HARRISHEALTH SYSTEM

AMBULATORY SURGICAL CENTER (ASC) AT LBJ GOVERNING BODY

Thursday, August 22, 2024
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**	**Ms. Jennifer Tijerina**	**1 min**
II.	**Approval of the Minutes of Previous Meeting** • ASC at LBJ Governing Body Meeting – May 23, 2024	**Ms. Jennifer Tijerina**	**1 min**
III.	**Executive Session**	**Ms. Jennifer Tijerina**	**25 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***		*(5 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**	**Ms. Jennifer Tijerina**	**2 min**
V.	**General Action Item(s)**	**Ms. Jennifer Tijerina**	**20 min**

A. General Action Item(s) Related to Quality: ASC at LBJ Medical Staff

1. Consideration of Approval of Credentialing Changes for Members of the Harris Health ASC at LBJ Medical Staff ***– Dr. Scott Perry*** *(5 min)*

2. Consideration of Approval of the 2023-2024 Quality Improvement Program for the ASC at LBJ ***– Mr. Matthew Reeder***

B. General Action Item(s) Related to Policies and Procedures

1. Consideration of Approval of New Policies and Procedures for the ASC at LBJ ***– Mr. Matthew Reeder and Dr. Scott Perry*** *(5 min)*

   i. ASC-P-4014 Professional Practice Evaluation
   ii. ASC-P-4015 Medical Staff Professionalism
   iii. ASC-P-4016 Ongoing Performance Data Review
   iv. ASC-P-4017 Medical Staff Health
   v. ASC-P-4018 Initial Performance Data Review and Annual Performance Peer Review
   vi. Workplace Safety and Violence Reduction Plan

2. Consideration of Approval of Amended Policies and Procedures for the ASC at LBJ ***– Mr. Matthew Reeder and Dr. Scott Perry*** *(5 min)*

   i. ASC-P-1003 Medication Administration
   ii. 2024-2025 Infection Control Program

C. Miscellaneous General Action Item(s)

1. Consideration of Approval of Appointment/Re-Appointment of Key Positions to the Ambulatory Surgical Center at LBJ ***– Mr. Matthew Reeder*** *(5 min)*

   i. Administrator – Matthew Reeder
   ii. Clinical Manager(s) – Randy Polanco, Rochelle Mariano, Jessica Larson
   iii. Medical Director – Scott Perry
   iv. Business Office Manager – Pollie Martinez
   v. QA/PI Officer – Gina Taylor
   vi. Medical Staff Privileges Officer – Jessey Thomas
   vii. Infection Control Coordinator – Maria Taylor
   viii. Pharmacy Officer – Alvin Nnabuife
   ix. Risk Manager – Erica Reyes
   x. Compliance Officer – Anthony Williams
   xi. Safety Officer – Harold Sias
   xii. Radiation Officer – Patricia Svolos
   xiii. Privacy Officer – Catherine Walther
   xiv. Medical Records Officer – Veronica DeLeon

VI.	**ASC at LBJ Medical Director and Administrator Reports**	**Ms. Jennifer Tijerina**	**10 min**
	A. Report Regarding Medical Staff Operations, Clinical Operations, Statistical Analysis of Services Performed and Operational Opportunities at the Ambulatory Surgical Center, Including Questions and Answers ***– Dr. Scott Perry and Mr. Matthew Reeder***		
VII.	**Adjournment**	**Ms. Jennifer Tijerina**	**1 min**

MINUTES OF THE HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER AT LBJ GOVERNING BODY MEETING
May 23, 2024 | 9:00 AM

AGENDA ITEM	DISCUSSION	ACTION/RECOMMENDATIONS
I. Call to Order & Record of Attendance	The meeting was called to order at 9:02 a.m. by Ms. Jennifer Tijerina, Chair. It was noted that a quorum was present and the attendance was recorded. Ms. Tijerina stated that while some Board members are in the room, others will participate by videoconference as permissible by state law and the Harris Health Videoconferencing Policy. Only participants scheduled to speak have been provided dial in information for the meeting. All others who wish to view the meeting may access the meeting online through the Harris Health website: 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 • ASC at LBJ Governing Body Meeting – February 22, 2024 • Special Call ASC at LBJ Governing Body Meeting – March 28, 2024		**Motion No. 24.05 - 07** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve the minutes of the February 22, 2024 meeting.** **Motion No. 24.05 - 08** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve the minutes of the March 28, 2024 meeting.**
III. Executive Session	At 9:05 a.m., Ms. Tijerina stated that the ASC Governing Body would enter into Executive Session for Items 'A through C' as permitted by law under Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007.	

	A. Discussion Regarding Medical Staff Applicants and Privileges for the Ambulatory Surgical Center (ASC) at LBJ Governing Body, Pursuant to Tex. Health & Safety Code Ann. §161.032 and Tex. Occ. Code Ann. §160.007 to Receive Peer Review and/or Medical Committee Report in Connection with the Evaluation of the Quality of Medical and Health Care Services, Including Consideration of Approval of Medical Staff Applicants and Privileges for the ASC at LBJ Governing Body Upon Return to Open Session	**No Action Taken.**
	B. Report by the Executive Vice President, Chief Compliance and Risk Officer, Regarding Compliance with Medicare, Medicaid, HIPAA and Other Federal and State Healthcare Program Requirements and a Status of Fraud and Abuse Investigations, Pursuant to Tex. Health & Safety Code Ann. §161.032, Including Possible Action Regarding this Matter Upon Return to Open Session	**No Action Taken.**
	C. Report Regarding Quality of Medical and 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 Governing Body 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 9:15 a.m., Ms. Tijerina reconvened the meeting in open session; she noted that a quorum was present and that no action was taken in Executive Session.	
V. General Action Item(s)	**A.** General Action Item(s) Related to Quality: ASC at LBJ Hospital Medical Staff	
	1. Approval of Credentialing Changes for Members of the Harris Health System ASC at LBJ Medical Staff Dr. Scott Perry, Medical Director, ASC, presented the credentialing changes for members of the Harris Health System ASC at LBJ Medical Staff. For May 2024, there were one (1) initial appointment and six (6) reappointments. A copy of the credentialing report is available in the permanent record.	**Motion No. 24.05 - 09** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.A.1. Motion carried.**
	2. Approval of Changes to the Ophthalmology Clinical Privileges Dr. Perry stated that revisions were made to various clinical privileges based upon the American Association for Accreditation of Ambulatory Surgery Facilities (AAAHC) survey to include the specific type of laser with the privileging criteria utilized at the Ambulatory Surgical Center at LBJ. Copies of the clinical privileges are available in the permanent record.	**Motion No. 24.05 - 10** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve V.A.2. Motion carried.**

	3. Approval of Changes to the OBGYN Clinical Privileges	**Motion No. 24.05 - 11** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.A.3. Motion carried.**
	4. Approval of Changes to the Urology Clinical Privileges	**Motion No. 24.05 - 12** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve V.A.4. Motion carried.**
	5. Approval of Changes to the Otolaryngology Clinical Privileges	**Motion No. 24.05 - 13** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.A.5. Motion carried.**
	6. Approval of Medical Director Appointment/ Reappointment • Dr. Scott Perry, Medical Director, ASC	**Motion No. 24.05 - 14** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve V.A.6. Motion carried.**
	B. General Action Item(s) Related to Policy and Procedures	

	1. Approval of New and/or Amended Policies and Procedures for the Ambulatory Surgical Center at LBJ Governing Body Mr. Matthew Reeder, R.N., Administrator, ASC at LBJ, presented the new and/or amended policy for the Ambulatory Surgical Center at LBJ as follows: • **Policy ASC-P-1009 – Pediatric Anesthesia (*New policy)*** o The policy includes criteria of treatment and needed equipment, supplies, and medications to treat a pediatric patient. ASC provides services to patients between the ages of ten (10) years old and seventeen (17) years old. • **Policy ASC-P-1011 – High Alert Medications *(New policy)*** o New policy in reference to high alert medications. • **Policy ASC-P-4005 – Incapacitated and Impaired Providers *(Changes throughout policy)*** o The policy is updated to reflect the process to address the impaired providers. To establish the guidelines to follow when a member of the Ambulatory Surgical Center (ASC) at LBJ's medical staff is or becomes incapacitated and impaired and the incapacity and/or impairment compromises the quality of patient care or patient safety. • **Policy ASC-P-5004 – Infection Control Plan *(Modification)*** o Changes throughout policy. • **Policy ASC-P-6014 – Facility Safety Manual of the ASC *(Changes throughout policy)*** o Reference changes and addition of Section VI. • **Policy ASC-P-6017 – Laser Safety Policy *(Updated)*** o Updated sections B, E, F and references. • **Policy ASC-P-6019 – Extracorporeal Shock Wave Lithotripsy (ESWL) Policy *(New policy)*** o The policy includes the processes for safely performing ESWL procedures in the ASC. Copies of the policies are available in the permanent record.	**Motion No. 24.05 - 15** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.B.1. Motion carried.**

	2. Approval of the Retirement of Policy and Procedures for the ASC at LBJ Mr. Reeder requested approval of the retirement of Policy ASC-P-6003 related to the Fire Drill/Alarm protocol at the ASC at LBJ. He stated that the policy is included in ASC-P-6014 - Facility Safety Manual. A copy of the policy is available in the permanent record.	**Motion No. 24.05 - 16** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.B.2. Motion carried.**
	3. Approval of the Amended Medical Staff Bylaws for the ASC at LBJ Dr. Perry presented the amended Medical Staff Bylaws for the ASC at LBJ, noting the following: • **Article III, Section 2 – Medical Staff Membership, Qualifications for Membership** ○ Removed reference to Texas Controlled Substances Registration as this no longer exists; ○ Added a requirement for all medical staff members to have completed an approved accredited residency program or be board certified in the specialty they are requesting privileges for; and ○ Added language to describe the process for individuals to request a waiver of one or more qualifications for membership if he/she is "unusually qualified", as defined in this section. • **Article VI, Section 1a – Reappointment Process** ○ Reappointment cycle extended from two (2) years to three (3) years and increased the volume of cases to reflect 3 years. • **Article IV, Section 2 – The Affiliate Staff** ○ Included the volume of cases to reflect 3 years. • **Article VII, Section 8 – Temporary Privileges** ○ Language was revised to further clarify temporary privilege process and requirements. • **Article VIII, Section 1 – Corrective Action - Procedure** ○ Language was added to reflect new state law requirement that any final adverse action that impacts the clinical privileges of a physician for more than fourteen (14) days must be reported to the Texas Medical Board.	**Motion No. 24.05 - 17** **Moved by Mr. Jim Robinson, seconded by Ms. Carol Paret, and unanimously passed that the Governing Body approve V.B.3. Motion carried.**

	• **Article VIII, Section 2 – Administrative Suspension**
	  ○ Language added to clarify instances that qualify as an administrative suspension, including the addition of an administrative suspension for failure to complete annual mandatory education.
	• **Article XI, Section 1. The Medical Executive Committee**
	  ○ Language added to include the peer review duties.
	A copy of the Medical Staff Bylaws is available in the permanent record.	

	4. Approval of the Amended Governing Body Bylaws for the ASC at LBJ Mr. Reeder stated as part of the regulatory requirements of the Ambulatory Surgical Center (ASC), the Governing Body is to review and approve the Governing Body Bylaws every two (2) years. A copy of the Governing Body Bylaws is available in the permanent record.	**Motion No. 24.05 - 18** **Moved by Ms. Carol Paret, seconded by Mr. Jim Robinson, and unanimously passed that the Governing Body approve V.B.4. Motion carried.**
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 noted that the ASC is dual accredited with the American Association for Accreditation of Ambulatory Surgery Facilities (Quad A) and the Accreditation Association for Ambulatory Health Care (AAAHC). To comply with regulatory requirements, the ASC is working to implement a monitoring process prior to May 29, 2024. He stated that the ASC has moved to a healthcare occupancy, specifically for the third floor of the ASC. Mr. Reeder mentioned that the ASC intends to relocate the emergency room entrance to facilitate ambulance entry and ensure safe patient access.	**As Presented.**
VII. Adjournment	There being no further business to come before the Governing Body, the meeting adjourned at 9:39 a.m.	

I certify that the foregoing are the Minutes of the Harris Health System ASC at LBJ Governing Body Meeting held on May 23, 2024.

Respectfully Submitted,

Jennifer Tijerina, MS, Chair

Recorded by Cherry A. Pierson, MBA

Thursday, May 23, 2024

Ambulatory Surgical Center (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 MEMBERS PRESENT	ASC at LBJ GB MEMBERS ABSENT	OTHER BOARD MEMBERS PRESENT
Jennifer Tijerina *(Chair)*		
Carol Paret		
Dr. Glorimar Medina		
Jim Robinson		
Matthew Reeder		
Dr. Scott Perry		

HARRIS HEALTH EXECUTIVE LEADERSHIP, STAFF & SPECIAL INVITED GUESTS	
Carolynn Jones	Louis Smith
Cherry Pierson	Maria Cowles
Daniel Smith	Dr. Matasha Russell
Derek Curtis	Nicholas J. Bell
Ebon Swofford *(Harris County Attorney's Office)*	Olga Rodriguez
Elizabeth Hanshaw Winn *(Harris County Attorney's Office)*	Randy Manarang
Dr. Esmaeil Porsa, *Harris Health System President & Chief Executive Officer*	Dr. Sandeep Markan
Dr. Jennifer Small	Sara Thomas *(Harris County Attorney's Office)*
Jennifer Zarate	Shawn DeCosta
Jessey Thomas	Dr. Steven Brass
John Matcek	Dr. Tien Ko
Kari McMichael	

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 22, 2024

Executive Session

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

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BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 22, 2024

Executive Session

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 Governing Body 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 22, 2024

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

Ambulatory Surgical Center Governing Body

August 2024 Medical Staff Credentials Report

HARRISHEALTH SYSTEM

Medical Staff Initial Appointments: 9

Medical Staff Reappointments: 0

Medical Staff Files for Discussion: 1

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 22, 2024

Consideration of Approval of the 2023-2024 Quality Improvement Program for the ASC at LBJ

ASC at LBJ
Quality Improvement Program
2023-2024

I. 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 furnished 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.

II. 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.

III. 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.

IV. 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.

V. 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.

VI. 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.

VII. 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 measurable 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.

VIII. 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 corning 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 from violent blows or other purposeful actions (source: National Center for Patient Safety)

Selection Basis:

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

Clinical Recommendation Statements:
According to the Agency for Healthcare Research and Quality's Prevention of Falls in Acute Care guideline, patient falls may be reduced by following a four-step approach:

1) evaluating and identifying risk factors for falls in the older patient;
2) developing an appropriate plan of care for prevention;
3) performing a comprehensive evaluation of falls that occur; and
4) performing a post-fall revision of plan of care as appropriate.

Additional information and resources, such as sample data collection forms and frequently asked questions (FAQs) about the measures, can be found on the ASC Quality Collaboration website at www.ascquality.org.

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APPENDIX C:
PATIENT SAFETY DATA REPORTING

I. In General:

A. Patient Safety Data Reporting is performed every month and reported quarterly. It includes the reporting of 3 Random Cases for each physician per quarter and all Adverse Events using the required 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 repo1i, 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)

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 22, 2024

Consideration of Approval of New Policies and Procedures for the ASC at LBJ

The new policies listed below are attached for your review.

1. ASC-P-4014: Professional Practice Evaluation
2. ASC-P-4015: Medical Staff Professionalism
3. ASC-P-4016: Ongoing Performance Data Review
4. ASC-P-4017: Medical Staff Health
5. ASC-P-4018: Initial Performance Data Review and Annual Performance Peer Review
6. ASC at LBJ Workplace Safety and Violence Reduction Plan

TITLE: PROFESSIONAL PRACTICE EVALUATION

PURPOSE: To establish a positive educational approach to performance issues and a culture of continuous improvement for Physicians/Practitioners and Advanced Practice Professionals (APP) which includes fairly, effectively, and efficiently evaluating the care being provided, comparing it to established patient care protocols and benchmarks when possible.

POLICY STATEMENT:

The Ambulatory Surgical Center (ASC) at LBJ Professional Practice Evaluation (PPE) includes several related but distinct components. The PPE process described in this policy is used when questions or concerns are raised about a practitioner's or APP's clinical performance. This process has traditionally been referred to as "peer review." This policy will provide constructive feedback, education, and performance improvement assistance to Practitioner's and APP's regarding the quality, appropriateness, and safety of the care they provide. This policy will effectively disseminate lessons learned and promote education sessions so that all Practitioner's and APP's in a relevant specialty area will benefit from the PPE process and also participate in the culture of continuous improvement, and promote the identification and resolution of system process issues that may adversely affect the quality and safely of care being provided to patients.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **PEER REVIEW:**

1. A process used when questions or concerns are raised about a Practitioner's or APP's clinical performance:

   a. The process used to confirm an individual's competence to exercise newly granted privileges described in the Policy on Initial Performance Data Review for Recently Granted Privileges.

b. The process used to evaluate a Practitioner's or APP's competence on an ongoing basis is described in the Ongoing Performance Data Review Policy (Policy ASC-P-4016);

c. Concerns regarding a Practitioner's or APP's professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy or Practitioner (ASC-P-4015) and Professional Health Policy (ASC-P-4017), respectively;

d. If a matter involves both clinical and behavioral concerns, the ASC Medical Director shall coordinate the reviews. The behavioral concerns shall be addressed pursuant to the Professionalism Policy.

2. STEP BY STEP REVIEW PROCESS: The steps are illustrated in the Flowchart of Professional Practice Evaluation Process and the ASC Medical Executive Committee (MEC) Case Review Algorithm, both of which are included in Appendix A to this policy.

a. Specific Triggers: The ASC shall identify adverse outcomes, clinical occurrences, or complications that will trigger the PPE process. The ASC MEC will approve these triggers and review them periodically to evaluate their effectiveness.

b. Reported Concerns: Physicians, APPs, and/or Harris Health employees may report to the ASC Medical Director concerns related to the safety or quality of care provided to a patient by an individual Practitioner or APP. The ASC PPE review form may be used for this purpose.

c. Other Cases or Issues: Cases or issues may be identified for review through any other means, including but not limited to those described in the PPE Manual (PPE Triggers that Prompt the PPE Review Process).

3. FOLLOW UP WITH INDIVIDUALS WHO REPORTED CONCERNS: Individuals who report concerns will receive a follow-up communication, either verbally or in writing. A template Response to Reported Concerns is included in the PPE Manual.

B. **PPE SPECIALIST:**

1. Log-in: All cases or issues identified for review shall be referred to the PPE Specialist, who will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet).

