SECTION II

ORGANIZATIONAL MANUAL

OF THE BYLAWS

MEDICAL AND DENTAL STAFF

CAROLINAS MEDICAL CENTER-MERCY

AND

CAROLINAS MEDICAL CENTER-PINEVILLE

APPROVED:

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ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in these manual:

1. "Allied Health Professional" means either a Dependent Practitioner or an Independent Practitioner. “Allied Health Professionals” means all Dependent Practitioners and Independent Practitioners;

2. "Specialty Board" shall mean those specialty boards that are members of the American Board of Medical Specialties or the American Osteopathic Association.

3. “Applicant” shall mean a Practitioner who has applied for appointment to the Medical Staff.

4. “Appointee” means any Physician or Dentist (Practitioner) who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital;

5. “Board” means the Board of Commissioners of Carolinas HealthCare System, who have the overall responsibility for the conduct of the hospital;

6. “Bylaws” shall mean the bylaws of the Medical Staff of Carolinas Medical Center - Mercy and Carolinas Medical Center - Pineville.

7. “CHS Hospitals” shall mean Carolinas Medical Center, Carolinas Medical Center-Mercy, Carolinas Medical Center-Pineville, Carolinas Medical Center-University and Carolinas Rehabilitation.

8. “CMC-C Credentials Committee” shall mean the credentials committee for the CHS Hospitals as further described in the CREDENTIALS POLICY.

9. “CMC-C Allied Health Review Committee” shall mean the allied health review committee for the CHS Hospitals as further described in the POLICY ON CLINICAL PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS.

10. “CMC-C Medical Executive Committee” shall mean the executive committee for the CHS Hospitals as further described in the CREDENTIALS POLICY.

11. “Dentist” shall mean a doctor of dental surgery (D.D.S.) or a doctor of dental medicine (D.M.D.) who has completed training requirements for certification by the American Board of Oral and Maxillofacial Surgery;

12. “Dependent Practitioner” shall mean a health care professional who is licensed by his/her respective licensing agency and who can only provide service under the direct supervision of a Supervising Physician, including without limitation: (i) a physician assistant; (ii) a certified registered nurse anesthetist; (iii) a certified nurse midwife; (iv) a registered nurse, first assistant; (v) a nurse practitioner; (vi) any other advanced practice registered nurse who is required to provide service under
the direct supervision of a Supervising Physician; and (vi) a recent graduate in any of the above-referenced professions who is permitted by state law and the applicable certifying agencies to practice at the Hospital prior to certification;

13. “DIPLOMATE” means that the physician is certified in their primary area of practice by the appropriate specialty and/or subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association or the Commission on Dental Accreditation of the ADA, as applicable.

14. “Facility Credentials Committee” shall mean shall mean the credentials committee of the Medical Staff.

15. “Facility Medical Executive Committee” shall mean: (i) for Carolinas Medical Center – Mercy, the executive committee of the Medical Staff; and (ii) for Carolinas Medical Center – Pineville, the executive committee of that portion of the Medical Staff practicing at Carolinas Medical Center – Pineville, which reports directly to the Facility Medical Executive Committee at Carolinas Medical Center – Mercy. Reference to “Facility Medical Executive Committee” without designation of a particular facility shall mean the Facility Medical Executive Committee of Carolinas Medical Center – Mercy, unless otherwise indicated by the context of the reference.

16. “Independent Practitioner” shall mean a health care professional, other than a Physician or a Dentist, who holds a doctorate degree, who has been licensed or certified by his/her respective licensing or certifying agencies and who is not required to provide service under the direct supervision of a Supervising Physician;

17. “Medical Staff” means all Practitioners (who are oral surgeons) who are given privileges to treat patients at either Carolinas Medical Center - Mercy or Carolinas Medical Center - Pineville;

18. “Medical Staff Leader” shall mean an Officer of the Medical Staff, a member of the Facility Medical Executive Committee, a Chair of a Department, a Section Chief, a Committee Chairman, and/or their designee.

19. “Patient Encounter” shall mean any action on the part of the Practitioner to provide medical or other patient care services to the patient in the Hospital or its facilities, including, without limitation, admission, treatment, performance or interpretation of diagnostic tests, or consultation, and may include the supervision of house staff and medical students; provided however, that Patient Encounter shall not include the ordering of tests on an out-patient basis.

20. “Peer” shall mean with respect to any Practitioner, any other Practitioner from the same discipline (for example, Physician and Physician, Dentist and Dentist).

