CAROMONT REGIONAL MEDICAL CENTER
MEDICAL STAFF ORGANIZATIONAL MANUAL

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual:

(1) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital.

(2) "CHIEF EXECUTIVE OFFICER" or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(3) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(4) "CREDENTIALING POLICY" means the Hospital's Medical Staff Credentialing Policy.

(5) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(6) "EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(7) "HOSPITAL" means CaroMont Regional Medical Center, Incorporated.

(8) "MEDICAL STAFF" means all physicians and dentists who have been appointed to the Medical Staff by the Board.

(9) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.

(10) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

1.B: TIME LIMITS

Time limits referred to in this 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.

1.C: 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 2

MEDICAL STAFF COMMITTEES

2.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of CaroMont Regional Medical Center 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 physician members are set forth in Article 5.A of the Medical Staff Bylaws.

(3) Unless otherwise provided, all hospital and administrative representatives on the committees shall be appointed by the CEO or designee.

2.B: MEETINGS, REPORTS AND RECOMMENDATIONS

(1) Unless otherwise indicated, each committee described in this Manual shall meet at least quarterly, or at the discretion of the chair, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Executive Committee.

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

2.C. CREDENTIALS COMMITTEE

2.C.1. Composition

(a) The Credentials Committee shall consist of the Chief of Staff-Elect (who shall serve as chair) and at least six additional Active Staff members who possess the qualifications set forth in Section 3.B of these Bylaws. Particular consideration is to be given to Past Chiefs of Staff and to other physicians knowledgeable in the credentialing and performance improvement processes.

(b) The initial Credentials Committee members shall be appointed for staggered, two-year terms.

(c) All new members of this Committee, either prior to beginning to serve on the Committee or while serving on the Committee, should obtain specific education and training regarding the credentialing process.

2.C.2. Duties

The Credentials Committee shall:

(a) in accordance with Chapter II of the Bylaws, 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;

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations;

(c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 2.A.3. ("Clinical Privileges for New Procedures") and Section 2.A.4. ("Clinical Privileges That Cross Specialty Lines") of Chapter II of these Bylaws;

(d) determine any continuing education requirements for members of the Medical Staff, beyond that which is required by the North Carolina State Medical Board; and,

(e) provide orientation training and guidance for department chairs regarding the scope of their responsibilities when reviewing applications for privileges.

2.C.3. Meetings, Reports, and Recommendations

The Credentials Committee shall meet as often as necessary to fulfill its responsibilities and shall maintain a record of its proceedings and actions pursuant to current Hospital record retention policies.

2.D. PHYSICIAN HEALTH AND BEHAVIOR COMMITTEE

1. The Physician Health and Behavior Committee shall consist of five appointed members of the Medical Staff. These shall be a past Chief of Staff or experienced Medical Staff Leader as committee chair and four members appointed by the Chief of Staff. All members, including the Chair, shall be appointed to serve for two year terms.. There will also be appropriate administrative representatives on

the committee for support and liaison, who shall serve as ex officio members without voting privileges.

2. The Physician Health and Behavior Committee shall receive, investigate, and make recommendations to the Executive Committee regarding grievances of a non-medical nature concerning Medical Staff members as well as concerns regarding a Medical Staff member's health or fitness for duty. The Physician Health and Behavior Committee shall establish a policy governing the manner in which grievances should be forwarded to it and the criteria for taking jurisdiction of a grievance. The Physician Health and Behavior Committee may engage in collegial intervention in an effort to resolve grievances. When making recommendations to the Executive Committee, the Physician Health and Behavior Committee shall state whether and to what extent the collegial intervention process has been used and the results obtained. Upon referral of a grievance from the Executive Committee to the Physician Health and Behavior Committee, the Physician Health and Behavior Committee may serve as an investigative committee pursuant to Chapter II, Article 4 of these Bylaws.

3. The Physician Health and Behavior Committee shall meet quarterly or as often as necessary and shall maintain a record of its proceedings. A copy of such record shall be maintained in the Medical Staff Office pursuant to current Hospital record retention policies.

4. All Committee proceedings, materials and the information considered by the Committee are considered confidential. Counsel for the Hospital shall be available to the Committee to assist with and make recommendations regarding the confidentiality and discoverability of Committee proceedings, materials and information.