2. Fact-Finding: The PPE Specialists will review, as necessary, the medical record, other relevant documentation, and the Practitioner's or APP's professional practice evaluation history. The PPE Specialists may also interview and gather information from Harris Health employees, Practitioner's, APP's, patients, family, visitors, and others who may have relevant information.

   a. For any Practitioner-specific or APP-specific concerns that may be referred for review from the serious safety event or sentinel event review provided, interviews and other fact-finding should be coordinated between the two processes, to the extent possible, to avoid redundancy and duplication of effort.

   b. Review and Determination: The PPE Specialists shall consult with the Chair of the ASC MEC if there is any uncertainty about the proper determination or review process for a case. The PPE Specialists will then:

      i. Determine that no further review is required and close the case pursuant to criteria approved by the ASC MEC. The PPE Specialists may not close cases that were commenced by a reported concerns from a Practitioner or APP. The PPE Specialists will provide periodic reports to the ASC MEC of cases closed pursuant to this subsection. Such reports should include the specific trigger that causes the case to be identified so the ASC MEC can evaluate the utility of such triggers;
      ii. Send an Awareness Letter based on criteria approved by the ASC MEC or; See Section G of this policy
      iii. Determine that further review is required.

c. Preparation of Case for Further Review: The PPE Specialists shall prepare cases that require further review. Preparation of the case may include the following:

i. Completion of the appropriate portions of the ASC PPE case review form;
ii. As needed, modifying the case review form to reflect specialty-specific issues, as may be directed by the ASC Medical Director;
iii. Preparation of a timeline or summary of the care provided;
iv. Identification of relevant patient care protocols or guidelines; and
v. Identification of relevant literature.

C. TRIAGE AND REGERRAL OF CASE FOR FURTHER REVIEW:

1. General: In their discretion, the ASC Medical Director may develop standard operating procedures to guide the triage and referral of cases for further review as described in this section.

2. Referral to Clinical Specialty Review Committee: The PPE Specialists will refer most cases requiring further review to the appropriate CSRC. The PPE Specialists will consult with the ASC MEC Medical Director if there is any uncertainty about which CSRC should review a case.

3. Referrals to ASC MEC: A case shall be referred to the ASC MEC designated by the ASC MEC Medical Director if the ASC MEC Medical Director determines the case involves a concern for which expedited review is needed.

4. Referrals to the ASC MEC in Executive Session:

a. If a Voluntary Enhancement Plan is currently in effect, the PPE Specialists will consult with the ASC Medical Director to determine if the case should be referred directly to the ASC MEC rather than to a CSRC.

b. The Chief of Service, working with the ASC Medical Director, may direct the PPE Specialists to refer a case directly to the ASC MEC if they determine that the case raises unusual or significant concerns for which direct referral to the ASC MEC is the most appropriate review process.

c. Referrals Involving Certain Complex Cases

i. Practitioner's or APP's from two or more specialties or Clinical Services;

ii. A member of the CSRC who would otherwise be expected to review the case; or

iii. A matter for which necessary clinical expertise is not available on the Medical Staff the PPE Specialists will consult with the ASC Medical Director regarding referral of the case. The ASC Medical Director will determine the appropriate review process, and may decide that two or more CSRCs will review the case and complete assessments simultaneously, that an assigned reviewer will complete the review, or that the case will be referred to the ASC MEC so that an external review may be obtained, see Section I.A. of this policy.

D. CLINICAL SPECIALTY REVIEW COMMITTEE (ASC MEDICAL EXECUTIVE COMMITTEE):

1. Review: When a case is assigned to a CSRC, a member of the CSRC will conduct the initial review of the case on behalf of the CSRC and then discuss the case with the other member(s) of the CSRC in reaching a determination. The CSRC member and CSRC shall complete the case review form.

2. Assistance from Assigned Reviewer: The CSRC member conducting the initial review or the CSRC may seek assistance from an Assigned Reviewer. The Assigned Reviewer will generally serve as a consultant to the CSRC member or CSRC. As may be requested, the Assigned Reviewer may also complete a case review form and report his or her findings back to the CSRC member or CSRC. In all cases, the CSRC remains responsible for completing the case review form.

3. Input from Practitioner or APP: If a CSRC member or an Assigned Reviewer has any questions or concerns about the care provided by the Practitioner or APP, the CSRC member or Assigned Reviewer shall obtain input from the Practitioner or APP prior to completing the review. Section 4 of this Policy and the PPE Manual (Request for Input from Practitioner or APP sent by CSRC, AR, or ASC MEC) contain additional information on obtaining input from the Practitioner or APP.

4. Determinations: CSRCs may

   a. with the agreement of the ASC MEC Medical Director

      i. Determine that no further review is required and the case is closed;
      ii. Send an Educational Letter to the Practitioner or APP
      iii. Conduct or facilitate Collegial Counseling with the Practitioner or APP; or

   b. Report their findings to the ASC MEC for determination

      i. Input from the Practitioner or APP must be obtained before an Educational Letter is sent or Collegial Counseling is conducted See Section G of this policy.

E. AMBULATORY SURGICAL CENTER MEDICAL EXECUTIVE COMMITTEE (MEC) EXECUTIVE SESSION:

1. Review of Prior Decisions: The ASC MEC will periodically review reports of cases closed and other determinations by individuals under this Policy. If the ASC MEC disagrees with a determination made by other parties, the ASC MEC may consult with the party who made the prior determination and may conduct an additional review of the case.

2. Review: The ASC MEC shall consider the Case Review Forms, supporting documentation, input obtained from the Practitioners or APPs involved, findings, and recommendations for all cases referred to it.

3. Case Presentation: A member of the CSRC responsible for the initial assessment, an Assigned Reviewer, ASC Medical Director, or designee, should present the case to the ASC MEC.

4. Determination if Additional Expertise or Information is Required: The ASC MEC shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the ASC Medical Director may:

   a. invite a specialist on the ASC Medical Staff with the appropriate clinical expertise to attend an ASC MEC meeting (either in person or electronically) as a guest to assist the ASC MEC in its review of issues, determinations, and follow-up actions;

   b. Assign the review to a Practitioner or APP on the Medical Staff with the appropriate clinical expertise, with a report of the assessment back to the ASC MEC; or

   c. Arrange for an external review from an individual not on the Medical Staff in accordance with this policy

5. Input from a physician or APP: If the ASC MEC has questions or concerns about the care provided by the physician or APP, the ASC MEC may obtain additional input from the physician or APP beyond what has already been obtained, prior to making any final determinations or findings.

6. Determinations: Based on its review of all information obtained, including input from the physician or APP, the ASC MEC may:

   a. Determine that no further review or action is required. If information was sought from the Practitioner or APP involved, the Practitioner or APP shall be notified of the determination.

   b. Send an Educational Letter See Section G of this policy

   c. Conduct or facilitate Collegial Counseling See Section I of this policy

   d. Develop a Voluntary Enhancement Plan, after consultation with the Medical Director See Section G of this policy.

As noted in Section G of this policy, input from the physician or APP must be obtained before an Educational Letter is sent, Collegial Counseling is conducted, or a Voluntary Enhancement Plan is proposed. In making this determination, the ASC MEC should consult the guidance in the Case Review Algorithm set forth in Appendix A.

F. **ASC MEC Officers:** Matters that require expedited review given the seriousness of the issue may be referred by the ASC MEC Medical Director to an ASC MEC Officers comprised of the ASC MEC Medical Director and the ASC MEC Officers. In such case, the ASC MEC Officers will conduct a preliminary review, take action necessary to protect patients, commence the process to obtain additional expertise if needed, and refer the case to a CSRC of the full ASC MEC for review.

1. Timeframes for review;

   a. General: The time frames specified in this section are provided only as guidelines. All participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final determination, within 90 days.

   b. Assigned Reviewers: Assigned Reviewers are expected to either consult with the CSRC member, CSRC, or ASC MEC, depending on who requested assistance, or submit a completed case review form, if applicable, within 14 calendar days of;

      i. The review being assigned; or
      ii. Their receipt of any requested input from the Practitioner or APP, whichever is later

   c. Clinical Specialty Review Committees: The CSRC member who conducts the initial review is expected to submit the completed portion of the case review form within 14 calendar days of the following, whichever is latest:

      i. The review being assigned;
      ii. Receipt of any requested input from the Practitioner or APP;
      iii. Receipt of information from an Assigned Reviewer or a case review form, if applicable. The CSRC is then expected to

complete its review within 30 calendar days of the following, whichever is later.

iv. Its receipt of the CSRC members assessment; or

v. Its receipt of any additional input requested from the Practitioner or APP.

d. External Reviewers: If an external review is sought as set forth, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for review).

2. No Further Review Required: Cases may be closed according to the process set forth in this Policy if a determination is made that there are no clinical issues or concerns presented in the case that require further review. Documentation of cases that are closed shall be provided to the PPE Specialists, who shall maintain records of closed cases and provide periodic reports to the ASC MEC. If information was sought from the Practitioner or APP involved, the Practitioner or APP shall also be notified of the determination. A letter that may be used for that purpose is included in the PPE Manual (Notice to Practitioner or APP That No Further Review or Action is Required When Input Had Been Requested).

3. Exemplary Care: If the ASC MEC determines that a Practitioner or APP provided exemplary care in a case under review, the Practitioner or APP should be sent a letter recognizing such efforts.

4. Pursuant to the Medical Staff Bylaws: This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner or APP. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the ASC MEC pursuant to the Medical Staff Bylaws or the elimination of any particular step in the Policy when deemed necessary under the circumstances. Such referral shall not preclude other action under applicable policies including policies of Harris Health, Baylor College of Medicine, The University of Texas Health Science Center at Houston's McGovern Medical School, or other third-parties with Practitioners or APPs on Harris Health's Medical Staff.

G. OPTIONS TO ADDRESS CLINICAL CONCERNS:

1. General: This Policy and the case review form in the PPE Manual discourage the use of any scoring, leveling, or grading of cases because those practices, while traditional, can foster a punitive, isolating, and destructive culture surrounding PPE activities. Instead, this Policy focuses on specific efforts to address any issues that may be identified in a constructive and educational manner and thus foster a culture of continuous improvement. As such, this Policy encourages the use of initial mentoring efforts and progressive steps by the ASC medical staff in order to successfully address questions relating to an individual's clinical practice.

2. Initial Mentoring Efforts: Initial Mentoring Efforts may include, but are not limited to, discussions, mentoring, coaching, and sharing of comparative data. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, brief documentation is encouraged to help determine if any pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's or APP's confidential file. A description of Initial Mentoring Efforts and progressive steps is included in this policy.

3. Progressive Steps: For matters that are reported to, or identified by, the PPE Specialists and reviewed under this Policy, the ASC Medical Staff will generally use Progressive Steps to address performance issues that may be identified. Additional information on each of the following Progressive Steps may be found in this Policy. A description of Initial Mentoring Efforts and Progressive Steps is included in this Policy.

   a. Awareness Letters: Intended to make Practitioners and APPs aware of an expectation or requirement. They are non-punitive, informational tools to help Practitioners and APPs self-correct and improve their performance through timely feedback.

      i. The ASC MEC will prepare a list of objective occurrences for which an Awareness Letter will be sent to a Practitioner or APP. The list may be modified by the ASC MEC at any time.
      ii. PPE Specialists will generate an Awareness Letter to be sent to a Practitioner or APP upon the occurrence of an event which has been identified ahead of time by the ASC MEC. The Awareness Letter will be signed by the ASC MEC

   b. Educational Letters: Describe the opportunities for improvement that were identified in the care reviewed and offer specific recommendations for future practice.

      i. Educational Letters may be sent by a CSRC, with the agreement of the ASC MEC Medical Director.
      ii. The Medical Director will be informed of the substance of any Educational Letter and may contact the PPE Specialists to review a copy of the letter.
      iii. A Sample Educational Letter is included in this policy.

   c. Collegial Counseling: A formal, planned, face-to-face discussion between the Practitioner or APP and the ASC Medical Director.

      i. A CSRC, with the agreement of the ASC Medical Director may use Collegial Counseling to address concerns with a Practitioner or APP.

ii. Collegial Counseling shall be followed by a letter that summarizes the discussion and the recommendations and expectations regarding the Practitioner's or APP's future practice at the ASC.

iii. The ASC Medical Director shall be informed of the substance of any Collegial Counseling and the follow-up letter, regardless of who conducts or facilitates it, and may contact the PPE Specialists to review a copy of the follow-up letter.

iv. A Collegial Counseling Checklist to help prepare for such a meeting and a Sample Follow-Up Letter to Collegial Counseling are included in this Policy.

4. Voluntary Enhancement Plan: The ASC MEC may develop a Voluntary Enhancement Plan to bring about sustained improvement in an individual's practice. This Policy provides examples of the elements that may be included in a Voluntary Enhancement Plan. However, a Voluntary Enhancement Plan may include any activity that the ASC MEC determines will help the Practitioner or APP to improve and is not disciplinary in nature. Additional guidance on Voluntary Enhancement Plans is included in the PPE Manual, including Voluntary Enhancement Plan Options – Implementation Issues Checklist and a Voluntary Enhancement Plan Template Letter.

a. If a Practitioner or APP disagrees with the need for a Voluntary Enhancement Plan developed by the ASC MEC, the Practitioner or APP is under no obligation to participate in the Voluntary Enhancement Plan. In such case, the ASC MEC cannot compel the Practitioner or APP to agree with the Voluntary Enhancement Plan. Instead, the ASC MEC may take other appropriate action pursuant to the Medical Staff Bylaws to resolve the matter.

b. Documentation: Awareness Letters, Educational Letters, follow-up letters to Collegial Counseling, and Voluntary Enhancement Plan documentation will be placed in the Practitioner's or APP's confidential file and considered in the reappointment process.

c. Confidentiality: All Initial Mentoring Efforts and Progressive Steps are part of the ASC's confidential performance improvement and PPE/Peer Review activities. Information related to them will be maintained in a confidential manner consistent with their privileged status under state and federal law.

H. OBTAINING INPUT FROM THE PRACTITIONER

1. Input Required: Obtaining input from the Practitioner or APP under review is an essential element of a transparent and constructive review process. Accordingly, no Educational Letter, Collegial Counseling, or Voluntary Enhancement Plan shall be implemented until the Practitioner or APP is first notified of the specific concerns and provides input as described in this Section. Prior notice and a request for input are not required before an Awareness Letter is sent to a Practitioner or APP.

2. Manner of Providing Input: The Practitioner or APP shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the correspondence to the Practitioner or APP (e.g., email or letter). Upon the request of either the Practitioner or APP, or the person or committee conducting the review, the Practitioner or APP may also provide input by meeting with appropriate individuals (as determined by the individual or committee conducting the review) to discuss the issues.

3. Office Records: As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner or APP to provide a copy of, or access to, medical records from the Practitioner's or APP's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input.

4. Sharing Identity of Any Individual Reporting a Concern: Since this policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") will not be disclosed to the Practitioner or APP unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

5. Retaliation Prohibited: Retaliation by the Practitioner or APP against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed through this Policy.

6. Discussions Outside Committee Meetings: Individual members of the ASC MEC should not engage in separate discussions with a Practitioner or APP regarding the review of a case unless the committee in question has asked the individual committee member to speak with the Practitioner or APP on its behalf. Similarly, unless formally requested to do so, Practitioners or APPs may not provide verbal input to the PPE Specialists or to any other individual and ask that individual to relay that verbal input to an individual or MEC involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Practitioners and APP's must also refrain from any discussions or lobbying with other Medical Staff members or Governing Body members outside the authorized review process outlined in this Policy.

7. Failure to Provide Requested Input or Attend Meeting: A Practitioner or APP is required to provide written input or attend a meeting as requested by a CSRC and/or the ASC MEC within the time frame specified by the committee. Failure to respond within the specified timeframe may mean the review will proceed without input from the Practitioner or APP.

I. ADDITIONAL PROVISIONS GOVERNING THE CLINICAL REVIEW PROCESS

1. External Reviews: Obtaining an external review is within the discretion of the ASC MEC acting in consultation with Harris Health's Chief Medical Executive. No Practitioner or APP has the right to demand the ASC obtain an external review in any particular circumstance.

   a. If a decision is made to obtain an external review, the Practitioner or APP involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner or APP shall be provided a copy of the reviewer's report (except that any comments related to care provided by other individuals shall be redacted).

b. The report of the external reviewer is a record of the committee that requested it and will be maintained in a confidential manner as described in this Policy.

2. System Process Issues: Quality of care and patient safety depend on many factors in addition to Practitioner or APP performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the ASC MEC. The referral will stay on the ASC MEC's agenda until it determines the issue has been resolved.

3. Peer Learning Sessions/Dissemination of Lessons Learned: Peer Learning Sessions and the dissemination of educational information through other mechanisms are integral parts of the PPE/peer review process and assist Practitioners and APPs in continuously improving the quality and safety of the care they provide. These activities will be conducted in a confidential manner, consistent with their confidential and privileged status under the state peer review protection law and any other applicable federal or state law. Additional guidance on Peer Learning Sessions is included in the PPE Manual.

4. Confidentiality: Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

   a. Documentation: All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

   b. Verbal Communications: Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality.

c. Email: Harris Health or other secure institutional e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner or APP whose care is being reviewed. All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line. E-mail should not be sent to personal e-mail accounts unless;

   i. the e-mail merely directs recipients to check their Harris Health or other secure institutional e-mail; or
   ii. the email is encrypted in a manner approved by Harris Health policy

d. Risk Management: Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

e. Participants in the PPE Process: All individuals involved in the PPE process (Medical Staff and Harris Health employees) will maintain the confidentiality of the process. All such individuals should sign an appropriate Confidentiality Agreement. Any breaches of confidentiality by Practitioners or APPs will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by Harris Health employees will be referred to human resources.

f. Practitioner or APP Under Review: The Practitioner or APP under review must also maintain all information related to the review in a strictly confidential manner, as required by Texas law. The Practitioner or APP may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the ASC MEC Medical Director, except for any legal counsel who may be advising the Practitioner or APP. Violations of this provision will be reviewed under the Medical Staff Professionalism Policy.

g. Communication with Practitioner or APP that Include a Deadline: Before any paper or electronic correspondence that includes a deadline for a response (for example, a request for input or to attend a meeting) is mailed or e-mailed to a Practitioner or APP, a text message should be sent or a phone call should be made (or voice mail left) to alert the Practitioner or APP that the correspondence is being sent. The intent of any such text message or phone call is to make the Practitioner or APP aware of the correspondence so that the deadline is not missed. However, failure to send a text message or make a phone call shall not be cause for the Practitioner or APP to miss a deadline.

h. Supervising Physicians and Advances Practice Professionals: Except as noted below, a physician who has a supervisory or collaborative relationship with an APP for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the APP. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an APP is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

5. Delegation of Functions: The ASC MEC is responsible for the PPE/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC MEC may delegate to the PPE Specialists, Assigned Reviewers, CSRC members, the authority to perform the functions described in this Policy on behalf of the ASC MEC. Actions taken by these individuals will be reported to and reviewed by the ASC MEC as set forth in this Policy.

a. When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of ASC management, or by a Medical Staff member, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

b. When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff members may perform the function personally or delegate it to another appropriate individual as set forth above.