21. “President of the Hospital” means the Chief Executive Officer of the Hospital or the Chief Executive Officer’s designee;
22. “President of the Medical Staff” means the President of the Medical Staff of Carolinas Medical Center - Mercy unless otherwise stated;

23. “Physicians” shall be interpreted to include both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”);

24. "Practitioner" shall mean a Physician or Dentist licensed to practice under the laws of the State of North Carolina.

25. “Peer Review Action” shall mean an action or recommendation of the Hospital, the Board or any committee of the Hospital or the Medical Staff which is taken or made in the conduct of Peer Review Activity, which is based on the competence or professional conduct of an individual Practitioner or Allied Health Professional (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely, with respect to a Practitioner, the clinical privileges or Medical Staff membership of the Practitioner, and with respect to an Allied Health Professional, the clinical privileges of the Allied Health Professional.

26. "Peer Review Activity" shall mean (I) any activity of the Hospital and/or Medical Staff with respect to a Practitioner (A) to determine whether an Applicant or Appointee may have clinical privileges at the Hospital or membership on the Medical Staff; (B) to determine the scope or conditions of such privileges or membership; (C) to change or modify such privileges or membership; (ii) any quality reviews activity conducted to measure, assess and improve individual or organizational performance; or (iii) any activity of a Hospital or Medical Staff committee established to review the quality and appropriateness of care provided by individuals who have been granted or are seeking privileges on the Medical Staff. In appropriate circumstances, upon approval of at least one of the officers of the Medical Staff, the Hospital or any committee that conducts Peer Review Activity may use the services of an external peer review body or organization to assist in conducting a Peer Review Activity. For example, the Hospital or any committee that conducts Peer Review Activity, upon approval of at least one of the Officers of the Medical Staff, may require the services of an external peer review body when there is no Practitioner within the service area of the Hospital who specializes in the same area as the Practitioner who is the subject of Peer Review Activity and is available to conduct a Peer Review Activity or when there is no Practitioner within the service area of the Hospital who is not either in practice with, or in direct economic competition with the Practitioner who is the subject of Peer Review Activity.

In appropriate circumstances, upon approval of at least one of the officers of the Medical Staff, the Hospital or any committee that conducts Professional Review Activity may use the services of an external peer review body or organization to assist in conducting a Professional Review Activity.

27. “Staff case” shall mean an indigent or medically indigent patient who is unable to pay the usual charges for medical care.

28. “Supervising Physician” shall mean a Physician on the Medical Staff who supervises a Dependent Practitioner in the manner described in the Policy on
Clinical Privileges for Allied Health Professionals.

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

CLINICAL DEPARTMENTS

ARTICLE II - PART A: CLINICAL DEPARTMENTS:
Section 1. Departments and Sections at Carolinas Medical Center - Mercy:

The following clinical departments and sections are established at Carolinas Medical Center - Mercy:

DEPARTMENT OF ANESTHESIOLOGY

DEPARTMENT OF FAMILY MEDICINE

DEPARTMENT OF MEDICAL SPECIALTIES
- Section of Cardiology
- Section of Emergency Medicine
- Section of Gastroenterology
- Section of Hematology/Oncology
- Section of Internal Medicine
- Section of Nephrology
- Section of Neurology and Rehabilitation
- Section of Pulmonology/Critical Care
- Section of Radiology

DEPARTMENT OF SURGICAL SPECIALTIES
- Section of Dentistry
- Section of General Surgery
- Section of Ophthalmology
- Section of Oral and Maxillofacial Surgery
- Section of Orthopedics
- Section of Pathology
- Section of Plastic Surgery
- Section of Thoracic and Cardiovascular Surgery
- Section of Urology
  - Specialty of Gynecology
  - Specialty of Neurosurgery
  - Specialty of Otolaryngology

ARTICLE II - PART A:
Section 2. Departments at Carolinas Medical Center - Pineville:

The following clinical departments are established at Carolinas Medical Center - Pineville:
ARTICLE II - PART A:
Section 3. Hospital-Based Physicians:

The hospital-based specialties of Emergency Medicine, Pathology and Radiology shall each be separate sections. These sections shall provide services for Carolinas Medical Center - Mercy and Carolinas Medical Center - Pineville. At Carolinas Medical Center - Mercy the Emergency Medicine Section shall be assigned to the Department of Medical Specialties. The Sections of Pathology and Radiology shall hold dual department assignments in the Departments of Medical Specialties and Surgical Specialties. At Carolinas Medical Center - Pineville the Emergency Medicine Section shall be assigned to the Department of Medical Specialties. The Sections of Pathology and Radiology shall hold dual department assignment in the Departments of Medical and Surgical Specialties.
ARTICLE II - PART A:
Section 4. Functions and Responsibilities of Departments and Sections:

Functions and responsibilities of departments and Department Chiefs and sections and section chiefs are set forth in Article IV of the Medical Staff bylaws.

