Medical Staff Organizational Manual

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MEDICAL STAFF ORGANIZATIONAL MANUAL

CAROMONT REGIONAL MEDICAL CENTER

ARTICLE I:
GENERAL PROVISIONS

Section 1.1 Definitions

The following definitions apply to terms used in this Organizational Manual

"**Board of Directors**" or "**Board**" means the Board of Directors of Gaston Memorial Hospital, Incorporated which does business as CaroMont Regional Medical Center, CaroMont Regional Medical Center – Belmont and CaroMont Regional Medical Center – Mt. Holly.

"**Chief Executive Officer**" or "**CEO**" means the CaroMont Health President/CEO who is individual appointed by the Board to act on its behalf in the overall management of the Hospital.

"**Clinical Privileges**" or "**Privileges**" means the rights granted to a Medical Staff member or a Privileged Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental or podiatry services specifically delineated to the applicant.

"**Credentialing Policy"** means the Medical Staff Credentialing Policy.

"**Hospital**" means Gaston Memorial Hospital, Incorporated d/b/a CaroMont Regional Medical Center,d/b/a CaroMont Regional Medical Center-Belmont, and d/b/a CaroMont Regional Medical Center – Mt. Holly, and all the activities, services and programs thereof.

"**Medical Executive Committee**" or "**MEC**" means the Executive Committee of the Medical Staff.

"**Medical Staff**" means all physicians and dentists who have been appointed to the Medical Staff by the Board of Directors.

"**Medical Staff Documents**" means all documents approved by the Medical Staff and Board of Directors for purposes of governance or the orderly operation of the Medical Staff, including, but not limited to these Bylaws, the Organizational Manual, and all Medical Staff Policies as may now or hereafter be duly adopted and/or amended and in effect.

"**Physician**" includes both physicians and dentists, unless the context indicates otherwise.

"**Privileged Practitioners**" means all Podiatry and Advanced Practitioners (Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Practice Pharmacists, Nurse Practitioners, and Physician Assistants). Privileged Practitioners may obtain Clinical Privileges but do not qualify for Medical Staff Membership.

Words used in this Organizational Manual are to be read as masculine or feminine gender, and as singular or plural, as the content requires. The captions and headings are for convenience only and are not intended to limit or define the scope or effect of any provision of the Organizational Manual.

Section 1.2 Time Limits

Time limits referred to this Organizational Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

Section 1.3 Delegation of Functions

When a function is to be carried out by a person or Committee, the person or the Committee, through its Chair, may delegate performance of the function to one or more qualified designees.

ARTICLE II
MEDICAL STAFF COMMITTEES AND FUNCTIONS

Section 2.1 Medical Staff Committees and Functions

a. This Article outlines the CaroMont Regional Medical Center Medical Staff Committees that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

b. Procedures for the appointment of Committee Chairs and members are set forth in the Medical Staff Bylaws.

c. Unless otherwise provided, the CEO or designee shall appoint appropriate Hospital or administrative staff to support each Committee.

Section 2.2 Meetings, Reports and Recommendations

a. Unless otherwise provided, each Committee described in this Organizational Manual shall meet as often as necessary, but at least quarterly, and shall maintain a permanent record of its proceedings, findings and actions. Each Committee shall provide a timely report of its activities to the Executive Committee.

b. Each Committee shall also report (with or without recommendation) to the Executive Committee any situation involving significant questions of clinical competency, patient care and treatment, professional ethics, infraction of Hospital or Medical Staff Bylaws or policies, or unacceptable conduct on the part of any individual appointed to the Medical Staff or granted clinical privileges.

c. Medical Staff Committee proceedings, materials and information considered by Medical Staff Committees shall be confidential as set forth in applicable Federal and North Carolina laws and regulations.

<u>Section 2.3</u> **<u>Credentials Committee</u>**

a. <u>Composition</u>

1. The Credentials Committee shall consist of the Chief of Staff-Elect (who shall serve as Chair) and at least six additional members of the Active Medical Staff. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. Particular consideration is to be given to providers with experience in credentialing and performance improvement functions.

2. All members of the Committee, including the Chair, shall be appointed to serve two-year terms and members may serve more than one term.

3. All new members of the Committee, either prior to beginning to serve on the Committee or while serving on the Committee, may consider obtaining education and training regarding the credentialing process as needed.

b. <u>Duties</u>

The Credentials Committee shall:

1. In accordance with the Medical Staff Bylaws and Medical Staff Credentialing Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges; conduct a thorough review of the applications; interview such applicants as may be necessary; and make written reports of its findings and recommendations;

2. Review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or currently holding clinical privileges and, as a result of such review, make a written or verbal report of its findings and recommendations;

3. Review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital;

4. Determine any continuing education requirements for members of the Medical Staff or persons holding clinical privileges, beyond that which is required by the North Carolina Medical Board or other licensing entity;

5. Meet monthly or as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

6. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.4 Provider Health and Behavior Committee

a. Composition

1. The Provider Health and Behavior Committee shall consist of at least five appointed members of the Medical Staff. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. A past Chief of Staff or experienced Medical Staff Leader shall serve as the Committee Chair (as appointed by the Chief of Staff).