6. No Legal Counsel or Recordings During Collegial Meetings: To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate Medical Staff members and ASC personnel. No counsel representing the Practitioner, APP, Medical Staff, or the ASC shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner or APP to invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

a. Practitioners or APPs may not create an audio or video recording of a meeting nor may they broadcast it in any manner (e.g., via live streaming). If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, Medical Staff or ASC personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

J. **PROFESSIONAL PRACTICE EVALUATION REPORTS:**

1. Practitioner / APP PPE History Reports: A Practitioner or APP history report showing all cases that have been reviewed for a Practitioner or APP within the past two years and their dispositions should be generated for each Practitioner or APP for consideration and evaluation by the appropriate ASC Medical Director and the ASC MEC in the reappointment process.

2. Reports to the ASC Medical Executive Committee, Medical Staff, and Governing Body: The PPE Specialists shall prepare reports at least annually that provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases, including numbers of cases closed at each level of the process; listing of education initiatives based on reviews; listing of system issues identified). These reports shall be disseminated to the ASC Medical Executive Committee, all Practitioners and APP's at the ASC, and the Governing Body for the purposes of reinforcing the primary objectives outlined in Section 1. A of this policy and permitting appropriate oversight.

3. Reports on Request: The PPE Specialists shall prepare reports as requested by the Medical Director, ASC MEC, or the Governing Body.

K. **PPE MANUAL:** The ASC MEC shall recommend Governing Body approval of forms, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Professional Practice Evaluation Manual. Such documents shall be developed and maintained by the PPE Specialists. Individuals performing pursuant to this Policy should use the document currently approved for that function and revise as necessary.

L. **SUBSTANTIAL COMPLIANCE:** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

M. **AGREEMENT TO VOLUNTARILY REFRAIN FROM EXERCISING CLINICAL PRIVILEGES OR OTHER PRACTICE CONDITIONS:** At any point in the review process described in this Policy, the ASC MEC or a representative designated by the ASC MEC Medical Director may ask a Practitioner or APP to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner or APP may also agree upon practice conditions that will protect the Practitioner, APP, patients, and staff during the review process. Prior to any such action, the Practitioner or APP shall be given the opportunity to discuss these issues with the ASC MEC Medical Director or their representatives and provide written input regarding them.

1. These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or APP or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

1. In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

N. **DEFINITIONS AND ACRONYMS:**

1. Assigned Reviewer: means a Practitioner or APP who is requested by the ASC Medical Director to:

   a. serve as a consultant and assist performing the review; or

   b. conduct a review, document his/her clinical findings on a case review form, submit the form to the ASC Medical Director that assigned the review, and be available to discuss findings and answer questions.

2. APP or Advanced Practice Professional: Shall have the same meaning as that term is defined in the Medical Staff Bylaws

3. Clinical Specialty Review Committee (CSRC): a committee of at least one Practitioner or APP from a clinical service or specialty, working in conjunction with the ASC Medical Director. The individual(s) and committee that will function as CSRCs will be designated by the ASC MEC Medical Director. CSRCs receive cases for review, obtain input from assigned reviewers as needed, complete the case review form in this Policy, and make a determination as described in Section 2.D of this Policy.

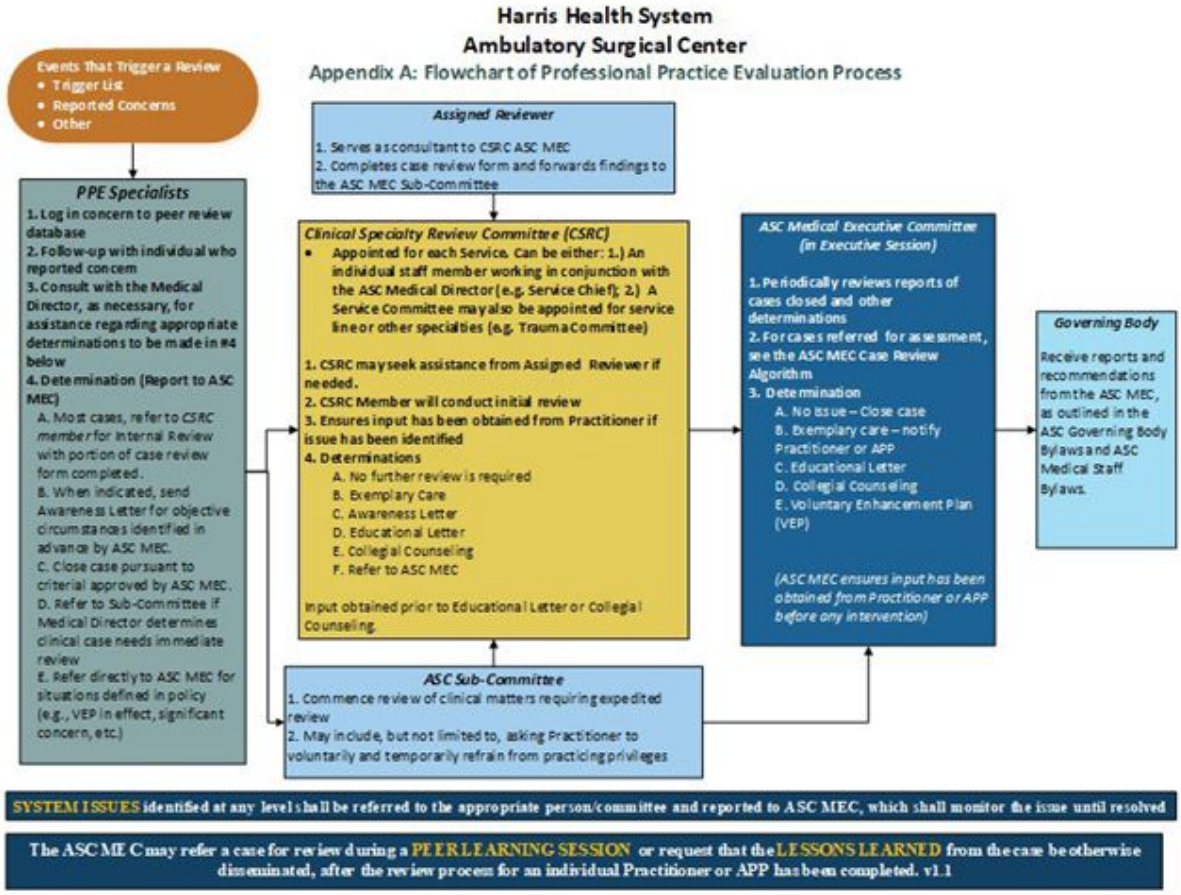
4. Executive Session: any meeting or portion of any meeting, of any section, department, or committee of the Medical Staff at which privileged and/or confidential information regarding quality assessment and improvement and/or peer review information is presented or discussed.

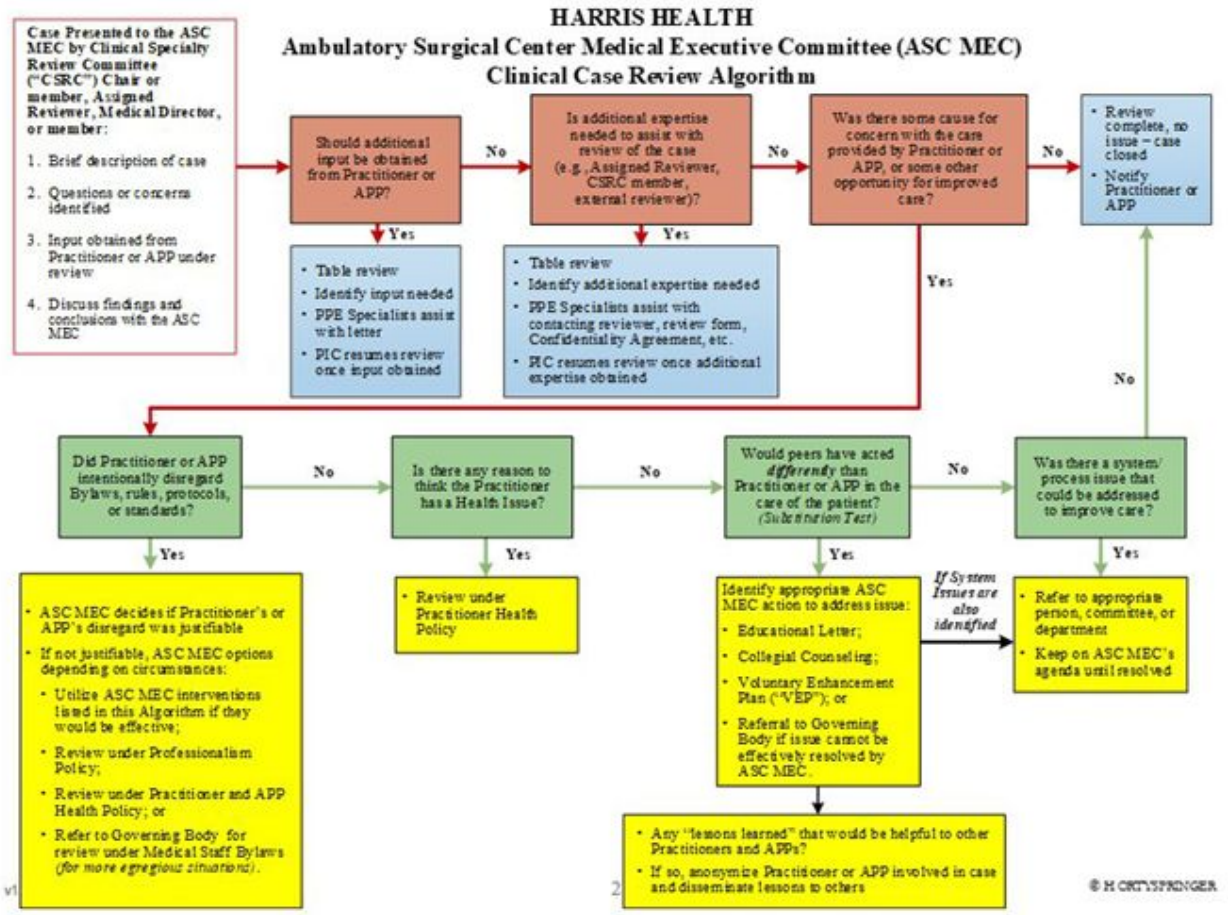
5. ASC Medical Executive Committee (ASC MEC): a multi-specialty medical peer review committee under Texas law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners and APPs in a constructive and educational manner to help address any clinical performance issues, and develops Voluntary Enhancement Plans as described in this Policy. The ASC MEC has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges to the Governing Body. The composition and duties of the ASC MEC are described in the Medical Staff Bylaws.

6. Practitioner: shall have the same meaning as that term is defined in the Medical Staff Bylaws.

7. Professional Practice Evaluation (PPE): refers to the ASC's routine peer review process. It is used to evaluate a Practitioner's or APP's professional performance when any questions or concerns arise. The PPE process outlined in this Policy is applicable to all Practitioners and APPs and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

Appendix A


Harris Health System
Ambulatory Surgical Center
Appendix A: Flowchart of Professional Practice Evaluation Process
Events That Trigger a Review
• Trigger List
• Reported Concerns
• Other
PPE Specialists
1. Log in concern to peer review database
2. Follow-up with individual who reported concern
3. Consult with the Medical Director, as necessary, for assistance regarding appropriate determinations to be made in #4 below
4. Determination (Report to ASC MEC)
A. Most cases, refer to CSRC member for Internal Review with portion of case review form completed.
B. When indicated, send Awareness Letter for objective circumstances identified in advance by ASC MEC.
C. Close case pursuant to criteria approved by ASC MEC.
D. Refer to Sub-Committee if Medical Director determines clinical case needs immediate review
E. Refer directly to ASC MEC for situations defined in policy (e.g., VEP in effect, significant concern, etc.)
Assigned Reviewer
1. Serves as consultant to CSRC ASC MEC
2. Completes case review form and forwards findings to the ASC MEC Sub-Committee
Clinical Specialty Review Committee (CSRC)
• Appointed for each Service. Can be either: 1.) An individual staff member working in conjunction with the ASC Medical Director (e.g. Service Chief); 2.) A Service Committee may also be appointed for service line or other specialties (e.g. Trauma Committee)
1. CSRC may seek assistance from Assigned Reviewer if needed.
2. CSRC Member will conduct initial review
3. Ensures input has been obtained from Practitioner if issue has been identified
4. Determinations
A. No further review is required
B. Exemplary Care
C. Awareness Letter
D. Educational Letter
E. Collegial Counseling
F. Refer to ASC MEC
Input obtained prior to Educational Letter or Collegial Counseling
ASC Sub-Committee
1. Commence review of clinical matters requiring expedited review
2. May include, but not limited to, asking Practitioner to voluntarily and temporarily refrain from practicing privileges
ASC Medical Executive Committee (in Executive Session)
1. Periodically reviews reports of cases closed and other determinations
2. For cases referred for assessment, see the ASC MEC Case Review Algorithm
3. Determination
A. No Issue – Close case
B. Exemplary care – notify Practitioner or APP
C. Educational Letter
D. Collegial Counseling
E. Voluntary Enhancement Plan (VEP)
(ASC MEC ensures input has been obtained from Practitioner or APP before any intervention)
Governing Body
Receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.
SYSTEM ISSUES identified at any level shall be referred to the appropriate person/committee and reported to ASC MEC, which shall monitor the issue until resolved
The ASC MEC may refer a case for review during a PEER LEARNING SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual Practitioner or APP has been completed. v1.1


HARRIS HEALTH
Ambulatory Surgical Center Medical Executive Committee (ASC MEC)
Clinical Case Review Algorithm
Case Presented to the ASC MEC by Clinical Specialty Review Committee ("CSRC") Chair or member, Assigned Reviewer, Medical Director, or member:
1. Brief description of case
2. Questions or concerns identified
3. Input obtained from Practitioner or APP under review
4. Discuss findings and conclusions with the ASC MEC
Should additional input be obtained from Practitioner or APP?
No
Yes
Table review
Identify input needed
PPE Specialists assist with letter
PIC resumes review once input obtained
Is additional expertise needed to assist with review of the case (e.g., Assigned Reviewer, CSRC member, external reviewer)?
No
Yes
Table review
Identify additional expertise needed
PPE Specialists assist with contacting reviewer, review form, Confidentiality Agreement, etc.
PIC resumes review once additional expertise obtained
Was there some cause for concern with the care provided by Practitioner or APP, or some other opportunity for improved care?
No
Yes
Review complete, no issue – case closed
Notify Practitioner or APP
No
Did Practitioner or APP intentionally disregard Bylaws, rules, protocols, or standards?
No
Yes
ASC MEC decides if Practitioner's or APP's disregard was justifiable
If not justifiable, ASC MEC options depending on circumstances:
Utilize ASC MEC interventions listed in this Algorithm if they would be effective;
Review under Professionalism Policy;
Review under Practitioner and APP Health Policy; or
Refer to Governing Body for review under Medical Staff Bylaws (for more egregious situations).
Is there any reason to think the Practitioner has a Health Issue?
No
Yes
Review under Practitioner Health Policy
Would peers have acted differently than Practitioner or APP in the care of the patient? (Substitution Test)
No
Yes
Identify appropriate ASC MEC action to address issue:
Educational Letter;
Collegial Counseling;
Voluntary Enhancement Plan ("VEP"); or
Referral to Governing Body if issue cannot be effectively resolved by ASC MEC.
If System Issues are also identified
Was there a system/process issue that could be addressed to improve care?
No
Yes
Refer to appropriate person, committee, or department
Keep on ASC MEC's agenda until resolved
Any "lessons learned" that would be helpful to other Practitioners and APPs?
If so, anonymize Practitioner or APP involved in case and disseminate lessons to others

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation					
	Provide Information	Committee Member			Hearing Panel	Governing Body
		CSRC	ASC MEC	Investigating Committee		
Employment/contract relationship with Harris Health	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	N	N	R
Relevant treatment relationship	Y	R	R	N	N	R
Significant financial relationship	Y	Y	Y	N	N	R
Direct competitor	Y	Y	Y	N	N	R
Close friends	Y	Y	Y	N	N	R
History of conflict	Y	Y	Y	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	N	N	R
Formally raised the concern	Y	Y	Y	N	N	R

Y ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that CSRCs and ASC MEC have no disciplinary authority.

In addition, the Chair of each of these committees always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner or APP under review.

N ("No") – means the Interested Member should not serve in the indicated role.

R ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

the document. https://sp2019apps.hchd.local/sites/dcc

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Governing Body Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict-of-interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Governing Body Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Governing Body or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the Medical Executive Board prior to being excused from the meeting); and (v) how the committee or Governing Body has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Governing Body's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Governing Body. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.

REFERENCES/BIBLIOGRAPHY:

(to be updated)

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:
	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: MEDICAL STAFF PROFESSIONALISM

PURPOSE: To establish guidelines for collegiality, collaboration, and professionalism at the Ambulatory Surgical Center (ASC) at LBJ in order to establish a culture of quality care and safety.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to establish a process that will be used to evaluate and collegially resolve concerns that a physician or Advanced Practice Professional (APP) has engaged in inappropriate conduct. It is also the policy of the ASC to treat each other with respect, courtesy, and dignity, and we ask all to conduct themselves in a professional and cooperative manner.

POLICY ELABORATIONS:

I. REPORTS OF INAPPROPRIATE CONDUCT:

A. DEFINITIONS:

1. **COLLEGIAL COUNSELING:** A formal, planned face-to-face discussion between a physician or APP and the ASC Medical Director. Collegial Counseling only occurs after a physician/APP or has had an opportunity to provide input regarding a concern. If the Collegial Counseling results from a matter that has been reported to the PPE Specialists and reviewed through this Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the physician's future practice at the ASC. A copy of the follow-up letter will be included in the physician/APP's file along with any response that the physician/APP would like to offer. In contrast, informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Counseling are referred to as Initial Mentoring Efforts. This Policy encourages the use of Initial Mentoring Efforts to assist Practitioners and APPs in continually improving their practices. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, documentation is recommended particularly if a pattern of behavior may be

developing. Any documentation will be maintained in physician/APP's confidential file.