5. To the fullest extent possible, service on this committee hall be considered as the primary Medical Staff obligation of each member of the Committee and the member shall not be required to serve on any other Medical Staff committee (unless he/she agrees to do so).

2. E. TRAUMA COMMITTEE

2. E. 1. Composition:

(a) The Trauma Committee will be multi-disciplinary, consisting of Medical Staff representing the various clinical specialties. ,
Members will be appointed for a two year term.

(b) The Medical Director of the Trauma Program will serve as chair of the Trauma Committee. In his absence he will designate a committee member to act as chair.

2.E.2. Duties:

The Trauma Committee shall:

(a) oversee activities related to trauma patients and the function of the Trauma Service through a multidisciplinary approach, including concurrent evaluation studies;

(b) oversee the implementation of North Carolina Trauma Center Designation Standards;

(c) develop, recommend, and evaluate new and revised policies, protocols and guidelines;

(d) recommend clinical outreach and improvement programs when appropriate; and,

(e) review and oversee Trauma Service Quality Assessment and Improvement activities

2.E.3. Meetings:

The Trauma Committee shall meet as often as necessary to fulfill its responsibilities (but at least quarterly); shall maintain a record of its findings, proceedings, and actions and shall make a written report thereof after each meeting to the Medical Executive Committee.

2.F. PEER REVIEW COMMITTEE

2.F. 1. Composition:

(a) The Peer Review Committee shall consist of members of the Active Medical Staff appointed by the Chief of Staff, one of whom shall be designated as Chair by the Chief of Staff and four ex officio members of the Allied Health Staff, who shall serve ex officio without vote. The members shall possess the qualifications set forth in Section 3.B of these Bylaws. Ex officio members shall be a certified midwife, a certified registered nurse anesthetist, one Allied Health provider who is either a physician assistant or nurse practitioner in the Department of Medicine, and one Allied Health provider who is either a physician assistant or nurse practitioner in the specialty of Surgery. Ex officio members shall participate in the Peer Review Committee only as requested by the Chair of the Peer Review Committee. For all members appointed to serve on the Peer Review Committee, particular consideration is to be given to physicians with experience in peer review and performance improvement functions All members, including the Chair, shall be appointed to serve for two year terms.. There will be appropriate administrative representatives on the committee for support and liaison.

2.F.2. Duties:

(a) The Peer Review Committee shall promote the highest quality care possible by evaluating the professional performance and trends of Medical Staff and Allied Health members, 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. The Peer Review Committee shall fairly and equitably investigate questionable or inappropriate clinical outcomes. The Peer Review Committee may receive referrals seeking further investigation of the clinical competence or clinical practice of any member of the Medical Staff or Allied Health Staff from the Executive Committee, the Chief Medical Officer or VPMA, and the Chief of Staff.

(b) The Peer Review Committee shall make recommendations to the Medical Executive Committee regarding concerns about the clinical competence or clinical practice of any members of the Medical Staff or Allied Health Staff. Upon referral of a question regarding an individual's clinical competence or clinical practice from the Executive Committee to the Peer Review Committee, the Peer Review Committee shall serve as an investigative committee pursuant to Chapter II, Article 4 of these Bylaws.

2.F.3 Meetings:

(a) The Peer Review Committee shall meet monthly or as often as the Chair deems necessary. A copy of the proceedings shall be kept and such record shall be maintained in the Medical Staff Office pursuant to current Hospital record retention policies.

(b) All Committee proceedings, materials and the information considered by the Committee are considered privileged and confidential. Counsel for the Hospital shall be available to the Committee to assist with and make recommendations regarding the confidentiality and discoverability of Committee proceedings, materials, and information.

2.H: JOINT CONFERENCE COMMITTEE

2.H.1 Composition:

The Joint Conference Committee shall consist of the President, three members of the Board of Directors, the Chief of Staff, the Immediate Past Chief of Staff, and the Chief of Staff-Elect of the Medical Staff.