2. All members of the Committee, including the Chair, shall be appointed to serve two-year terms and members may serve more than one term.

b. Duties

The Provider Health and Behavior Committee shall:

1. Receive, investigate, and make recommendations to the Executive Committee regarding grievances not directly related to clinical performance privileging concerning Medical Staff members or Privileged Practitioners or regarding other concerns related to the health or fitness for duty of any Medical Staff member or Privileged Practitioner;

2. Engage in collegial intervention, as appropriate, in an effort to resolve grievances. When making recommendations to the Executive Committee, the Provider Health and Behavior Committee shall state whether and to what extent the collegial intervention process has been used and the results of such intervention;

3. May serve as an Investigative Committee pursuant to the Medical Staff Bylaws upon referral of a grievance or other concern from the Medical Executive Committee;

4. Meet as needed and as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

5. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.5 Trauma Committee

a. Composition

1. The Trauma Committee is a multi-disciplinary Committee, consisting of members of the Medical Staff representing various clinical specialties. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff.

2. Members of the Committee shall be appointed to serve two-year terms and members may serve more than one term.

3. The Medical Director of the Trauma Program shall serve as Committee Chair.

b. Duties

The Trauma Committee shall:

1. Oversee activities related to trauma patients and the function of the Trauma Service through a multidisciplinary approach, including concurrent evaluation studies;

2. Oversee the implementation of, and compliance with, the North Carolina Trauma Center Designation Standards;

3. Develop, recommend and evaluate new and revised Trauma policies, protocols and guidelines;

4. Recommend clinical outreach and improvement programs when appropriate;

5. Review and oversee Trauma Service Quality Assessment and Improvement activities;

6. Meet at least quarterly or as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

7. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.6 Peer Review Committee

a. Composition

1. The Peer Review Committee shall consist of members of the Active Medical Staff as appointed by the Chief of Staff. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. The Chief of Staff shall appoint the Chair of the Committee. Particular consideration is to be given to providers with experience in peer review and performance improvement functions.

2. All members of the Committee, including the Chair, shall be appointed to serve two-year terms and members may serve more than one term.

b. Duties

The Peer Review Committee shall:

1. Promote the highest quality care by evaluating the professional performance and trends of Medical Staff members and Privileged Practitioners holding clinical privileges, identifying system problems that may lead to errors, educating practitioners,

creating a transparent culture that encourages success and self-improvement, and providing constructive and timely feedback to providers;

2. Fairly and equitably investigate questionable or inappropriate clinical outcomes;

3. Receive referrals from the Executive Committee, Chief Physician Executive, VP Medical Affairs, Service Line Physician leaders, and/or the Chief of Staff and engage in further investigation of the clinical competence or clinical practice of any member of the Medical Staff or any Privileged Practitioner holding clinical privileges at the Hospital;

4. Make recommendations to the Executive Committee regarding concerns about the clinical competence or clinical practice of any member of the Medical Staff or any Privileged Practitioner holding clinical privileges at the Hospital;

5. May serve as an Investigative Committee pursuant to the Medical Staff Bylaws upon referral of a question regarding an individual's clinical competence or clinical performance from the Medical Executive Committee;

6. Meet monthly or as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

7. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.7 High Reliability Organization (HRO) Committee

a. Composition

1. The High Reliability Organization (HRO) Committee shall consist of at least three members of the Active Medical Staff, the Vice President, Medical Affairs, and other members representing multiple clinical and non-clinical areas of CaroMont Health. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. All members of the Committee shall be entitled to vote on any matter considered by the Committee.

2. Members of the Medical Staff and Privileged Practitioners appointed to the Committee shall be appointed to serve two-year terms and members may serve more than one term.
3. The Chair of the Committee shall be the Vice President, Medical Affairs.

b. Duties

The HRO Committee shall:

1. Define and address organizational-wide priorities for creating a culture of high reliability and developing priorities for overall performance improvement based upon CaroMont Health's strategic plan;

2. Provide oversight of all HRO initiatives, seminars, educational programs and performance improvement activities;
3. Remove barriers, provide resources, and make recommendations to the organization and to the Medical Staff that guide successful design and implementation of highly reliable processes;
4. Receive ongoing high-level education on HRO principles, the science of safety and human performance, and characteristics of HRO leaders;
5. Determine how to measure preventable harm and errors;
6. Emphasize the importance of psychological safety to the organization;
7. At least annually or more frequently as needed, identify wildly important goals (HRO WIGs) that advance a culture of high reliability;
8. Develop the skills, structure, processes and training methods most important to execute the HRO WIGs;
9. Develop implementation plans that include communication, education, training, accountability mechanisms, and effectiveness monitoring;
10. Address Fair and Just Culture as it applies to psychological safety and encouragement of robust error and event reporting;
11. Review quality, safety and performance improvement data trends to assist in prioritizing enterprise risks around safe patient care within the organization;
12. Provide oversight for the Quality Assurance Performance Improvement (QAPI) Plans for CaroMont Regional Medical Center, CaroMont Endoscopy Center, and CaroMont Specialty Surgery;
13. Recommend policies concerning the safe use of drugs in the Hospital, including new drug preparations requested for use in the Hospital, hazardous drugs and investigational drugs;
14. Meet monthly or as often as deemed necessary by the Chair; and
15. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.8 Pharmacy and Therapeutics Committee

c. Composition

1. The Pharmacy and Therapeutics Committee shall consist of at least five members of the Active Medical Staff, the Pharmacy Director, and one representative each of nursing and Hospital administration. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. Only

Medical Staff members, Privileged Practitioners and the Pharmacy Director shall be entitled to vote on any matter considered by the Committee.