2. **INAPPROPRIATE CONDUCT:** Conduct defined in Appendix B

3. **INVESTIGATION:** A non-routine, process to review concerns pertaining to a physician or APP. The ASC Medical Director has the authority to initiate and conduct an Investigation. The process to address issues of professional conduct as outlined in this Policy does not constitute an investigation.

4. **PROFESSIONAL PRACTICE EVALUATION SPECIALISTS:** Staff who support the ASC Medical Director on the Professional Practice Evaluation (PPE) process generally and the review of issues related to professionalism described in this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

5. **PROFESSIONALISM MANUAL:** Forms, checklists, template letters and other documents that assist with the implementation of this Policy. Such documents shall be developed and maintained by the PPE Specialists and approved for use by the ASC.

6. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP):** Shall have the same meaning as those terms are defined in the Medical Staff Bylaws.

7. **SEXUAL HARASSMENT AND OTHER IDENTITY-BASED HARASSMENT:** Conduct defined in Appendix B of this Policy.

B. **REPORTS:**

1. ASC employees, Practitioners, or APPs who observe, or are subjected to, Inappropriate Conduct by a Practitioner or APP shall report the incident in a timely manner by submitting a report through an approved Harris Health reporting mechanism:

   a. Individuals receiving such reports will forward it to the PPE Specialists.

   b. The PPE Specialists shall notify the ASC Medical Director of all reported concerns and log them in a confidential peer review database.

c. Concerns involving Sexual Harassment or Other Identity-Based Harassment will be immediately referred for investigation in accordance with Section J.2. of this Policy.

2. **FOLLOW-UP WITH INDIVIDUAL WHO FILED REPORT:** The PPE Specialists shall follow up with individuals who file a report. A response to the individual reporting concerns about conduct is included in the Professionalism Manual.

C. **RESOLUTION OF MINOR CONCERNS:**

1. **CRITERIA FOR RESOLUTION OF MINOR CONCERNS:** A reported concern may be resolved without the need for further review under this Policy if the ASC Medical Director determines that:

a. The reported concern is minor in nature;

b. There is no history or pattern with the Practitioner or APP in question

2. **PROCEDURE FOR RESOLUTION OF MINOR CONCERNS:** For concerns that qualify as minor, the ASC Medical Director will communicate with the Practitioner or APP about the matter. The purpose of this communication is to make the Practitioner or APP aware that another individual perceived the Practitioner's or APP's behavior as unprofessional and the Practitioner or APP may reflect and self-correct as needed. No conclusions about the Practitioner's or APP's behavior are reached as a result of this process, so there is no need for fact-finding or input from the Practitioner or APP. The Medical Director may choose to follow up with a brief note to the Practitioner or APP memorializing any conversation.

a. The ASC Medical Director will notify the PPE Specialists that a minor concern has been resolved in this manner. A Form to Document Resolution of Minor Concerns is included in the Professionalism Manual.

3. **REPORTS TO ASC MEC:** The PPE Specialists will provide the ASC MEC with periodic reports of minor concerns that have been resolved under this section to allow for oversight of the process and consistency.

D. PROCEDURE WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED:

The steps set forth below apply to reported concerns about behavior that, as determined by the ASC Medical Director, involve more serious allegations or a pattern of behavior.

1. Preliminary Notification to Practitioner or APP: The ASC Medical Director shall notify the Practitioner or APP that a concern has been raised and that the matter is being reviewed. Generally, this preliminary communication should occur via a brief telephone call, a personal discussion, or e-mail as soon as practical. The Practitioner or APP should be informed that they will be invited to provide input regarding the matter after further review of the reported concern has occurred and before any review by the ASC MEC. The Practitioner or APP should also be reminded to avoid any action that could be perceived as retaliation.

2. Case Review by Service Chief: A case review form will be sent to the Practitioner or APP's Service Chief by the ASC Medical Director to inform them of the reported concern and request their review of the matter.

3. Fact-Finding: The ASC Medical Director shall, in their discretion, interview witnesses or others who were involved in the incident and gather necessary documentation or information needed to assess the reported concern. An Interview Tool for Fact-Finding: Script, Questions and Guidance that may be used for such interviews is included in the Professionalism Manual.

    a. If an allegation involves Sexual Harassment or other Identity-Based Harassment, fact-finding will occur in accordance with Section J.2 of this Policy.

4. Determination by the ASC Medical Director

a. No Further Review Required: Following the investigation, the ASC Medical Director may determine that a reported concern does not raise issues that need to be addressed pursuant to this Policy. In such case, no input regarding the circumstances will be sought from the Practitioner or APP and the matter will be closed. A letter will be sent to the Practitioner or APP notifying them of the reported concern and that the case was closed without further review. The Practitioner or APP and the ASC MEC will be notified of this determination and documentation that the matter was closed will be maintained.

b. Further Review Required: The ASC Medical Director may determine that a matter should be reviewed further by the ASC MEC. In such case, the Practitioner's or APP's input and perspective will be obtained as set forth in Section E of this Policy. The matter shall then be referred to the ASC MEC. The PPE Specialists shall prepare a summary report of the matter for review by the ASC MEC and provide the ASC MEC with all supporting documentation.

i. If an allegation involves Sexual Harassment or Other Identify-Based Harassment, further review will be determined in accordance with Section J.2 of this Policy.

E. OBTAINING INPUT FROM THE PRACTITIONER OR APP:

1. General: The ASC Medical Director or PPE Specialists will provide details of the concern (but not a copy of any reported concern) to the Practitioner or APP and ask the Practitioner or APP to provide a written explanation of what occurred and their perspective on the incident. A Cover Letter to Practitioner or APP Seeking Input Regarding Behavior Concern which may be used for this purpose is included in the Professionalism Manual. If an allegation involves Sexual Harassment or other Identity-Based Harassment, obtaining input from the Practitioner or APP will occur in accordance with Section J.2. of this Policy.

2. Sharing Identity of Any Individual Reporting a Concern: Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter will not be disclosed to the Practitioner or APP unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

3. Reminder of Practitioner's or APP's Obligations: The ASC Medical Director will remind the Practitioner or APP of the need to maintain confidentiality and the importance of avoiding any actions that could be viewed as retaliation as part of seeking their input. The Cover Letter to Practitioner or APP Seeking Input Regarding Behavior Concern set forth in the Professionalism Manual addresses these issues. If concerns about confidentiality and non-retaliation are more significant, the Practitioner or APP may be required to sign a Confidentiality and Non-Retaliation Agreement (a copy of which is included in the Professionalism Manual) prior to providing detailed information regarding the concern to the Practitioner or APP.

4. Failure of the Practitioner or APP to Provide Requested Input or Attend Meeting: A Practitioner or APP is required to provide written input or attend a meeting as requested by the ASC Medical Director within the time frame specified. Failure to respond within the timeframe result in a review that will proceed without input from the Practitioner or APP.

F. ASC MEDICAL EXECUTIVE COMMITTEE PROCEDURE:

1. Initial Review: The ASC MEC shall review, in Executive Session, the summary prepared by the PPE Specialists and supporting documentation, including the Service Chief's review, and response from the Practitioner or APP. If necessary, the ASC MEC may also meet with the individual who submitted the report and any witnesses to the incident. The ASC MEC may consult with or include in the review another physician or APP or any other individual who would assist in the review.

2. Practitioner or APP and ASC MEC Meeting: If either the ASC MEC or the Practitioner or APP believes it would be helpful prior to the ASC MEC concluding its review and making a determination, a meeting may be held between the Practitioner or APP and the ASC MEC to discuss the circumstances further and obtain additional facts. At its discretion, the ASC MEC may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The ASC MEC may also obtain additional written input from the Practitioner or APP as set forth in Section D of this policy. If an allegation involves Sexual Harassment or other Identity-Based Harassment, this meeting will occur in accordance with Section J.2. of this Policy.

3. Refusal to Provide Information or Meet with ASC MEC: A Practitioner or APP who refuses to provide information or meet with the ASC MEC will be addressed as set forth in Section D of this policy.

G. ASC MEC DETERMINATION:

1. After its review of relevant information, including input from the Practitioner or APP, the ASC MEC may:

   a. Determine that no further review or action is required;

   b. Send the Practitioner or APP an Educational Letter, providing guidance and counsel;

   c. Engage in Collegial Counseling with the Practitioner or APP and provide education and coaching (a Collegial Counseling Checklist and Follow-Up Letter to Collegial Counseling are included in the Professionalism Manual);

   d. Develop a Voluntary Enhancement Plan for Conduct (VEP), as described in Section H of this Policy (an Implementation Issues Checklist for VEPs for Conduct is included in the Professionalism Manual); or

   e. refer the matter for Corrective Action as set forth in the ASC Medical Staff Bylaws.

2. ASC MEC Review Not an Investigation: A review conducted by the ASC MEC or by any individual pursuant to this Policy shall not constitute an Investigation.

3. Additional Reports of Inappropriate Conduct: If additional reports of Inappropriate Conduct are received concerning a Practitioner or APP, the ASC MEC may continue to use the collegial and progressive steps outlined in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

4. Determination to Address Concerns through Practitioner/APP Health Policy: The ASC MEC may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns and the review process outlined in the Practitioner/APP Health Policy is more likely to successfully resolve the concerns.

H. VOLUNTARY ENHANCEMENT PLAN FOR CONDUCT:

1. General: The ASC MEC may determine it is necessary to develop a Voluntary Enhancement Plan (VEP) for the Practitioner or APP. One or more members of the ASC MEC should personally discuss the VEP with the Practitioner or APP to help ensure a shared and clear understanding of the elements of the VEP. The VEP will also be presented in writing, with a copy being placed in the Practitioner's or APP's file, along with any statement the Practitioner or APP would like to offer.

2. Voluntary Nature of a VEP: If a Practitioner or APP agrees to participate in a VEP developed by the ASC MEC, such agreement will be documented in writing. If a Practitioner or APP disagrees with a recommended VEP developed by the ASC MEC, the Practitioner or APP is under no obligation to participate in it. In such case the ASC MEC cannot compel the Practitioner or APP to agree with the VEP. Instead, the ASC MEC will refer the matter review and action pursuant to the Medical Staff Bylaws.

3. VEP Options: A VEP for conduct may include, but is not limited to, one or more of the actions in this Section. None of these actions entitles the Practitioner or APP to a hearing or appeal as described in the Medical Staff Bylaws, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. A VEP Options for Conduct – Implementation Issues Checklist that may be used to assist with implementation of the following VEP options is included in the Professionalism Manual

   a. Education/CME (or equivalent for APPs): Within a specified period of time, the Practitioner or APP, must arrange for education or CME related to behavioral matters of a duration and type approved by the ASC MEC;

   b. Meeting with Designated Group to Conduct Enhanced Collegial Counseling: The Practitioner or APP may be invited to meet with a designated group to discuss the concerns with the Practitioner's or APP's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff Leaders, Harris Health leaders, outside consultants, if the ASC MEC determines that involvement is reasonably likely to impress upon the Practitioner or APP involved the seriousness of the matter and the necessity for the Practitioner's or APP's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner or APP after the meeting;

   c. Periodic Meetings with Medical Staff Leaders or Mentors: The ASC MEC may recommend that the Practitioner or APP be required to meet periodically with one or more medical staff leaders or a mentor designated by the ASC MEC. The purpose of these meetings is to provide input and updates on the Practitioner's or APP's performance, as well as to offer assistance and support with any challenging issues the Practitioner or APP may be encountering;

d. Review of Literature Concerning the Connection Between Behavior and Patient Safety: The ASC MEC may recommend that the Practitioner or APP review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the ASC MEC summarizing the information reviewed and how it can be applied to the individual's practice;

e. Behavior Modification Course: The ASC MEC may recommend that the Practitioner or APP complete a behavior modification course that is acceptable to the ASC MEC. The cost of this external assistance shall be borne by the Practitioner or APP, unless the ASC MEC determines otherwise.;

f. Personal Code of Conduct: The ASC MEC may develop a personal code of conduct for the Practitioner or APP, which provides specific guidance regarding the expectations for future conduct and outlines the specific consequences of the Practitioner's or APP's failure to abide by it; and/or

g. Other: Elements not specifically listed above may be included in a VEP. The ASC MEC has wide latitude to tailor VEPs to the specific concerns identified, always with the objective of helping the Practitioner or APP to improve his or her performance and to protect patients and staff.

I. GOVERNING BODY

1. Governing Body: The Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

J. REVIEW OF REPORTS OF SEXUAL HARASSMENT AND OTHER IDENTITY BASED HARASSMENT

1. Sexual Harassment and other Identity-Based Harassment is defined in Appendix B of this Policy.

2. Review Process for Sexual Harassment and Other Identity-Based Harassment Concerns: All reports of potential Sexual Harassment and other Identity-Based Harassment will be immediately referred to the Practitioner or APP's affiliated medical school's Title IX Coordinator or designee to investigate. If the Practitioner or APP is not affiliated with a medical school, then the report of potential Sexual Harassment and other Identity-Based Harassment will be immediately referred to Harris Health's Office of Corporate Compliance to investigate. Upon completion of the investigation, the outcome of the investigation conducted by the affiliated medical school or the Office of Corporate Compliance will be communicated to the ASC MEC, with an opportunity for the ASC MEC to ask questions or seek clarity from the investigating body.

3. Agreements to Voluntarily Refrain from Clinical Activities During Review: While a Practitioner or APP may be asked to voluntarily refrain from exercising clinical privileges pending the review of any behavioral matter under this Policy, particular attention will be paid to whether it is necessary to utilize such a temporizing safeguard while an allegation of Sexual Harassment or other Identity-Based Harassment is being reviewed.

K. ADDITONAL PROVISIONS GOVENING THE PROFESSIONALISM REVIEW PROCESS:

1. Confidentiality: Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

   a. Documentation: All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents will be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. Failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

   b. Verbal Communications: Telephone and in-person conversations should take place in private, at appropriate times, and in locations to minimize the risk of a breach of confidentiality.

c. E-Mail: Harris Health e-mail may be used to communicate between individuals participating in the professionalism review process, including with the Practitioner or APP in question. All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication," in the subject line. Email should not be sent to non-Harris Health accounts unless the e-mail directs recipients to check their Harris Health e-mail account.

d. Participants in the Review Process: All individuals involved in the review process will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. A Confidentiality Agreement – Medical Staff Leader and Confidentiality Agreement – Medical Staff Leader and Confidentiality Agreement – Harris Health Employee are included in the Professionalism Manual.

e. Practitioner or APP Under Review: The Practitioner or APP under review must maintain all information related to the review in a strictly confidential manner. The Practitioner or APP may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the written permission of Harris Health, except for any legal counsel who may be advising the Practitioner or APP. Violations of this provision will be reviewed under this Policy.

2. Communications with Practitioner or APP that Include a Deadline: Before any paper or electronic correspondence that includes a deadline for a response is mailed or e-mailed to a Practitioner, a text message should be sent or a phone call should be made to alert the Practitioner or APP that the correspondence is being sent. The intent of any such text message or phone call is to make the Practitioner or APP aware of the correspondence so that the deadline is not missed. However, failure to send a text message or make a phone call shall not be cause for the Practitioner or APP to miss a deadline.

3. Immediate Referrals for Review Pursuant to the ASC Medical Staff Bylaws: This Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about Inappropriate Conduct by Practitioners or APPs. However, a single incident of Inappropriate Conduct or a pattern of Inappropriate Conduct may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy or the elimination of any particular steps in this Policy, to review pursuant to the ASC Medical Staff Bylaws.

4. Coordination with Other Policies that Govern Professional Conduct: If a report of unprofessional behavior involves an issue that is also governed by a policy outside the ASC such as a Harris Health policy that governs professional conduct, the ASC Medical Director will notify Harris Health's Chief Medical Executive.

5. No Legal Counsel or Recordings During Collegial Meetings: To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate ASC personnel. No counsel representing the Practitioner or APP or the ASC shall attend any of these meetings. In their discretion, the ASC may permit a Practitioner or APP to invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

    a. Practitioners or APPs may not create an audio or video recording of a meeting. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, the ASC may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, the ASC may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

6. Education Regarding Appropriate Professional Behavior: The ASC shall educate Practitioners and APPs regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of Inappropriate Conduct.

7. Letters Placed in Practitioner's or APP's Confidential File: Copies of letters sent to the Practitioner or APP as part of the efforts to address the Practitioner's or APP's conduct shall be placed in the Practitioner's or APP's confidential file. The Practitioner or APP shall be given an opportunity to respond in writing, and the Practitioner's or APP's response shall also be kept in the Practitioner's or APP's confidential file.

8. When Both Clinical and Behavioral Concerns are at Issue: If a matter involves both clinical and behavioral concerns, the ASC MEC shall coordinate reviews pursuant of the applicable policy and address with the Practitioner or APP in consolidated manner.

9. Supervising Physicians and Advanced Practice Professionals: Except as noted below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional for state licensure purposes shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving the Advanced Practice Professional. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

10. Delegation of Functions: The ASC MEC is responsible for the professionalism/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC MEC may expressly delegate to the PPE Specialist(s) the authority to perform functions described in this Policy on behalf of the ASC MEC. Actions taken by these individuals will be reported to and reviewed by the ASC MEC as set forth in this Policy.

    a. When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by an ASC leader, a Medical Staff member, or the ASC MEC, the individual may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating party is responsible for ensuring that the designee appropriately performs the function delegated. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

    b. When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more ASC MEC member may perform the function personally or delegate it to another appropriate individual as set forth in this Policy.

11. Substantial Compliance: While every effort will be made to comply with provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

12. Professionalism Issue Summary Form: Once a professionalism concern is resolved, the PPE Specialists should complete the Professionalism Issue Summary Form and maintain this within the Practitioner's or APP's confidential file. These forms facilitate the identification of trends, inform the determinations made by the ASC MEC when assessing professionalism issues, and supplement both the ongoing performance data review and reappointment processes. A Professionalism Issue Summary Form is included in the Professionalism Manual.