2.H.2 Duties:

The Joint Conference Committee shall consider and discuss medical-administrative matters and make such recommendations to the Board of Directors in respect thereto as the committee considers to be in the best interest of the Hospital and its patients. The Joint Conference Committee will be the committee that deliberates issues affecting the discharge of Medical Staff responsibilities.

2.I: PERFORMANCE IMPROVEMENT COUNCIL

2.I.1 Composition:

The Performance Improvement Council shall be appointed by the Chief of Staff and be composed of appropriate Medical Staff and Nursing Leaders, Community Members, as well as Administrative Leadership The Chair shall be an experienced Medical Staff member.

2.I.2 Duties:

(a) The Performance Improvement Council is responsible for supporting organizationwide efforts of performance improvement. The Performance Improvement Council plans the organizationwide improvement processes to be utilized. The Council realizes that the clear definition of an approach used at all levels in the organization to address improvement issues is imperative to a successful performance improvement initiative. Additionally, the Council recommends corporationwide priorities for improvement based on the Strategic Plan. The Council also assures that performance is assessed systematically, recommends to the Board of Directors the allocation/reallocation of appropriate resources, and assures that improvement activities are implemented based on assessments and that achieved improvements are maintained.

(b) Hospital Health and Safety. The Performance Improvement Council, acting by and through the designated member of Senior Management who serves on that Council, shall manage and direct the review of sentinel events in conjunction with the Health and Safety Policy for CaroMont Regional Medical Center, Gaston Ambulatory Surgery, and CaroMont Specialty Surgery. In carrying out these duties, the designated member of Senior Management shall convene any necessary subcommittees to carry out the work of the Performance Improvement Council. The Performance Improvement Council, acting by and through the designated member of Senior Management, shall establish and implement any and all action plans necessary to prevent the repeat of sentinel events. In addition, the Performance Improvement Council, acting by and through the designated member of Senior Management, shall design and implement a plan for evaluating the effectiveness of any action plans and report the results of the sentinel event review to the appropriate parties.

(c) Continuing Medical Education Committee Activities. The Performance Improvement Council shall serve as CaroMont Regional Medical Center's Continuing Medical Education Committee. Acting by and through the Continuing Medical Education Physician Course Director (as appointed by the Chief of Staff), the Performance Improvement Council shall evaluate the continuing medical education offerings of CaroMont Regional Medical Center to insure compliance with all "Essential Areas and Elements" established by the Accreditation Council for Continuing Medical Education.

2J: PHARMACY AND THERAPEUTICS COMMITTEE

3.J.1 Composition:

The Pharmacy and Therapeutics Committee shall consist of at least five Medical Staff members, the Pharmacy Director, and one representative each from nursing service and hospital management. Only the Medical Staff members and the Pharmacy Director shall be entitled to vote.

3.J.2 Duties:

The Pharmacy and Therapeutics Committee shall:

(a) 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;

(b) develop and recommend to the Executive Committee policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

(c) define and review all significant untoward drug reactions;

(d) maintain and periodically review the hospital formulary or drug list;

(e) recommend drugs to be stocked on the nursing unit floors and by other services;

(f) 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;

(g) recommend policies concerning the safe use of drugs in the Hospital, including new drugs, drug preparations requested for use in the Hospital, hazardous drugs and investigational drugs;

(h) monitor guidelines for automatic stop orders for drugs as specified in the rules and regulations or other hospital policy;

(i) serve as an advisory group to the Medical Staff and pharmacist on matters pertaining to choice of available drugs; and

(j) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

ARTICLE 3

AMENDMENTS

This Manual may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of any proposed amendments shall be distributed to all voting members of the Medical Staff at least fourteen (14) days prior to the Executive Committee meeting, and any such Medical Staff member shall have the right to submit written comments to the Executive Committee regarding the same. No such amendment shall be effective unless and until it has been approved by the Board. Anything to the contrary contained in this Manual notwithstanding, neither the Board nor the Medical Staff may unilaterally amend this Manual.

ARTICLE 4

ADOPTION

This Medical Staff Organizational Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this Manual.

Adopted by the Medical Staff:

Date: January 8, 2001

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Sam T. Drake, M.D.
Chief of Staff

Approved by the Board of Directors:

Date: January 22, 2001

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Mr. Steve B. Whitlow
Chair, Board of Directors