2. Members of the Medical Staff and Privileged Practitioners appointed to the Committee shall be appointed to serve two-year terms and members may serve more than one term.

d. Duties

The Pharmacy and Therapeutics Committee shall:

16. Review the appropriateness of the prophylactic, empiric and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;

17. Develop and recommend to the Executive Committee policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

18. Define and review all significant adverse drug reactions;

19. Maintain and periodically review the hospital formulary or drug list;

20. Recommended drugs to be stocked on Hospital units/floors and by other services;

21. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital and report decisions and/or concerns to the Executive Committee for action;

22. Recommend policies concerning the safe use of drugs in the Hospital, including new drug preparations requested for use in the Hospital, hazardous drugs and investigational drugs;

23. Monitor guidelines for automatic stop orders for drugs as specified in the rules and regulations or other Hospital policy;

24. Serve as an advisory group to the Medical Staff and pharmacy on matters pertaining to choice of available drugs;

25. Prevent unnecessary duplication in stocking drugs or drugs that have identical amounts of the same therapeutic ingredients;

26. Meet quarterly or as often as deemed necessary by the Chair; and

27. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.9 Bylaws and Policies Committee

a. Composition

1. The Bylaws and Policies Committee shall consist of at least five members of the Active Medical Staff. In addition, one or more Privileged Practitioners may be appointed to this Committee at the discretion of the Chief of Staff. Particular consideration is to be given to providers with experience in creating or revising Bylaws or Medical Staff policies. The Committee Chair shall be appointed by the Chief of Staff.

2. All members of the Committee, including the Chair, shall be appointed to serve two-year terms and members may serve more than one term.

b. Duties

The Bylaws and Policies Committee shall:

1. Draft, review, and/or revise any proposed new policies or policy revisions initiated by the Committee or received from the Executive Committee, Hospital administration, Nursing, Service Lines, or other clinical or non-clinical areas and make recommendations to the Executive Committee and Medical Staff regarding such policies;

2. Draft, review, and/or revise any proposed Medical Staff Bylaws amendments initiated by the Committee or received from the Executive Committee, Hospital administration, Nursing, Service Lines, or other clinical or non-clinical areas and make recommendations to the Executive Committee and Medical Staff regarding any amendments to the Medical Staff Bylaws;

3. Serve as the liaison between the Medical Staff and the Executive Committee regarding any issues affecting the adoption or amendment of the Medical Staff Bylaws as well as the adoption, amendment, or retirement of any Medical Staff policies;

4. Meet as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

5. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

Section 2.10 CRMC-Belmont Liaison Committee

a. Composition

1. The CRMC-Belmont Liaison Committee shall consist of at least three members of the Active Medical Staff with substantial practice responsibilities at CaroMont Regional Medical Center-Belmont (CRMC-Belmont). In addition, one or more Privileged Practitioners who practice primarily at CRMC-Belmont may be appointed to this Committee at the discretion of the Chief of Staff. The Committee Chair shall be appointed by the Chief of Staff. One member of the Committee will be the CRMC-Belmont At-Large physician member of MEC.

2. All members of the Committee, including the Chair, shall be appointed to serve two-year terms and members may serve more than one term.

3. The Chair of the Committee will serve as a voting member of the Medical Executive Committee.

b. Duties

The CRMC-Belmont Liaison Committee shall:

1. Facilitate the sharing of information between Medical Staff and Privileged Practitioners practicing primarily at CaroMont Regional Medical Center and those practicing primarily at CRMC-Belmont;

2. Provide information to the Executive Committee and assist the Executive Committee in understanding, the specific concerns, interests or needs of Medical Staff members and Privileged Practitioners practicing at CRMC-Belmont;

3. Consult with hospital administration on quality related issues specific to CRMC-Belmont.
4. Receive and act on reports on recommendations specific to CRMC-Belmont from Medical Staff Committees or other groups as appropriate.

5. Meet as often as necessary to fulfill its responsibilities as determined at the discretion of the Committee Chair; and

6. Maintain a record of its proceedings and ensure that a copy of such record shall be maintained in the Medical Staff Office.

ARTICLE III
ADOPTION AND AMENDMENT

Pursuant to the Medical Staff Bylaws, this Medical Staff Organizational Manual is adopted and made effective upon approved by the Medical Executive Committee and Board, superseding and replacing any and all previous Medical Staff Organizational Manual pertaining to the subject matter herein. Medical Staff Committee activities shall be undertaken pursuant to the requirements of this Organizational Manual. The Organizational Manual may be amended from time to time pursuant to the procedures set forth in the Medical Staff Bylaws.