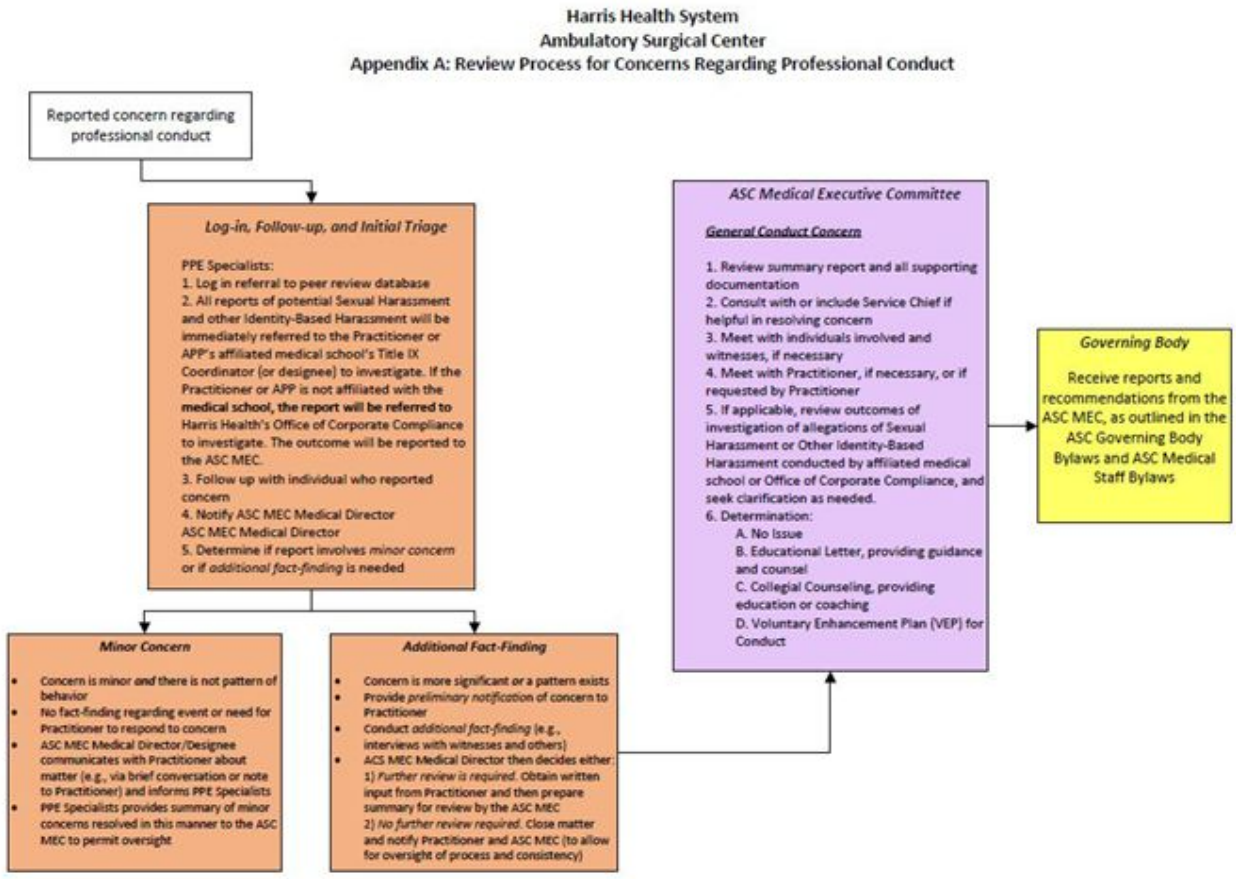
13. Reports to Practitioners, APPs, and the Governing Body: The ASC MEC shall prepare reports at least annually that provide aggregate information regarding the professionalism review process (e.g., numbers of concerns reviewed by department or specialty; the types of dispositions for those concerns; etc.). These reports should be disseminated to all Practitioners and APPs at the ASC, and the Governing Body for the purposes of reinforcing the purpose of this Policy and permitting appropriate oversight. A sample Summary Report for Professionalism Review Activities to Be Provided to All Practitioners, APPs, MEC, and Governing Body is included in the Professionalism Manual.

14. Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions: At any point in the review process described in this Policy, the ASC MEC may ask a Practitioner or APP to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, the Practitioner or APP may also agree upon practice conditions that will protect the Practitioner or APP, patients, and the ASC during the review process. Prior to any such action, the Practitioner or APP shall be given the opportunity to discuss these issues with the ASC MEC or its representatives and provide written input regarding them.

    a. These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or APP or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

b. In light of the voluntary and non-disciplinary nature of these actions, they do not generally represent matters that require any report to any State Board or to the National Practitioner Data Bank.

Appendix A


Harris Health System
Ambulatory Surgical Center
Appendix A: Review Process for Concerns Regarding Professional Conduct
Reported concern regarding professional conduct
Log-in, Follow-up, and Initial Triage
PPE Specialists:
1. Log in referral to peer review database
2. All reports of potential Sexual Harassment and other Identity-Based Harassment will be immediately referred to the Practitioner or APP's affiliated medical school's Title IX Coordinator (or designee) to investigate. If the Practitioner or APP is not affiliated with the medical school, the report will be referred to Harris Health's Office of Corporate Compliance to investigate. The outcome will be reported to the ASC MEC.
3. Follow up with individual who reported concern
4. Notify ASC MEC Medical Director
ASC MEC Medical Director
5. Determine if report involves minor concern or if additional fact-finding is needed
Minor Concern
Concern is minor and there is not pattern of behavior
No fact-finding regarding event or need for Practitioner to respond to concern
ASC MEC Medical Director/Designee communicates with Practitioner about matter (e.g., via brief conversation or note to Practitioner) and informs PPE Specialists
PPE Specialists provides summary of minor concerns resolved in this manner to the ASC MEC to permit oversight
Additional Fact-Finding
Concern is more significant or a pattern exists
Provide preliminary notification of concern to Practitioner
Conduct additional fact-finding (e.g., interviews with witnesses and others)
ACS MEC Medical Director then decides either:
1) Further review is required. Obtain written input from Practitioner and then prepare summary for review by the ASC MEC
2) No further review required. Close matter and notify Practitioner and ASC MEC (to allow for oversight of process and consistency)
ASC Medical Executive Committee
General Conduct Concern
1. Review summary report and all supporting documentation
2. Consult with or include Service Chief if helpful in resolving concern
3. Meet with individuals involved and witnesses, if necessary
4. Meet with Practitioner, if necessary, or if requested by Practitioner
5. If applicable, review outcomes of investigation of allegations of Sexual Harassment or Other Identity-Based Harassment conducted by affiliated medical school or Office of Corporate Compliance, and seek clarification as needed.
6. Determination:
A. No Issue
B. Educational Letter, providing guidance and counsel
C. Collegial Counseling, providing education or coaching
D. Voluntary Enhancement Plan (VEP) for Conduct
Governing Body
Receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws

APPENDIX B

DEFINITION OF INAPPROPRIATE CONDUCT AND SEXUAL HARASSMENT/OTHER IDENTITY-BASED HARASSMENT

1. ***"Inappropriate Conduct"*** means behavior that, as determined by the ASC MEC, adversely affects the healthcare team's ability to work effectively and/or has a negative effect on the communication and collaboration necessary for quality and safe patient care. To aid in both the education of Practitioners and APPs and the enforcement of this Policy, ***"Inappropriate Conduct"*** includes, but is not limited to:

   (a) abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Harris Health personnel, Practitioners, or APPs (e.g., belittling, berating, or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

   (b) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, APPs, Harris Health personnel, or Harris Health;

   (c) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Bylaws documents or other applicable policies;

   (d) intentional misrepresentation to Harris Health administration, Medical Staff Leaders, other Practitioners or APPs, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

   (e) offensive language (which may include profanity or similar language) while in Harris Health or while speaking with patients, nurses, or other Harris Health personnel;

   (f) retaliating against any individual who may have reported a quality or behavior concern about a Practitioner or APP, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner or APP may not, under any circumstances, approach and discuss the matter with any such individual, nor may the Practitioner or APP engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

   (g) unprofessional physical contact with another individual or other aggressive behavior that is threatening or intimidating;

   (h) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

   (i) repeatedly failing to maintain and renew in a timely manner all credentials required by the Medical Staff Bylaws;

   (j) derogatory comments about the quality of care being provided by Harris Health, another Practitioner or APP, or any other individual outside of appropriate Medical Staff or Harris Health administrative channels;

(k) unprofessional medical record entries impugning the quality of care being provided by Harris Health, Practitioners or APPs, or any other individual, or criticizing Harris Health or Harris Health's policies or processes, or accreditation and regulatory requirements;

(l) altering or falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(m) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(n) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(o) unprofessional access, use, disclosure, or release of confidential patient information;

(p) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(q) use of social media in a manner that involves Inappropriate Conduct as defined in this Policy or other Medical Staff or Harris Health policies;

(r) disruption of hospital operations, hospital or Medical Staff committees, or departmental affairs;

(s) refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Bylaws, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Harris Health employees);

(t) conduct that is inconsistent with the ethical obligations of health care professionals; and/or

(u) engaging in **Sexual Harassment or other Identity-Based Harassment** as defined in Section 2 of this Appendix.

ADDITIONAL NOTE REGARDING INAPPROPRIATE CONDUCT:

This Policy is not intended to interfere with a Practitioner's or APP's ability to express, in a professional manner and in an appropriate forum:

(1) opinions on any topic that are contrary to opinions held by other Practitioners or APPs, Medical Staff Leaders, or Harris Health personnel;

(2) disagreement with any Medical Staff or Harris Health Bylaws, policies, procedures, proposals, or decisions; or

(3) constructive criticism of the care provided by any Practitioner or APP, nurse, or other Harris Health personnel.

2. ***Sexual Harassment and Other Identity-Based Harassment*** are a form of ***Inappropriate Conduct***, and include verbal or physical conduct that:

(a) is unwelcome and offensive to an individual who is subjected to it or who witnesses it;

(b) could be considered harassment from the objective standpoint of a "reasonable person"; and

(c) is covered by state or federal laws governing discrimination. This includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are ***not*** dispositive in determining whether conduct is Sexual Harassment or Other Identity-Based Harassment for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Medical Executive Committee, and/or the Governing Body. The intent of this provision is to create higher expectations for professional behavior by Practitioners and APPs than the minimum required by federal or state law.

Sexual Harassment and Other Identity-Based Harassment include all of the following behaviors:

Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures;

Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and assault;

Quid Pro Quo: suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action; and

Retaliation: retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

REFERENCES/BIBLIOGRAPHY:

Harris Health System Medical Staff Professionalism policy

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:
	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: ONGOING PERFORMANCE DATA REVIEW

PURPOSE: To assist in the collection and maintenance of Physician/Practitioner and Advanced Practice Professionals practice data.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ to establish a process that will be used to evaluate and gauge professional performance of physicians/practitioners and Advanced Practice Professional (APP) at the ASC. The ASC makes an effort to provide educational opportunities that help all Practitioners and APPs consistently provide quality, safe, and effective patient care.

POLICY ELABORATIONS:

I. DEFINITIONS

A. **MEDICAL STAFF LEADER:** The ASC Medical Director

B. **ONGOING PERFORMANCE DATA REVIEW (OPDR):** The ongoing review and analysis of data that helps to identify issues or trends in Practitioners and/or APPs performance that may impact quality of care and patient safety. OPDR promotes an efficient, effective and meaningful evidence-based reappointment process. A flow chart of the OPDR process is attached as Appendix A.

C. **PROFESSIONAL PRACTICE EVALUATION SPECIALISTS:** Staff who support the ASC Medical Director on the Professional Practice Evaluation (PPE) process generally and the review of issues related to professionalism described in this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

D. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP):** Shall have the same meaning as those terms are defined in the Medical Staff Bylaws.

II. DATA TO BE COLLECTED:

A. Data Elements Specific to Clinical Service, or its Subdivisions, as Applicable: Each Clinical Service, or its subdivisions, as applicable, shall determine the OPDR data to be collected for each Practitioner and APP by clinical service, or its subdivisions, as applicable and, where appropriate, the expected parameters of performance for each data element. All data elements and parameters shall be approved by the ASC Medical Executive Committee (MEC).

B. Data Elements for All Practitioners and APPs: The ASC MEC shall also establish OPDR data (core) elements that are relevant to all Practitioners and APPs irrespective of clinical service and, where appropriate, the expected parameters of performance for each data element.

C. Guidelines: The following guidelines will be used in determining the OPDR data elements to be collected:

1. PPE Specialist will support the OPDR process at the direction of the ASC MEC;

2. Harris Health medical informatics/information technology department representatives will be consulted to determine the available information system capabilities at the direction of the ASC MEC through the Service Level Agreement;

3. For OPDR elements that are specific to the Clinical Service, or its subdivisions, as applicable, the type of data that would reasonably be expected to reflect clinically significant issues for the Clinical Service, or its subdivisions, as applicable, shall be considered; and

4. When possible, the expected parameters of performance shall be based on relevant clinical literature.

D. Examples of Data Elements: Consistent with AAAHC accreditation standards and the guidelines set forth above, data to be collected may include, but is not limited to, the following data elements and considerations, if applicable to the Clinical Service, or its subdivisions:

1. Utilization data, Medical Record Delinquency, standard of care, patient outcomes;

2. Clinical care is selected for review on an ongoing basis;

3. The selection process for care to be reviewed applies to all similarly privileged healthcare professionals;

4. All clinical incidents are reviewed in accordance with the organization's peer review policies and procedures;

5. All privileged health care professionals are reviewed at least annually by a peer or supervising health care professional.

III. REPORTS:

A. Frequency and Content: An OPDR report for each Practitioner and APP will be prepared by a PPE Specialist at least every 12 months. The PPE Specialist will provide a summary report of OPDR reports to the ASC Medical Director at least every 12 months. A Practitioner or APP OPDR report may include:

1. The activity during the OPDR period:

2. Clinical performance as measured by the approved clinical service and other OPDR data elements;

3. The number of Educational Letters sent pursuant to ASC-P-4014 Professional Practice Evaluation Policy;

4. The number of cases reviewed pursuant to the ASC-P-4014 requiring action; and

5. The number of validated professionalism concerns requiring action and addressed pursuant to ASC-P-4015 Medical Staff Professionalism.

B. Review by the ASC Medical Director: The summary report will be prepared in a manner that allows the ASC Medical Director to review the data or other relevant information and shall make one of the following determinations:

1. Exceptional Performance or Significant Improvement. The data indicate that the Practitioner's or APP's performance has been exceptional or that there has been a significant improvement, in which case the Medical Director is encouraged to acknowledge the Practitioner's or APP's efforts.

2. Acceptable Performance. The data do not reflect a pattern or issue regarding the Practitioner's or APP's performance that requires further review.

3. Review the OPDR Report with Practitioner or APP allowing initial mentoring efforts. The data reflect an issue or concern with the Practitioner's or APP's performance, but the issue or concern is not so significant that further review is necessary under the PPE Policy or the Medical Staff Professionalism Policy. In such case, the Medical Director may engage in Initial Mentoring Efforts with the Practitioner or APP. Any such Initial Mentoring Efforts should be documented via a follow-up letter or e-mail to the Practitioner or APP, with such documentation being included with the ongoing PDR report.

4. Forward for Review under Other Applicable Policy. The data reflect a pattern or issue that requires further review. In such case, the Medical Director shall notify the PPE Specialists, who shall log the report and proceed in accordance with the PPE Policy or the Medical Staff Professionalism Policy, as applicable.

5. Insufficient Volume. The data reflect insufficient activity at the ASC to evaluate the Practitioner's or APP's practice, in which case the Medical Director shall document this finding on the OPDR report for consideration at reappointment. In these circumstances, the procedures set forth in the Medical Staff Bylaws for low volume Practitioners and APPs shall be followed.

OPDR reports involving the Medical Director will be reviewed by an individual of like credentialing who has clinical privileges at the ASC and of like specialty.

After the ASC Medical Director review of OPDR reports, and if in agreement with the report, will sign the summary report. The PPE Specialist shall retain copies of the signed summary report. The PPE Specialist shall provide a copy of the report to the Practitioner or APP or notify the Practitioner or APP how to access the report. OPDR reports will be provided at the time of reappointment for consideration of the Practitioner or APP's performance.

IV. DELEGATION OF FUNCTIONS

A. The ASC MEC is responsible for the OPDR process described in this Policy, subject to the oversight by the Governing Body. To promote a prompt and effective review process, the ASC Medical Director may delegate to the PPE Specialist the authority to perform the functions described in this Policy on behalf of the ASC MEC. Actions taken by these individuals will be reported to and reviewed by the ASC MEC as set forth in this Policy.

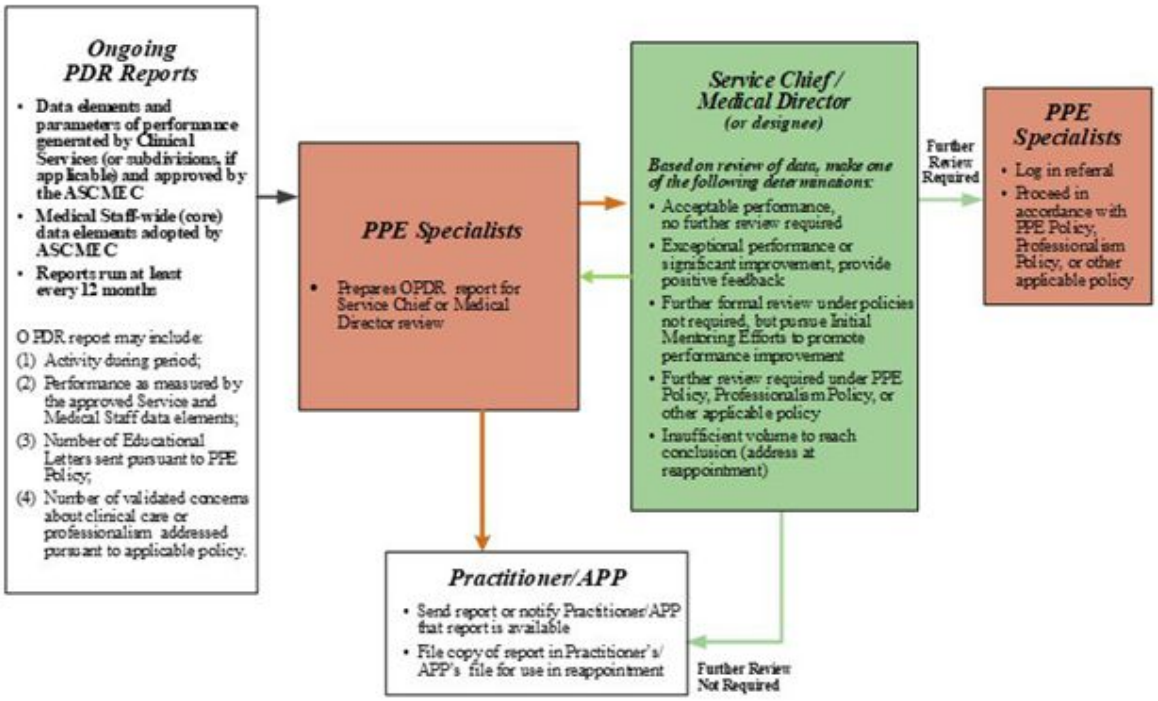
B. When a function under this Policy is to be carried out by a delegate of the ASC Medical Director, any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the ASC Medical Director is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

C. When an individual assigned a function under this Policy is unavailable or unable to perform that function, the ASC Medical Director may delegate it to another appropriate individual as set forth above.

