).
2) After the wound is closed, the surgical technician will remove the drapes from the patient.
3) The anesthesia provider must secure the patient's airway and ventilate with an Ambu® bag.
4) The circulating nurse will obtain a stretcher for the patient and move the patient to the designated area for the Vertical Evacuation.

b. In the event of a non-environmental disaster (e.g., active shooter):

1) The surgeon and the anesthesia provider must secure the patient to the best of his or her ability with consideration given to the specific threat posed.
2) All Workforce members involved in the patient's care should either Shelter-In-Place or evacuate to a safe area.

3. **Pre-Op/PACU:**

In the event of a fire, tornado, or other environmental disaster requiring Vertical Evacuation:

1) All pending surgeries will be suspended.
2) All patients will be transported to the area designated for Vertical Transfer.

4. **Discharge Points:**

During a Vertical Evacuation, the ASC Administrator will report to Workforce members the specific locations to discharge "homebound" patients and to discharge patients requiring further care.

REFERENCES/BIBLIOGRAPHY:

Quad A Version 8.2

OFFICE OF PRIMARY RESPONSIBILITY:

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
4/13/2017	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body
	2.0	Revised / Approved 03/29/2018	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/14/2019	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/13/2020	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Revised / Approved 02/25/2021	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

		Revised / Approved 02/17/2022	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body

ATTACHMENT A

HAZARD VULNERABILITY ANALYSIS (HVA) RISK RATING

Ambulatory Surgical Center Top 10 Rated Events

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Top 10 ASC Scored Events (Average)

Updated January 2023

	Type Of Event	Risk
Rank	Top Rated Events from ACS HVAs	Relative Threat 0 – 100%
1	Hurricane / Tropical Storm	40%
2	Water Disruption / Contamination	30%
3	Epidemic / Pandemic	29%
4	Flood, External	28%
5	Communication / Telephony Failure	27%
6	HVAC Failure	25%
7	Power Outage	24%
8	Information Systems Failure	23%
9	Temperature Extremes	23%
10	Severe Thunderstorm	21%

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 17, 2023

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

Medical Staff Bylaws

August 2023~~2~~

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

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(2) ~~(2)~~ Meet the minimum case requirement by performing the number of cases by surgical service:

a. General Surgery - ~~-~~at least ten ~~thiryten~~ (10~~30~~10) cases during the prior (12) month period and performing at least twenty~~sixtytwenty~~ (206~~02~~0) cases within the prior two (2) year appointment period;

b. Gynecology - at least ten (10) cases during the prior (12) month period and performing at least twenty (20) ~~fifteenten (10510) cases during the prior (12) month period and performing at least thirtytwenty (203020)~~ cases within the prior two (2) year appointment period;

c. Ophthalmology - at least ten (10) cases during the prior (12) month period and performing at least twenty (20) ~~thirtyten (103010) cases during the prior (12) month period and performing at least sixtytwenty (202060)~~ cases within the prior two (2) year appointment period;

d. Oral Maxillofacial~~Orthopedics~~ - at least five~~ten~~ (5~~10~~) cases during the prior (12) month period and performing at least ten~~twenty~~ ~~(20~~(10) cases within the prior two (2) year appointment period;

e. Orthopedics~~Otolayrngology~~ - at least ten (10) cases during the prior (12) month period and performing at least twenty (20) ~~twentyten (12010) cases during the prior (12) month period and performing at least fourtytwenty (2420)~~ cases within the prior two (2) year appointment period;

f. Otolayrngology - at least five~~ten~~ (5~~10~~) cases during the prior (12) month period and performing at least ten~~twenty~~ (2~~0~~10) cases within the prior two (2) year appointment period;

g. Plastics~~Otolayrngology~~ - 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

h. Urology~~Otolayrngology~~ - 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) ~~(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.

~~Exception: A chief Physician of a surgical service as defined in Article III, Section 2. may ask the Governing Body for an exception to the case minimums as defined in Article IV, Section 2.a.(2) for up to two (2) Medical Staff members of their surgical service. The chief physician of the surgical service may present the physicians to be exempted to the medical director and the medical executive committee of the ASCThe chief Physician of the surgical service may present an exemption to the medical director of the ASC.~~

~~Place case minimums per service. Stay away from exceptions.~~

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

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(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

_____
Arthur Bracey, MD
Chair, ASC Governing Body

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, May 18, 2023

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

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

GOVERNING BODY BYLAWS OF

THE AMBULATORY SURGICAL CENTER (ASC) AT LBJ

TABLE OF CONTENTS

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.

~~1.~~2. The term "Administrator" shall refer to the person filling that office pursuant to Article VI.

~~2.~~3. The term "Medical Staff" means all practitioners (as such term is defined below) who maintain privileges to treat patients in the ASC.

~~3.~~4. The term "Medical Director" shall refer to the person filling that office pursuant to Article VI.

5. 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 VI~~I~~) 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~~ biannual basis. The ASC quality reports may be reported to the Harris Health Quality Governance Council, who reports to the Board of Trustees.

Commented [TLS1]: The reports are provided on a biannual basis

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. A~~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 who are members of the Board of Trustees serve without compensation and all ASC Governing Body members 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.~~

The following powers are reserved to the Harris Health Board of Trustees and the ASC Governing Body is prohibited from taking any action on the following matters without the prior approval of the Harris Health Board of Trustees.

a. Expenditure of Harris Health funds;
b. Adoption, amendment or revocation of the Governing Body Bylaws of the Ambulatory Surgical Center at LBJ;
c. Appointment and removal of the members of the ASC Governing Body.

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;

~~. Items relating to fiscal affairs, including statistical and financial reports, together with cumulative reports for the fiscal year-to-date;~~

~~. Reports and items from standing committees; if any;~~

~~. Reports and items from special committees, if any;~~

~~.~~d. Miscellaneous items;

~~.~~e. Administrator's Report;

~~.~~f. Medical Director's Report; and

~~.~~g. Executive session items.

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 as part of the yearly Harris Health System Board calendar.

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 (the most recent version~~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 Aannual 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 by the ASC Governing Body at the ~~March~~ Annual Meeting of the ASC Governing Body. Each officer shall hold office until his/her successor shall have been duly elected or until his/~~ or~~ her prior death, resignation, or removal.

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:

a. 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.

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 Harris Health 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 October ~~March~~ 1 and ends on the last day of September~~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 every two (2) years or earlier if deemed necessary by the ASC Governing Body. ~~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 ASC Governing Body in Harris County, Texas on _____ [Insert Date].

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, _____ ____, [insert date]~~2022.~~

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

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

_____
~~Kimberly Monday~~Ewan Johnson, M.D., Ph.D.
Chair, Board of Trustees
Harris County Hospital District d/b/a
Harris Health System