ARTICLE III

MEDICAL STAFF COMMITTEES AND FUNCTIONS

ARTICLE III - PART A: MEDICAL STAFF COMMITTEES AND FUNCTIONS:

This Article outlines the Medical Staff committees of Carolinas Medical Center - Mercy and Carolinas Medical Center - Pineville that carry out quality assessment and other functions delegated to the Medical Staff. Procedures for the appointment of committee chairpersons and members are set forth in Article V of the Medical Staff bylaws.

CAROLINAS MEDICAL CENTER - MERCY COMMITTEES:
ARTICLE III - PART B: FACILITY MEDICAL EXECUTIVE COMMITTEE:

(a) The Facility Medical Executive Committee shall consist of the officers of the Medical Staff, the Immediate Past President of the Medical Staff, the Chairperson of the Facility Credentials Committee, the Department Chiefs of each clinical department, the President of the Medical Staff of Carolinas Medical Center - Pineville, and the Chiefs of the hospital-based specialties of Anesthesiology, Emergency Medicine, Pathology and Radiology. The Chiefs of the Sections of Family Practice, Internal Medicine, Cardiology, and Gastroenterology from the Department of Medical Specialties, and the Chiefs of the Sections of General Surgery, Gynecology, Neurosurgery, Plastic Surgery, Oral and Maxillofacial Surgery, and Urology from the Department of Surgical Specialties will be permanent members of the Committee. Additionally, a chief from one of the remaining sections of the Department of Medical Specialties and a chief from one of the remaining sections of the Department of Surgical Specialties shall serve rotating terms of one year as set forth in (d) below.

(b) The President of the Medical Staff shall be chairperson of the Facility Medical Executive Committee.

(c) The Chairperson of the Board and the President of Carolinas Medical Center - Mercy and Carolinas Medical Center - Pineville may attend meetings of the Facility Medical Executive Committee and participate in its discussions, but without vote.

(d) Service of section chiefs who are not permanent members on the Medical Executive Committee shall be as follows:
(1) An alphabetized list of the sections in the Department of Medical Specialties and the Department of Surgical Specialties that do not have permanent representatives on the Facility Medical Executive Committee shall be prepared. On the first year that the Medical Staff bylaws are operational, the chief of the first section on the list in the Departments of Medical Specialties and Surgical Specialties shall serve on the Facility Medical Executive Committee. The term of service shall be for the remainder of the chiefs’ appointment term. Thereafter, in subsequent years, the chiefs from the next section on the list in the Departments of Medical Specialties and Surgical Specialties shall serve on the Facility Medical Executive Committee for a one-year term.

(e) The duties and meeting requirements of the Facility Medical Executive Committee of Carolinas Medical Center - Mercy are set forth in Article V, Part D of the Medical Staff Bylaws.

ARTICLE III - PART C: MEDICAL RECORD AND UTILIZATION MANAGEMENT COMMITTEE:
Section 1. Composition:

(a) The Medical Record and Utilization Management Committee shall consist of at least the following:

(1) one (1) Medical Staff Appointee from each clinical department;
(2) one (1) representative from pathology;
(3) the President of the Hospital or a designee; and
(4) representatives from medical records, nursing service, social service, and other departments of the hospital who shall serve, ex officio, without vote.

(b) The President of the Medical Staff shall select one of the Physician members to serve as chairperson of this committee.

ARTICLE III - PART C:
Section 2. Duties:

(a) Medical Record Functions. The committee shall:

(1) determine that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge; and

(2) conduct periodic reviews of summary information regarding the timely completion of all medical records.
(b) Utilization Management Functions: The committee shall:

(1) monitor utilization to evaluate over-utilization, under-utilization, and the efficient use of the hospital’s resources;

(2) formulate a written utilization review plan for the hospital, to be approved by the Facility Medical Executive Committee, the President of the Hospital and the Board. Such plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payor requirements; and

(3) evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations on the same to the attending Physician, the Facility Medical Executive Committee and the President of the Hospital. No Practitioner shall have review responsibility for any extended stay cases in which that Practitioner has been professionally involved.

(c) Blood Utilization Review Functions: The committee shall review blood transfusions for proper utilization, particular attention being given to the use of whole blood versus component blood elements. Each actual or suspected transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the amount used, and the amount of wastage.