Appendix A

HARRIS HEALTH

Appendix A: Flowchart of Ongoing Performance Data Review ("OPDR") Process



4862-3969-5141, v. 1.0 6 © Horty Springer

REFERENCES/BIBLIOGRAPHY:

Harris Health System Ongoing Performance Data Review (Opdr) Policy

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:
	1.0		The Ambulatory Surgical Center (ASC) at LBJ Governing Body

TITLE: THE AMBULATORY SURGICAL CENTER MEDICAL STAFF HEALTH POLICY

PURPOSE: The Ambulatory Surgical Center (ASC) at LBJ is committed to providing safe, quality care, which can be compromised if a Practitioner/Physician or Advanced Practice Professionals is suffering from a health issue that is not appropriately addressed.

POLICY STATEMENT:

It is the policy of the ASC to outline the process that will be used to evaluate and collegially resolve concerns that a Practitioner/Physician or Advanced Practice Professionals (APP) may have a health issue. A flowchart that outlines the review process described in this Policy is set forth in Appendix A. The ASC is also committed to assisting Practitioners and (APP) in addressing health issues so they may practice safely and competently.

POLICY ELABORATIONS:

I. DEFINITIONS:

1. **EXECUTIVE SESSION:** A meeting or portion of a 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.

2. **GOVERNING BODY**: The Governing Body of the ASC.

3. **HEALTH ISSUE**: A physical, mental, or emotional condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently.

4. **INCAPACITATED PROVIDER:** An ASC medical staff member who is unable to provide care because of a physical or mental illness that requires immediate medical attention.

5. **IMPAIRED PROVIDER:** An ASC medical staff member with a physical, behavioral, or mental impairment that could affect their ability to perform their clinical privileges.

6. **MEDICAL STAFF LEADER:** The ASC Medical Director

7. **PROFESSIONAL PRACTICE EVALUATION SPECIALISTS:** Staff who support the ASC Medical Director on the Professional Practice Evaluation (PPE) process generally and the review of issues related to professionalism described in this Policy. This may include Harris Health employees contracted through the Service Level Agreement.

8. **PHYSICIAN/PRACTITIONER AND ADVANCED PRACTICE PROFESSIONAL (APP):** Shall have the same meaning as those terms are defined in the Medical Staff Bylaws.

II. REPORTS OF POTENTIAL HEALTH ISSUES:

A. Duty to Self-Report:

1. General Duty: Practitioners or APPs who have a Health Issue are required to report it to the Medical Staff Leader.

2. Exception: The duty to self-report does not apply to;

a) A Health Issue that will be fully resolved before the Practitioner or APP next exercises his or her clinical privileges; or

b) A Health Issue that was evaluated as part of a Practitioner's or APP's application for appointment or reappointment to the Medical Staff.

B. Reports of Suspected Health Issues by Others:

1. General: Any Practitioner, APP, or Harris Health ASC employee who is concerned that a Practitioner or APP may be practicing with a Health Issue shall report the concern to a Medical Staff Officer or another Medical Staff Leader.

2. Reporting: All concerns shall be entered into the Harris Health electronic incident reporting system. A Health Issue Reporting Form that may be used to report potential Health Issues is set forth in the Practitioner/APP Health Manual. The form outlines warning signs to facilitate the objective reporting of these issues.

3. Anonymous Reports: Practitioners, APPs, and employees may report concerns anonymously. However, all individuals are encouraged to identify themselves when making a report so that the PPE Specialists may contact the reporter for additional information that may help the Practitioner or APP and safeguard patients, if necessary.

4. Reports by Those in Treatment Relationships: A Practitioner or APP who becomes aware of a Health Issue affecting another Practitioner or APP as a result of his or her treatment relationship with that Practitioner or APP is not expected to report the Health Issue internally pursuant to this Policy. However, the treating Practitioner or APP should encourage the Practitioner or APP to self-report the issue to the extent required by Section 2.A of this Policy.

In addition, the treating Practitioner or APP should consider whether a mandatory report is required under state law to the applicable licensing board or any other state agency. If the treating Practitioner or APP believes a mandatory report is necessary pursuant to state law, he or she should notify the Practitioner or APP and encourage the Practitioner or APP to self-report prior to making the mandatory report. The treating Practitioner or APP may consult with the Chief Medical Executive ("CME") for assistance and resources in such matters, but should not disclose to the CME information that identifies the Practitioner or APP.

III. RESPONSE TO IMMEDIATE THREATS

A. If a potential Health Issue is reported that raises immediate concerns because either:

1. The Practitioner or APP is providing services at the ASC at that time; or

2. The Practitioner or APP is expected to provide services in the very near future such that the ASC MEC would not have time to meet prior to the Practitioner's or APP's provision of services.

By way of example and not limitation, this section applies to an Incapacitated Practitioner or APP who is unable to practice medicine because of a physical or mental illness that requires immediate medical attention (e.g., seems disoriented or displays erratic behavior while rounding on patients). Or, an Impaired Practitioner or APP with a physical, behavioral, or mental impairment that could affect their ability to perform their clinical privileges (e.g., suspected of being under the influence of drugs or alcohol while working.)

B. Interim Safeguards to Protect Patients and Others: If a Practitioner or APP becomes incapacitated due to a physical or mental illness that requires immediate medical attention during a patient's surgery/procedure, the incapacitated Practitioner or APP must be assessed and given proper aid. The procedures outlined in Policy ASC-P-4005 will be followed.

C. If the ASC Medical Director or their designee believes the Practitioner or APP may have a Health Issue and that action is necessary to protect patients, the Practitioner or APP, or others, the Practitioner or APP should be asked to voluntarily refrain from exercising his or her clinical privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner or APP either before or after any tests or evaluations regarding the Practitioner or APP have been completed.

1. Agreement to Voluntarily Refrain: If the Practitioner or APP agrees to voluntarily refrain from exercising his or her privileges, the ASC Medical Director or their designee may assign the Practitioner's or APP's patients to another individual with appropriate clinical privileges. Affected patients shall be informed that the Practitioner or APP is unable to proceed with their care due to an emergency situation. Any wishes expressed by the Practitioner or APP or patients regarding a covering Practitioner or APP will be respected to the extent possible. The Practitioner's or APP's agreement to voluntarily refrain is not reportable to the National Practitioner Data Bank or state licensing board. Such agreements should be documented in a letter or other correspondence to the Practitioner or APP that is maintained in the Practitioner's or APP's Confidential Health File, as described in the next section.

2. Other Action: If the Practitioner or APP will not agree to:

a) Voluntarily refrain from exercising his or her privileges; or

b) Conditions on his or her practice that are deemed necessary, an individual authorized by the Medical Staff Bylaws to impose a summary suspension will consider whether a summary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

D. Referral for Log-In and Follow-Up: Following the immediate response described above, the matter shall be referred to the PPE Specialists for log-in and follow-up as described in the next section

IV. LOG-IN AND FOLLOW-UP:

A. Logging of Reports and Creation of Confidential Health File: The PPE Specialists will log any report of a Health Issue and create a Confidential Health File that is maintained separately from the credentials or quality files (however, the existence of the Confidential Health File will be noted in the credentials or quality file). See Section XII. of this Policy for more information on Confidential Health Files

B. Follow-up with Individual Who Filed Report: The PPE Specialists will follow up with individuals who file a report. A Response to Individual Who Reported Concerns About a Health Issue that may be used for this purpose is included in the Practitioner/APP Health Manual.

C. Fact-Finding: The ASC Medical Director or their designee shall interview witnesses or others who may have information and gather any other necessary documentation or information needed to assess the reported concern. An Interview Tool for Fact-Finding is included in the Practitioner/APP Health Manual.

D. Referral to the ASC MEC: All suspected Health Issues will be referred to the ASC MEC for its review as set forth in the next section.

V. ASC MEDICAL EXECUTIVE COMMITTEE REVIEW

A. Individuals Participating in Review/Additional Clinical Expertise: If the ASC MEC determines that it would be necessary or helpful in addressing the reported concern, it may consult with a subject matter expert or any other individual with relevant expertise. Any individual who participates in a review is an integral part of Harris Health's ASC review process, and shall be governed by the same responsibilities and legal protections that apply to other participants in the process.

B. Additional Fact-Finding: The ASC MEC may review any documentation relevant to the Health Issue. It may also meet with the individual who initially reported the concern and any other individual who may have relevant information. An Interview Tool for Fact-Finding (Script and Questions) is included in the Practitioner/APP Health Manual.

C. Meeting with Practitioner or APP: If the ASC MEC believes that a Practitioner or APP may have a Health Issue, the ASC MEC shall meet with the Practitioner or APP. At this meeting, the Practitioner or APP will be advised of the nature of the concern, asked to provide input, and informed of the ASC MEC's recommendations. Talking Points for Meeting with Practitioner/APP About Health Issue that may be used to help the ASC MEC prepare for and conduct such meetings are included in the Practitioner/APP Health Manual.

D. Practitioner's or APP's Refusal to Obtain Assessment: If a Practitioner or APP refuses to obtain a health assessment that is recommended by the ASC MEC or provide the results to the ASC MEC, the process outlined in Section XI. of this Policy will be followed.

E. Self-Disclosure to Other Entities: In its discretion, the ASC MEC may encourage the Practitioner or APP to self-disclose the Health Issue to other entities where the Practitioner or APP practices. The ASC MEC may point out that Medical Staff Bylaws and related documents typically require Practitioners or APPs to self-disclose such information. If applicable, documentation confirming that the self-disclosure occurred should be obtained.

VI. INTERIM SAFEGUARDS PENDING COMPLETION OF ASSESSMENT

A. If a Practitioner or APP agrees to obtain an assessment, the ASC MEC may also recommend that the Practitioner or APP voluntarily take one or more of the following actions while the assessment is pending:

1. Agree to specific conditions on his or her practice, which could include obtaining assistance from other Practitioners or APPs during patient care activities;

2. Refrain from exercising some or all privileges at the ASC; or

3. Take a leave of absence.

If a Practitioner or APP does not agree to take a temporary voluntary action recommended by the ASC MEC while the assessment is pending, an individual authorized by the Medical Staff Bylaws to impose a summary suspension will consider whether a summary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

VII. ASSESSMENT OF HEALTH STATUS

A. General: The ASC MEC may require the Practitioner or APP to undergo a physical, mental, cognitive, or other examination or other assessment by an appropriate clinician. This may include, but is not limited to, an assessment by the state Physicians Health Program or other applicable program. The ASC MEC may also ask the Practitioner or APP to provide a letter from his or her treating physician confirming the Practitioner's or APP's ability to safely and competently practice, and authorize the treating physician to meet or speak with the ASC MEC.

B. Person to Conduct Assessment: The ASC MEC shall select the health care professional or organization to perform any examination, testing, or evaluation, but may seek input from the Practitioner or APP. More than one health care professional or organization may be asked to perform an examination, test, or evaluation, and this may occur either concurrently or serially.

C. Cost of Assessment: The Practitioner or APP shall be responsible for any costs associated with the assessments described in the prior section, unless the ASC MEC determines otherwise.

D. Forms: The Practitioner/APP Health Manual includes the following forms, which should be used when implementing the provisions of this section:

1. Consent for Disclosure of Information and Release from Liability, which authorizes the ASC to release information to the health care professional or organization conducting the evaluation;

2. Authorization for Release of Protected Health Information, which authorizes the health care professional or organization conducting the evaluation to disclose information about the Practitioner or APP to the ASC MEC; and

3. Health Status Assessment Form, which documents the results of an evaluation.

VIII. REINSTATEMENT/RESUMING PRACTICE

A. Request for Reinstatement from Leave of Absence or to Resume Practicing.

1. Leave of Absence: If a Practitioner or APP was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner or APP must apply for reinstatement of privileges using the process set forth in the Medical Staff Bylaws. However, prior to applying for reinstatement, the Practitioner or APP must first submit a written request to the ASC MEC for clearance to apply for reinstatement and be granted written permission by the ASC MEC.

2. Agreement to Refrain Without Formal Leave of Absence: In all other circumstances where the Practitioner or APP refrained from practicing (e.g., voluntary agreement between Practitioner or APP and ASC MEC; Practitioner or APP was absent from Medical Staff duties while participating in a treatment program or otherwise addressing a Health Issue), the Practitioner or APP must submit a written request to the ASC MEC and receive written permission to resume exercising his or her clinical privileges.

B. Additional Information: Before acting on a Practitioner's or APP's request for clearance to apply for reinstatement from a leave of absence or to resume practicing, the ASC MEC may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's or APP's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner or APP to undergo a health assessment conducted by a physician or entity chosen by the ASC MEC in order to obtain a second opinion on the Practitioner's or APP's ability to practice safely and competently.

C. Determination by the ASC Medical Executive Committee: If the ASC MEC determines that the Practitioner or APP is capable of practicing safely and competently without conditions, this decision will be documented. The Practitioner or APP may then:

1. Proceed with the reinstatement process outlined in the Medical Staff Bylaws, if a leave of absence was taken;

2. Resume practicing, if no leave of absence was taken; or

3. If the ASC MEC determines that conditions should be placed on a Practitioner's or APP's practice as a condition of reinstatement or resuming practice; it will follow the process outlined in the following Section.

IX. CONDITIONS OF CONTINUED PRACTICE

A. General: The ASC MEC may ask the Practitioner or APP to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. Examples of Conditions of Continued Practice are included in the Practitioner/APP Health Manual.

B. Refusal to Agree to Conditions: If the Practitioner or APP does not agree to conditions requested pursuant to the prior paragraph, the ASC MEC cannot compel the Practitioner or APP to comply with them. In that situation, the ASC MEC will refer the matter review and action pursuant to the Medical Staff Bylaws.

C. Reasonable Accommodations: Reasonable accommodations may be made consistent with Human Resources policies, including, as applicable such policies of Harris Health, Baylor College of Medicine, The University of Texas Health Science Center at Houston's McGovern Medical School, or other third-parties with Practitioners or APPs on Harris Health's Medical Staff, to assist the Practitioner or APP in resuming his or her practice. Examples of reasonable accommodations include, but are not limited to, providing assistive technology or equipment or removing architectural barriers. The ASC MEC will consult with appropriate personnel to determine whether reasonable accommodations are feasible.

D. Voluntary Agreement to Conditions Not a Restriction: A Practitioner's or APP's voluntary agreement to conditions similar to the Examples of Conditions of Continued Practice in the Practitioner/APP Health Manual generally does not result in a "restriction" of that Practitioner's or APP's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank (NPDB) or to any state licensing board or other government agency, nor would it entitle a Practitioner or APP to a hearing under the Medical Staff Bylaws. However, the ASC MEC will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board or agency, the ASC MEC should consult with Harris Health legal counsel and communicate with the Practitioner or APP about the matter prior to any such report being made.

X. GOVERNING BODY

A. Governing Body: The Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

XI. CONFIDENTIAL HEALTH FILES/REAPPOINTMENT PROCESS

A. Creation of Confidential Health File: Reports of potential Health Issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's or APP's Confidential Health File, which shall be maintained on the ASC Medical Director's behalf by the PPE Specialists as a separate file and shall not be included in the credentials file or the quality file.

B. Information Reviewed at Reappointment: The information reviewed by those involved in the reappointment process will not routinely include the documentation in a Practitioner's or APP's Confidential Health File. Instead, the process set forth in this subsection will be followed.

1. When a reappointment application is received from an individual who has a Health Issue that is currently being reviewed or monitored by the ASC MEC, or that has been reviewed and resolved in the past reappointment cycle, the PPE Specialists shall contact the ASC Medical Director.

2. The PPE Specialist will prepare a Summary Health Report and submit it to the ASC Medical Director. The Summary Health Report shall be included in the credentials file and reviewed by the ASC Medical Director and the ASC MEC subject to any conditions on the review of health information set forth in the Medical Staff Bylaws.

3. The ASC MEC's Summary Health Report will state that it is actively monitoring, or has monitored in the past reappointment cycle, a Health Issue involving the Practitioner or APP. It will not contain details or specifics regarding the Health Issue. The Summary Health Report will also include a recommendation regarding the Practitioner's or APP's ability to perform the duties of Medical Staff membership and safely exercise clinical privileges. A Sample Summary Health Report for Use at Reappointment is included in the Practitioner/APP Health Manual.

XII. ADDITIONAL PROVISIONS GOVERNING THE REVIEW OF HEALTH ISSUES

A. Confidentiality: Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process

1. Documentation: All documentation that is prepared in accordance with this Policy shall be maintained in the Practitioner's or APP's Confidential Health File. All documents will be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under state or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged. Access to the Confidential Health File for recredentialing purposes is governed by Section XII of this Policy. Any other request to manner shall not be viewed as an indication that the document is not privileged. Access to the Confidential Health File for recredentialing purposes is governed by Section XI of this Policy. Any other request to access the Confidential Health File must be approved by the ASC MEC.

2. Verbal Communications: Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality.

3. E-Mail: Harris Health or other secure institutional e-mail may be used to communicate between individuals participating in the health review process, including with the Practitioner or APP in question. All e- mails should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line. E-mail should not be sent to personal e-mail accounts unless the e-mail merely directs recipients to check their Harris Health or other institutional secure e-mail.

4. Participants in the Review Process: All individuals involved in the review process will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

B. Health Issues Identified During Credentialing Process: A Health Issue that is identified during the credentialing process shall be addressed pursuant to the Medical Staff Bylaws. If a determination is made by the ASC MEC that the involving the Practitioner or APP is qualified for appointment and privileges, but has a Health Issue that should be monitored or treated, the matter shall undergo ongoing monitoring or oversight of treatment pursuant to this Policy.

C. Immediate Referrals for Review Pursuant to the Medical Staff Bylaws: Nothing in this Policy precludes the elimination of any particular step in the Policy if necessary to effectively address a Practitioner or APP Health Issue. Similarly, nothing in this Policy precludes referral of a matter to review pursuant to the Medical Staff Bylaws if a Practitioner or APP fails to abide by this Policy or any agreement reached with the ASC MEC.

D. No Legal Counsel or Recordings During Collegial Meetings: To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner or APP shall generally involve only the Practitioner or APP and the appropriate Medical Staff Leaders and ASC personnel. No counsel representing the Practitioner or APP or the Medical Staff or the ASC shall attend any of these meetings. In their discretion, the ASC Medical Director may permit a Practitioner or APP to invite another Practitioner or APP to the meeting. In such case, the invited Practitioner or APP may not participate in the discussion or in any way serve as an advocate for the Practitioner or APP under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

1. Practitioners or APPs may not create an audio or video recording of a meeting. If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, the ASC Medical Director may require that smart phones, tablets, and similar devices be left outside the meeting room. In exceptional circumstances, the ASC Medical Director or ASC personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

E. Identity of Individual Who Reports a Health Issue

1. General Rule: Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of an individual reporting a concern or otherwise providing information about a matter generally will not be disclosed to the Practitioner or APP.

