# HENDRICK MEDICAL CENTER
# BROWNWOOD

# MEDICAL STAFF
# ORGANIZATION MANUAL

***Effective June 5, 2025***

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# ARTICLE 1

# GENERAL

## 1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials & Procedures Policy.

## 1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Administrative Leadership, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Physician or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws Documents. 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 who is assigned a function under this Manual is unavailable or unable to perform that function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

## 1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Manual, technical or minor deviations from the procedures set forth within this Manual will not invalidate any review or action taken.

ARTICLE 2

CLINICAL DEPARTMENTS

## 2.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments will be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors will be considered in determining whether a clinical department should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in this Manual and in the bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) it has been determined by the Medical Staff leadership and the CAO that there is a clinical and administrative need for a new department; and

(e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors will be considered in determining whether the dissolution of a clinical department is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in this Manual or in the bylaws;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

(c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department; or

(e) a majority of the voting members of the department vote for its dissolution.

## 2.B. LIST OF CLINICAL DEPARTMENTS

The following clinical departments are established:

- Department of Medicine
- Department of Surgery

## 2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and Department Chairs are set forth in the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

## 3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other individuals (e.g., other Medical Staff members, Advanced Practice Providers, Hospital personnel, legal counsel, employer representatives, etc.) may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

## 3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

## 3.C. MEETINGS, REPORTS AND RECOMMENDATIONS

(1) Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions, and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make reports to the MEC and to other committees and individuals as may be indicated in this Manual.

(2) Between meetings of a committee, the Chair, in conjunction with the CMO or another committee member, may take steps as necessary to implement and operationalize the decisions of the committee. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding a committee's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

## 3.D. CREDENTIALS/BYLAWS COMMITTEE

### 3.D.1. Composition:

The Credentials/Bylaws Committee shall consist of at least five physician members of the Active Staff appointed by the Chief of Staff with one of the members designated as the Chair.

### 3.D.2. Duties:

The duties of the Credentials/Bylaws Committee shall be to develop and maintain an unbiased system to:

(a) review and evaluate the qualifications, competence, and performance of each applicant for initial appointment, reappointment or modification of appointment and for clinical privileges and make appropriate recommendations to the MEC and the Board in accordance with the Credentials Policy;

(b) review and report on matters, including the clinical or ethical conduct of any Practitioner assigned or referred to it by the MEC; and

(c) review, as needed but at least annually, the Medical Staff Bylaws and Rules and Regulations, and submit recommendations to the MEC for changes in these documents. The Committee will review, as needed, but at least every three years, the Medical Staff Policies, and submit recommendations to the MEC for changes in these documents. **(Revision approved by the BOT on 8/16/2017)**

### 3.D.3. Meetings:

The committee shall meet at least bi-monthly and maintain a permanent record of its proceedings and actions.

## 3.E. ETHICS COMMITTEE

### 3.E.1. Composition:

The Ethics Committee shall be composed of members appointed jointly by the Chief of Staff and the CAO and shall include appropriate non-physician members.

### 3.E.2. Duties:

The duties of the Ethics Committee shall be to provide guidance, evaluation, or consultation regarding ethical issues surrounding patient care such as end-of-life issues, pain management, etc.

3.E.3. Meetings:

The committee shall meet at least annually and maintain a permanent record of its proceedings and actions.

3.F. PROFESSIONAL REVIEW COMMITTEE

3.F.1. Composition:

(a) The Professional Review Committees ("PRC") for Surgery and Medicine will consist of the following voting members:

(1) the Chair of the Department;

(2) the Vice Chair of the Department; and

(3) three At-Large members, appointed by the Chair of the Department and Chief of Staff.

(b) The following individuals will serve as non-voting members to facilitate the PRC's activities:

(1) CMO; and

(2) a representative(s) from Medical Staff Services.

3.F.2. Duties:

The PRC is a non-disciplinary body, whose primary charge is to attempt to resolve the clinical performance issues referred to it in a constructive and successful manner. The PRC makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The PRC will perform the following specific functions:

(a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

(d) identify variances from rules, regulations, policies, or protocols which do not require physician review, but for which an informational letter may be sent to the Practitioner involved in the case;

(e) review cases referred to it and perform such other functions as outlined in the PPE Policy;

(f) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

(g) work with Medical Staff Leaders to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy; and

(h) perform any additional functions as may be set forth in applicable policy or as requested by the MEC or the Board.

3.F.3. Meetings, Reports, and Recommendations:

The PRC will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The PRC will submit reports of its activities to the MEC and the Board on a regular basis. The PRC's reports will 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; listing of education initiatives based on reviews; listing of system issues identified). These reports will not include the details of any reviews or findings regarding specific Practitioners unless the PRC determines such information is necessary for the MEC to address a matter.

3.G. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.C of the Medical Staff Bylaws.

ARTICLE 4

MEDICAL STAFF PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff, through its Medical Staff Leaders and the committees outlined in Article 3 of this Manual, will be actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(b) the Hospital's and individual Practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) use of information about adverse privileging determinations regarding any Practitioner;

(e) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(f) the utilization of blood and blood components, including review of significant transfusion reactions;

(g) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(h) appropriateness of clinical practice patterns;

(i) significant departures from established patterns of clinical practice;

(j) education of patients and families;

(k) coordination of care, treatment and services with other Practitioners and Hospital personnel;

(l) accurate, timely and legible completion of medical records;

(m) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of the Medical Staff Bylaws;

(n) the use of developed criteria for autopsies;

(o) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(p) nosocomial infections and the potential for infection;

(q) unnecessary procedures or treatment; and

(r) appropriate resource utilization.

## ARTICLE 5

## AMENDMENTS

This Manual will be amended in accordance with the amendment process outlined in the Medical Staff Bylaws.

ARTICLE 6

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Medical Staff: 

Board of Trustees: _____