2. Exceptions:

a) Consent: The ASC MEC may, in its discretion, disclose the identity of the reporter to the Practitioner or APP if the reporter specifically consents to the disclosure with the reporter being reassured that he or she will be protected from retaliation.

b) ASC Medical Staff Hearing: The identity of the reporter shall be disclosed to the Practitioner or APP if information provided by the reporter is used to support an adverse professional review action that results in an ASC Medical Staff hearing.

3. Practitioner or APP Guessing the Identity of Reporter: This section does not prohibit the ASC MEC from notifying a Practitioner or APP about a Health Issue concern that has been raised even if the description of the concern would allow the Practitioner or APP to guess the identity of the reporter. In such case, the ASC Medical Director or ASC MEC will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner or APP to avoid any action that could be perceived as retaliation.

F. Supervising Physicians and Advanced Practice Professionals: Except as set forth below, a physician who has a supervisory or collaborative relationship with an Advanced Practice Professional for state licensure purposes shall be notified if a concern is being reviewed pursuant to this Policy involving the Advanced Practice Professional. The disclosure to the supervising or collaborating physician will be limited to a general statement that a Health Issue is currently being reviewed and that additional information will be forthcoming once the Advanced Practice Professional has signed an appropriate authorization. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy and may be required to sign a Confidentiality Agreement. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

G. Redisclosure of Drug/Alcohol Treatment Information: In the course of addressing a Health Issue pursuant to this Policy, the ASC may receive written or verbal information about the treatment of a Practitioner or APP from a federally-assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The ASC may not re-disclose such information without a signed authorization from the Practitioner or APP. An Authorization for Re-Disclosure of Drug/Alcohol Treatment Information that may be used for this purpose is included in the Practitioner/APP Health Manual.

H. Educational Materials: The ASC MEC shall recommend educational materials that address Practitioner/APP Health Issues and emphasize prevention, identification, diagnosis, and treatment of Health Issues. This Policy and any educational materials approved by the ASC MEC shall be made available to Practitioners, APPs, and ASC personnel.

I. Delegation of Functions: The ASC MEC is responsible for the health/quality assurance process described in this Policy, subject to the oversight of the ASC Governing Body. To promote a prompt and effective review process, the ASC Medical Director and ASC MEC may expressly delegates to the PPE Specialists the authority to perform the functions described in this Policy on behalf of the ASC Medical Director and MEC. Actions taken by these individuals will be reported to and reviewed by the ASC Medical Director and MEC as set forth in this Policy.

1. When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of ASC leadership, by an ASC Medical Staff member, or by an ASC Medical Executive Committee, or the individual, may delegate performance of the function to a qualified designee who is a Practitioner, APP, or ASC employee. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

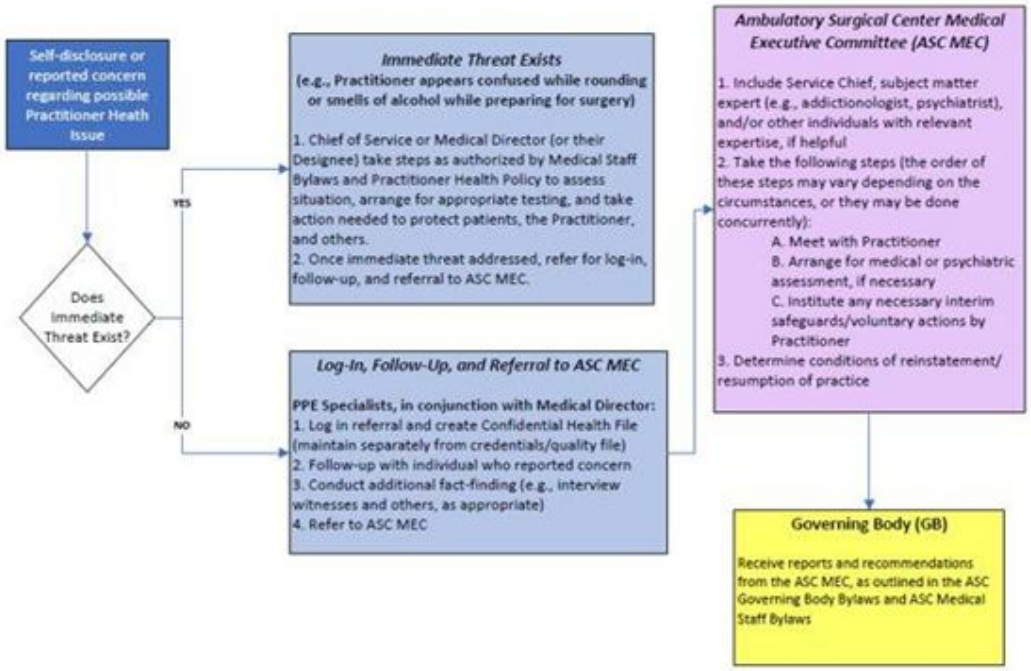
J. Practitioner/APP Health Manual: The ASC MEC shall approve forms, checklists, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Practitioner/APP Health Manual. Such documents shall be developed and maintained by the PPE Specialists as delegated by the ASC Medical Director. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary.

K. Substantial Compliance: While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

L. Reports to the ASC Governing Body: The ASC MEC shall prepare reports at least annually that provide de-identified information regarding the review of Health Issues as set forth in this Policy. These reports should be disseminated to the Governing Body for the purposes of reinforcing the primary objectives outlined in Section I of this Policy and permitting appropriate oversight. A sample Summary Report for Practitioner/APP Health Issue Review Activities to Be Provided to Governing Body is included in the Practitioner/APP Health Manual.

HARRIS HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

APPENDIX A: REVIEW PROCESS FOR PRACTITIONER HEALTH ISSUES



APPENDIX B – EXAMPLES OF HEALTH ISSUES

A Health Issue is any physical, mental, or emotional condition that could adversely affect a Practitioner's or APP's ability to practice safely and competently. Examples of Health Issues include, but are not limited to, the following:

1. Substance or alcohol abuse;

2. Use of any medication, whether prescription or over-the-counter, that can affect alertness, judgment, or cognitive function (such as, but not limited to, the use of pain or anti-anxiety medication);

3. Any temporary or ongoing mental health concern, including, but not limited to, bipolar disorders or disorders caused by a major family event (e.g., death of spouse or child, divorce) or a major job-related event (e.g., death or significant injury to patient);

4. Carotid, vertebral, or other brain surgery or intervention;

5. Chemotherapy with a drug known to effect neurotoxicity (brain) or to have cardiac or neurotoxicity (peripheral nerves);

6. Radiation therapy to head;

7. Medical condition (e.g., stroke or Parkinson's disease), injury, or surgery resulting in temporary or permanent loss of fine motor control or sensory loss;

8. Shoulder surgery, brachial plexus surgery, hand or carpal tunnel surgery for a surgeon;

9. A back injury impacting ability to stand in the Operating Room or other procedure lab;

10. Major surgery;

11. Infectious/contagious disease that could compromise patient safety or jeopardize other health care workers; and

12. Any cognitive impairment or diagnosed dementia (e.g., Alzheimer's disease, Lewy body dementia).

The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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

TITLE: **INITIAL PERFORMANCE DATA REVIEW AND ANNUAL PERFORMANCE PEER REVIEW**

PURPOSE: The Ambulatory Surgical Center (ASC) at LBJ is committed to providing safe, quality care and as such all Practitioners/Physicians and Advanced Practice Professionals (APP) who are granted clinical privileges at the Ambulatory Surgical Center (ASC) at LBJ are subject to initial performance data review (IPDR) and annual performance peer review (APPR) to validate clinical competence.

POLICY STATEMENT:

All Practitioners and APPs who are granted new clinical privileges at the Ambulatory Surgical Center (ASC) at LBJ are subject to IPDR and APPR. Practitioner's and APP's at the ASC will be asked to submit clinical competence validation in order to continue to exercise the clinical privileges that have been granted to them. Additionally, the process allows validation of professionalism, which includes the ability to work with others in a professional manner that promotes quality and safety; and the ability to satisfy all other responsibilities of Practitioners and APP's who are granted clinical privileges at the ASC. The process also validates continued clinical competence and professionalism through annual review by similarly privileged and/or similarly licensed peers as required by the Accreditation Association for Ambulatory Health Care (AAAHC) Standard 2.III.A.

POLICY ELABORATIONS:

I. DEFINITIONS:

1. **ANNUAL PERFORMANCE PEER REVIEW (APPR):** Annual clinical competence and professionalism review of a Practitioner/Physician by a similarly privileged and/or similarly licensed peer. A flowchart that depicts the IPDR process to confirm competence and professionalism is attached as Appendix A.

2. **INITIAL PERFORMANCE DATA REVIEW (IPDR):** A limited period during which a Practitioner/Physician's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment,

shall be subject to IPPR. A flowchart that depicts the IPDR process to confirm competence and professionalism is attached as Appendix A.

3. **PROFESSIONAL PRACTICE EVALUATION SPECIALISTS (PPE):** The clinical and non-clinical staff who support the professional practice evaluation (PPE) process and the IPDR process described in this Policy as designated by the ASC Medical Director.

II. IPDR AND APPR CLINICAL ACTIVITY REQUIREMENTS:

A. Development of Clinical Activity Requirements:

1. Each Surgical Service, or its subdivisions, as applicable, will determine the following IPDR clinical activity requirements:

a) For New Practitioners and APPs:

i. The number and types of procedures or cases that will be reviewed to confirm a new Practitioner's or APP's competence to exercise the core and special privileges in his or her specialty;
ii. How those reviews are to be documented; and
iii. The expected time frame in which the evaluation will be completed.

B. For Practitioners and APPs with Existing Clinical Privileges who are Requesting New Privileges:

1. The number and types of procedures or cases that must be reviewed to confirm a Practitioner's or APP's competence to exercise a new privilege that is granted during a term of appointment or at reappointment;

2. How the reviews are documented; and

3. The expected time frame in which the review will be completed.

C. For Practitioners and APPs with Existing Clinical Privileges Who Require Annual Performance Peer Review:

1. The number and types of procedures or cases that must be reviewed to evaluate a Practitioner's or APP's continued competence to exercise the core and special privileges in his or her specialty;

2. How the reviews are documented; and

3. The expected time frame in which the review will be completed.

D. In developing such determinations, the ASC, as applicable, should attempt to identify index procedures or cases that will demonstrate a Practitioner's or APP's competence to perform a bundle of privileges. The ASC Medical Executive Committee (MEC) may modify the IPDR requirements for a particular applicant if the applicant's credentials indicate that additional or different IPDR may be required.

E. Gathering IPDR and APPR Data:

1. Mechanism for IPDR and APPR Review:

a) Data to be reviewed: The IPDR clinical activity requirements will utilize at least one of the following review mechanisms to confirm competence:

i. Retrospective chart review by internal or external reviewers selected by the ASC Medical Director or designee;
ii. Concurrent proctoring of procedures or patient care practices; and/or
iii. Discussion with individuals involved in the care of the Practitioner's or APP's patients or who have observed the Practitioner during patient care activities.
iv. Review of available data from ASC-P-4016, other quality data, and concerns about professionalism may also be used to confirm competence.

b) Selection of Cases: The ASC Medical Director or designee will select the specific cases to be evaluated and the individuals who will be asked to provide information about the Practitioner or APP with the goal of being an effective and fair review process. The cases should be selected randomly or in a deliberate manner that ensures a representative sample is reviewed. Generally, IPDR should not be conducted on the first cases because of the possible selection bias that may result. Practitioners or APPs shall notify the ASC Medical Director or designee when cases subject to review are scheduled or have been completed.

c) Cooperation of Practitioner and/or APP: As a condition of Medical Staff appointment and clinical privileges, Practitioners and APPs are required to cooperate with the data gathering outlined in this Policy.

2. IPDR and APPR Reviewers: Practitioners and APPs who have completed the IPDR process described in this Policy and who hold applicable clinical privileges are obliged to provide a reasonable amount of service as an IPDR and APPR Reviewer through chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Reviewers will be assigned by the ASC Medical Director. If no qualified Practitioners or APPs are available, the ASC Medical Director shall consult with the ASC Medical Executive Committee regarding the need for an external review. IPDR and APPR Reviewers act on behalf of, and their work product is a record of, the ASC Medical Executive Committee.

3. Partners as IPDR and APPR Reviewers: Consistent with the conflict-of-interest guidelines set forth in the Professional Practice Evaluation Policy (ASC-P-4014), partners and other individuals who are affiliated in practice with a Practitioner or APP may serve as IPDR and APPR reviewers and conduct chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Such individuals shall comply with the standard procedures that apply to all other individuals who serve as IPDR and APPR reviewers, such as the use of ASC forms and the requirements related to confidentiality.

F. IPDR for Professionalism: In addition to assessing clinical competence, the IPDR process for new Practitioners and APPs will also assess the Practitioner's or APP's professionalism based on the following criteria:

1. Cooperation with the IPDR clinical activity requirements for the Practitioner's or APP's specialty and the monitoring process described in this Policy;

2. Compliance with the Medical Staff Professionalism Policy (ASC-P-4015), including appropriate interactions with ASC workforce members, Practitioner and/or APP colleagues, and patients and their families;

3. Compliance with medical record documentation requirements, including those related to use of the Electronic Health Record (EHR);

4. Completion of orientation and annual ASC requirements; and

5. Compliance with protocols that have been adopted by the ASC Medical Executive Committee.

The ASC Medical Executive Committee may recommend that these criteria for professionalism be modified or expanded, with such modifications or expansions being reviewed and approved by the ASC Medical Executive Committee.

G. Notice of IPDR Requirements: When notified that a request for privileges has been granted, Practitioners and APPs shall be informed of the relevant IPDR clinical activity requirements and of their responsibility to cooperate in satisfying those requirements. New applicants will also be informed that the IPDR process will be used to assess their professionalism, as described above. An Initial Appointment Letter and a Reappointment Letter which inform Practitioners and APPs of their IPDR requirements are included in the IPDR Manual.

H. Review of IPDR and APPR Results:

1. Review by PPE Specialist: Information gathered for purposes of IPDR/APPR shall be reported to the PPE Specialist, who shall compile the information and prepare it for subsequent review as set forth in this Policy.

a) If any information gathered for IPDR/APPR suggests that a concern may exist that requires expedited review, the IPDR/APPR Reviewer and/or the PPE Specialist shall notify the ASC Medical Director, who shall determine whether the concern should be referred for processing under the Professional Practice Evaluation Policy (ASC-P-4014), the Medical Staff Professionalism Policy (ASC-P-4015) or the ASC Medical Staff Bylaws.

b) The PPE Specialists shall determine whether a Practitioner's or APP's cases or activities have been reviewed pursuant to the Professional Practice Evaluation Policy or the Medical Staff Professionalism Policy. If so, a summary of these matters shall be included with the Practitioner's IPDR results.

2. Review by the ASC Medical Director: At the conclusion of the expected time frame for completion of the IPDR or APPR, the ASC Medical Director shall review the results of a Practitioner's or APP's IPDR and/or APPR and provide a report to the ASC Medical Executive Committee. As noted in this Policy, the ASC Medical Director may assign a designee to perform these functions. The report shall address:

a) The Practitioner or APP fulfilled the clinical activity requirements;

b) The results of the IPDR confirmed the Practitioner's or APP's clinical competence;

c) The results of the IPDR confirmed the Practitioner's or APP's professionalism;

d) Additional IPDR is required to make an appropriate determination regarding clinical competence and/or professionalism; and/or

e) The results of the APPR confirmed the Practitioner's or APP's continued clinical competence.

The IPDR and APPR Review Forms will be used to document the review by the ASC Medical Director. The ASC Medical Director may engage in initial mentoring efforts with a Practitioner or APP where the IPDR/APPR results indicate that competence and professionalism are

confirmed, but where there is an opportunity for the Practitioner or APP to improve upon an aspect of their clinical care or citizenship responsibilities.

3. Review by ASC Medical Executive Committee: Based on the assessment and report by the ASC Medical Director, review of the IPDR and APPR results, and all other relevant information, the ASC Medical Executive Committee will make one of the following determinations and notify the Practitioner.

   a) Competence and Professionalism are Confirmed: The IPDR and APPR process has confirmed clinical competence and professionalism for all clinical privileges and no further review is necessary.

   b) Questions or Concerns Exist:

      i. Extend IPDR Due to Questions: Some questions exist and additional IPDR is needed to confirm clinical competence and/or professionalism with respect to some or all clinical privileges. In such case(s), the ASC Medical Executive Committee will identify what additional IPDR is needed and the time frame necessary.

      ii. Conclude IPDR/APPR, but Use Collegial Counseling or Voluntary Enhancement Plan: Concerns exist about the Practitioner's or APP's competence to exercise some or all of the clinical privileges granted or the Practitioner's or APP's professionalism. In such case, the ASC Medical Executive Committee will identify the details of the Collegial Counseling or the Voluntary Enhancement Plan that should be pursued with the Practitioner or APP in order to adequately address the concerns. Prior to making such a determination, the ASC Medical Executive Committee will obtain the input of the Practitioner as set forth in Section I of this Policy.

      iii. Recommendations to the Governing Body: If more significant concerns exist about a Practitioner or APP, the Governing Body shall receive reports and

recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

4. Low Volume Practitioners:

a) Extend IPDR Due to Inactivity: The time period for IPDR will be extended for up to six months because the individual did not fulfill the IPDR clinical activity requirements for some or all clinical privileges, thus preventing an adequate assessment of the individual's clinical competence or professionalism. The time frame for initial IPDR will generally not extend beyond 12 total months after the initial granting of privileges.

b) Automatic Relinquishment of Certain Privileges Due to Inactivity: The individual shall automatically relinquish specific clinical privileges for which the individual failed to meet the applicable requirements per the ASC Medical Staff Bylaws.

c) Grant Exception to Certain Low Volume Practitioners and APPs: The ASC Medical Executive Committee may determine that a low volume Practitioner or APP will be permitted to maintain appointment and clinical privileges beyond the initial IPDR period based on the limited availability of needed services in a specialty area, coverage requirements, the rare nature of a given procedure or treatment, or other relevant factors. In these circumstances, the Practitioner's or APP's competence and professionalism will be confirmed as follows:

i. Completion of the initial IPDR requirements over the duration of the Practitioner's or APP's three-year appointment term and/or reliance on the ongoing clinical and professionalism review processes that are conducted for all Practitioners and APPs; and

ii. Review of any supplemental performance data regarding the Practitioner or that may be obtained from other entities where the Practitioner or APP maintains a more active practice.

iii. The ASC Medical Executive Committee may decide that IPDR has been completed with respect to certain clinical privileges while additional action will be taken with respect to other clinical privileges. Letters that can be used to inform the Practitioner or APP of the decision of the ASC Medical Executive Committee are included in the IPDR Manual.

5. Governing Body: The Governing Body shall receive reports and recommendations from the ASC MEC, as outlined in the ASC Governing Body Bylaws and ASC Medical Staff Bylaws.

6. Input by Practitioner or APP:

a) General: When concerns have been raised about the Practitioner or APP or other information is required, the Practitioner or APP shall be provided notice of the issue and shall respond in writing. Upon the request of either the Practitioner or APP or the committee conducting the review, the Practitioner or APP may also provide input by meeting with appropriate individuals to discuss the issues.

b) The committee requesting input may also ask the Practitioner or APP to provide a copy of records from the Practitioner or APP that are relevant to a review being conducted under this Policy. Failure to provide such copies will be viewed as a failure to provide requested input. Any records obtained from the Practitioner or APP pursuant to this section will be maintained as part of the confidential PPE/peer review file.

7. Decision Not an Adverse Action: A decision that a Practitioner or APP will automatically relinquish his or her clinical privileges for failure to satisfy clinical activity requirements is not an adverse action that must be reported to the National Practitioner Data Bank or any state licensing board.

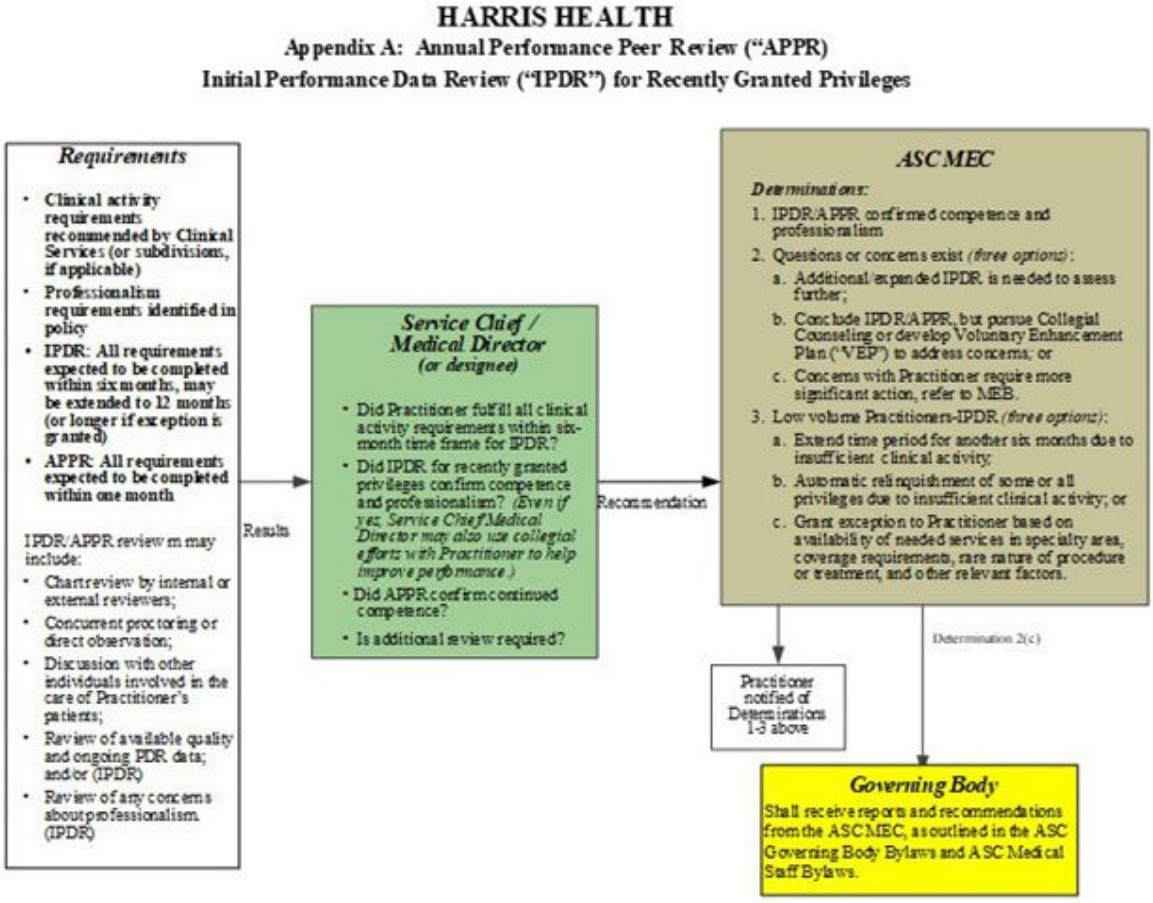
8. Future Application for Privileges: A Practitioner or APP who automatically relinquishes certain privileges will be ineligible to apply for the clinical privileges in question for two years from the date of automatic relinquishment.

I. Delegation of Functions: The Medical Director and ASC Medical Executive Committee are responsible for the IPDR/quality assurance process described in this Policy, subject to the oversight of the Governing Body. To promote a prompt and effective review process, the ASC Medical Executive Committee may delegate to the PPE Specialist or other ASC workforce members, the authority to perform the functions described in this Policy on behalf of the ASC Medical Director and Medical Executive Committee. Actions taken by these individuals will be reported to and reviewed by the ASC Medical Executive Committee as set forth in this Policy.

1. When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, they may delegate performance of the function to a qualified designee who is a Practitioner or APP credentialed to practice at the ASC or is bound by the Service Level Agreement. Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. When an individual assigned a function under this Policy is unavailable or unable to perform that function, they may delegate it to another appropriate individual as set forth above.

APPENDIX A – Annual Performance Peer Review Initial Performance Data Review for Recently Granted Privileges



The Ambulatory Surgical Center (ASC) at LBJ

REVIEW/REVISION HISTORY:

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

HARRISHEALTH
AMBULATORY SURGICAL CENTER AT LBJ

The Ambulatory Surgical Center at LBJ

WORKPLACE SAFETY AND VIOLENCE REDUCTION PLAN

June 2024

I. INTRODUCTION:

The Occupational Safety and Health Administration (OSHA) has made a determination that Healthcare workers face an increased risk of work-related assaults resulting primarily from violent behaviors of their patients. The National Institute for Occupational Safety and Health (NIOSH) lists three groups of risk factors that lead to violence in healthcare: clinical, environmental, and organizational. The Ambulatory Surgical Center (ASC) at LBJ Workplace Safety and Violence Prevention Plan (Plan) addresses these factors and describes the parameters within which a safe environment of care is established, maintained, and improved. The elements listed within the plan are directed toward managing the activities of the employees in order to reduce the risk of injuries to patients, visitors, and the workforce and to help employees respond appropriately after incidents of workplace violence.

The following workplace safety and violence prevention plan has been developed to protect health care providers and employees from violent behavior and threats of violent behavior that may occur within the facility. This Plan conforms to requirements set forth in Section 331.004 of the Texas Health and Safety Code.

II. PURPOSE:

A. The purpose of the Plan is to mitigate obstacles impacting the ability of the organization to provide a safe environment for the ASC's patients, visitors, and workforce.

B. This occurs through:
   1. Annual workplace violence prevention education;
   2. Standardized system for responding to and investigating violent or potentially violent incidents;
   3. Environmental Assessment; and
   4. Review and evaluation of current workplace safety processes.

III. WORKPLACE VIOLENCE:

A. The definition of Workplace Violence utilized within the ASC is in alignment with Texas Health and Safety Code §331.004 and includes the following:

1. An act or threat of physical force against a health care provider or employee that results in, or is likely to result in, physical injury or psychological trauma; and

2. An incident involving the use of a firearm or other dangerous weapon, regardless of whether a health care provider or employee is injured by the weapon.

B. Training/Education

1. Workplace safety education begins with the new employee orientation program for all new employees. Employees entering areas in which they may encounter patients with behavioral issues are required to take an additional course related to workplace violence prevention techniques.

2. The ASC provides annual workplace violence prevention education within the annual required training or education provided to the facility's health care providers and employees who provide direct patient care. Educational opportunities are provided in the event of modification to workplace safety processes or introduction of new equipment.

3. Satori Alternatives to Managing Aggression (SAMA) training is provided to all nursing who are at an increased risk of caring for aggressive patients.

C. Incident Reporting and Investigations

1. Facility health care providers and employees who witnesses or experience a workplace violence incident shall immediately report the incident following the guidelines set forth in ASC-P-4004 and Harris Health System Policy 6.27 Workplace Violence Prevention.

2. All incidents of workplace violence shall be documented in the Electronic Incident Reporting System (eIRS) or documented using downtime forms when the eIRS is not available.

3. Incidents of workplace violence shall be investigated timely by the ASC.

D. Post-Incident Responsibilities

1. It is the responsibility of the ASC to consider adjusting patient care assignments following an occurrence of workplace violence. This may prevent a health care provider or employee of the ASC from treating or providing services to a patient whom has physically abused or threatened them.

2. ASC supervisors are encouraged to refer employees who exhibit job stress or anger management or who may be a victim of workplace violence to the Employee Assistance Program. ASC supervisors may request assistance, when necessary, from Harris Health's Department of Public Safety and/or Harris Health's Human Resources Department when workplace violence issues arise.

3. The ASC's health care providers and/or employees are empowered to pursue criminal charges via the responding law-enforcement agency.

4. Patients identified as disruptive will be flagged in Epic according to applicable policies.

E. Environmental Safety

1. Patients who are at increased risk of harming themselves or others have their environment assessed routinely for environmental hazards including ligature risks.

2. Supervisors are to assess the ASC's workspace to ensure that safety measures and equipment are functioning appropriately.

F. Management of Disruptive Patients and Visitor Behavior

1. The ASC has a zero-tolerance stance against workplace violence including verbal and physical acts of violence. The ASC takes threats seriously and shall take action as appropriate to assure the safety of facility health care providers, employees and patients.

2. The zero-tolerance policy is indicated with signage and patient education.

3. Security shall be contacted for any anticipated disruptive behavior.

IV. WORKPLACE SAFETY AND VIOLENCE PREVENTION COMMITTEE:

A. The ASC will partner with the Harris Health Workplace Safety and Violence Prevention Committee (Committee). The Committee is comprised of security, nursing, providers, and ancillary personnel. This interdisciplinary group meets monthly and operates as a subcommittee to Harris Health System Workplace Safety and Violence Prevention Committee. The objectives of the committee are:

1. Regularly assess workplace violence prevention processes and alignment with policy;

2. Assess and improve prevention strategies to decrease workplace violence by workforce members, patients, families, or visitors;

3. Establish processes to provide education and support learning from events to inform practice changes; and

4. Solicit information when developing and implementing this Workplace Safety and Violence Prevention Plan.

V. REFERENCES/BIBLIOGRAPHY:

Harris Health System Policies and Procedures 6.27 Workplace Violence Prevention

Harris Health System Policies and Procedures 3.63 Incident Reporting and Response

Harris Health System Policy 464 Suicide/Homicide Screening, Assessment and Intervention

Harris Health System Code of Conduct

Texas Health and Safety Code § 331.004.

VI. REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers, and Stakeholders etc.)

BOARD OF TRUSTEES

HARRISHEALTH SYSTEM

Ambulatory Surgical Center at LBJ Governing Body

Thursday, August 22, 2024

Consideration of Approval of Amended Policies and Procedures for the ASC at LBJ

The amended policies listed below are attached for your review.

1. ASC-P-1003: Medication Administration
2. 2024-2025 Infection Control Program

TITLE: MEDICATION ADMINISTRATION

PURPOSE: To establish guidelines for the safe and accurate administration of medications to patients at the Ambulatory Surgical Center (ASC) at LBJ.

POLICY STATEMENT:

It is the policy of the Ambulatory Surgical Center (ASC) at LBJ, through the implementation of the measures outlined below, to ensure the accuracy of medication administration and the safety of patients.

POLICY ELABORATIONS:

I. DEFINITIONS:

A. **ADMINISTRATION SYSTEMS**: Commercial products for the preparation of IV products within a single, closed system prior to administration to a patient (i.e., 'Adapt-a-vial' and 'Add-a-vial').

B. **AUTOMATED DISPENSING CABINET (ADC)**: An automated medication supply system (e.g., Pyxis Med Station or Anesthesia Station) used for storage and record keeping of medication.

C. **COMPOUND STERILE PREPARATION (CSP)**: A dose of a medication or nutrient prescribed for a specific patient that must be prepared for administration in a sterile environment. CSP involves specific calculation of doses and multiple transfers of product outside of original containers. "Ready to Use" commercial products, commercial administration systems, and preparation of a single medication for administration via IV push shall not be considered a CSP.

D. **ELECTRONIC MEDICATION ADMINISTRATION RECORD (EMAR)**: A point-of-care process utilizing barcode reading technology to monitor and document beside medication administration.

E. **INTRAVENOUS (IV) PUSH**: The delivery of a small volume of medication directly into the venous circulation via syringe.

F. **MEDICATION ADMINISTRATION RECORD (MAR)**: The printed and/or paper version of the eMAR.

G. **QUALIFIED LICENSED PERSONNEL (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.

H. **READY TO USE PREPARATION**: Pre-packaged IV mixtures prepared by a commercial vendor and ready for administration to a patient.

I. **SECURITY OF MEDICATIONS**: For the purposes of this policy, security of the storage area for medications is defined as "under the constant surveillance of authorized users or secured within a locked device, cabinet, or room where only authorized personnel have access."

J. **STANDARD CONCENTRATION**: The accepted "normal" amount of medication to be added to a specific volume of solution.

II. GENERAL PROCEDURES:

A. *Orders for Medication:*

1. All medications and biologics given to patients of the ASC must be approved by a physician with a signed order.
2. Physician orders given verbally for drugs and biologics must be followed by a written order signed by the prescribing physician.

    a) The registered nurse or QLP that receives a verbal order from a physician must repeat the order back to the prescribing physician and the prescribing physician must verify that the order is correct.
    b) When administering a medication pursuant to a verbal order, it must be documented in the patient's medical record that the medication was administered pursuant to a verbal order and must document the name of the prescribing physician.

3. Only a physician, registered nurse, or other QLP may administer the medication to the patient.

B. *Disposal of Medication:*

Medications from containers with illegible labels or drugs that have changed color, consistency or are outdated shall be returned to the ASC Pharmacy for disposal in accordance with the ASC's policy on the *Disposal of Outdated Medication*.

C. *Medications in the ADC:*

1. All medications and biologicals must be current, dated, and refrigerated when necessary. All medication refrigerators will be monitored for proper temperature.
2. The "override" function of the ADC shall be used to access doses when the benefit to the patient receiving the medication is greater than the risk of the pharmacist not reviewing the order prior to administration (i.e., sudden and severe change in the clinical status of the patient).

D. *Medication Administration:*

1. Medications shall be administered utilizing the "eight right" of medication administration.
2. The "eight right" of medication administration includes the following:

    a) Right drug;
    b) Right dose;
    c) Right route;
    d) Right time;
    e) Right patient;
    f) Right reason;
    g) Right documentation; and
    h) Right assessment for administration and response to medication.

3. Medications administrated contrary to any of the first five "rights" shall be documented exactly as administered to the patient and entered into the Harris Health System Electronic Incident Reporting System.
4. Medications not given, refused, or given off schedule shall be documented in the MAR.
5. No medication shall be left at a patient's bedside unless written by a physician.
6. Patients of the ASC are not allowed to self-administer medications.

E. *Medication Labeling:*

1. All medications and biologicals not immediately administered and removed from the original container or packaging are labeled in a standard format in accordance with law, regulation, and standards of practice.
2. The Label must include:
    a) Medication/biological name;
    b) Medication/biological strength;
    c) Amount or volume if not apparent from the container or packaging;
    d) Expiration date a time; and
    e) The name or initials of the person transferring the drug.

III. PROCEDURE FOR MEDICATION ADMINISTRATION:

A. Physicians, registered nurses, or other QLPs, shall administer medication according to the following procedure:

1. *Operating Room:*

    a) The surgeon prepares a written order prior to surgery of the medications that he or she needs for surgery.
    b) A registered nurse obtains the medication from the ADC and/or pharmacy and administers the medication to the patient pursuant to the surgeon's written order.

2. *Pre-Op:*

    a) Written Orders: The surgeon or anesthesiologist writes an order prior to admission to the ASC. A registered nurse or QLP obtains the medication from the ADC and administers the medication to the patient.
    b) Verbal Orders: The surgeon or anesthesiologist gives a verbal order to a registered nurse or QLP for a medication. The registered nurse or QLP verifies the verbal order by repeating it back and verified to the physician or surgeon. After verification of the verbal order, the

registered nurse or QLP obtains the medication from the ADC and administers the medication to the patient. The Registered Nurse or QLP receiving the verbal order documents the order in the patient's medical record.

3. *Post Anesthesia Recovery Unit:*

The Anesthesiologist provides written orders for any medications administered in the Post Anesthesia Recovery Unit.

IV. STANDARD ADMINISTRATION TIMES:

A. Medication administration times are followed in accordance with the standards set forth by the Association of Perioperative Registered Nurses (AORN).

B. Standard administration times are followed to provide consistency for medication administration schedules with consideration of pharmacological characteristics of certain medications, and patient convenience unless otherwise noted by the physician entering the order in the patient's medical record.

V. MEDICATION STANDARD CONCENTRATIONS:

A. The ASC Pharmacy does not dispense IV CSP medications.

B. For medication orders with non-standard concentrations, the ASC pharmacy will contact the physician prior to the surgery in order to clarify the order and recommend an appropriate standard concentration.

C. The ASC pharmacy will use ready to use preparations from commercial vendors.

REFERENCES/BIBLIOGRAPHY:

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

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:
9/16/16	1.0	9/16/16	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed/ Approved 3/29/18	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) at LBJ Governing Body
		Reviewed / 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
		Revised / Approved 02/16/2023	The Ambulatory Surgical Center (ASC) at LBJ Governing Body
		Reviewed / Approved 02/22/2024	The Ambulatory Surgical Center (ASC) Governing Body

ASC at LBJ
Infection Control Program
2024~~2~~-2025~~3~~

I. INTRODUCTION

A. Program Description

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

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

B. Program Principles and Goals

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

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

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

II. PROCEDURE

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

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

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

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

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

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

III. PROJECTS

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

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

C. Adenosine TriPhosphate (ATP) Monitoring
1. Test the operating room suites, pre-operative bays, and post-operative bays
2. Results will be maintained at a 95% pass rate each quarter