ARTICLE III - PART C:
Section 3. Meetings, Reports and Recommendations:

(a) The Medical Records and Utilization Management Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

(b) The Medical Records and Utilization Management Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART D: CRITICAL CARE COMMITTEE:
Section 1. Composition:

(a) The Critical Care Committee shall consist of at least the following:

(1) five (5) Medical Staff Appointees; and
(2) representatives from nursing service and cardiopulmonary services, who shall serve, ex officio, without vote.

(b) The President of the Medical Staff shall select one of the Physician members to serve as chairperson of this committee.

ARTICLE III - PART D:
Section 2. Duties:

The Critical Care Committee shall:

(a) monitor and evaluate the appropriateness and quality of patient care provided in the Coronary Care Unit and Intensive Care Unit and other special care areas;

(b) review utilization and patterns of use of the Coronary Care Unit and Intensive Care Unit and other special care areas; and

(c) develop, review, and recommend policies and procedures as appropriate concerning the functioning of the Coronary Care Unit and Intensive Care Unit and other special care areas.

ARTICLE III - PART D:
Section 3. Meetings, Reports and Recommendations:

(a) The Critical Care Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

(b) The Critical Care Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART E: NOMINATING COMMITTEE:

The composition, duties, and meeting requirements of the Nominating Committee are set forth in Article III, Part B of the Medical Staff bylaws.

ARTICLE III – PART F: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEES:
Section 1. Composition:

(a) Medical Specialties Quality Improvement Committee
   (1) shall be multidisciplinary and consist of members of the various sections of the clinical department of Medical Specialties
   (2) shall have its chairperson and members appointed by the President
(b) Surgical Specialties Quality Improvement Committee
   (1) shall be multidisciplinary and consist of members of the various
       sections of the clinical department of Surgical Specialties
   (2) shall have its chairperson and members appointed by the President
       of the Medical Staff

ARTICLE III – PART F: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEES:
Section 2. Duties:

The Medical and Surgical Specialties Quality Improvement Committees shall:

(a) oversee all quality assessment and improvement systems for the Medical
    Staff, evaluate and review such systems with respect to comprehensiveness,
    consistent operation, timeliness and function in accordance with defined
    procedures for all cases meeting the Hospital definition of reviewable
    circumstances;

(b) review and evaluate the quality and appropriateness of care rendered;

(c) review and evaluate quality assessment and improvement initiatives for
    planning and utilization, objective, written criteria and that conclusions
    reached through the process are supported by a rationale that specifically
    addresses the issues for which the Peer Review Activity was conducted,
    including, as appropriate, reference to the professional literature and relevant
    clinical practice guidelines;

(d) provide to the Practitioner whose performance is being reviewed an
    opportunity for participation in the Peer Review Activity;

(e) review and evaluate actions taken on quality assessment and improvement
    findings, the documentation of findings and conclusions and the
    effectiveness of remedial action. The results of Peer Review Activities will be
    considered in (i) Practitioner-specific credentialing, reappointment and
    privileging decisions at the Hospital and at all other CHS Hospitals as
    contemplated by the CREDENTIALS POLICY and by the reporting and
    sharing of such results through the CMC-C Medical Executive Committee,
    and (ii) as appropriate, in the Hospital’s and other CHS Hospitals’
    performance improvement activities;

(f) track Peer Review Actions over time, and monitor for effectiveness.
ARTICLE III – PART F: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEES:
Section 3. Meetings, Reports, and Recommendations:

(a) The Medical and Surgical Specialties Quality Improvement Committees shall meet as often as necessary to fulfill their duties, but at least quarterly; shall maintain a permanent record of findings, proceedings, and actions; and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

(b) The Medical and Surgical Specialties Quality Improvement Committees shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies, or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

CAROLINAS MEDICAL CENTER - PINEVILLE COMMITTEES

ARTICLE III - PART G: FACILITY MEDICAL EXECUTIVE COMMITTEE:

(a) The Facility Medical Executive Committee shall consist of (i) the officers of the Medical Staff, including the Immediate Past President of Carolinas Medical Center - Pineville, (ii) the Chiefs of the Departments of Anesthesiology, Medical Specialties, Surgical Specialties, and Women and Children’s Services, (iii) the Credentials Committee Chairman, (iv) Critical Care/Pulmonology Committee Chairman and (v) four (4) members-at-large, all of whom shall be hospital-based physicians.

(b) The Vice Chiefs may attend meetings of the Facility Medical Executive Committee and participate in its discussions, but without vote unless they are attending on behalf of their respective Chief.

(c) The President of the Medical Staff of Carolinas Medical Center - Pineville shall be chairperson of the Medical Executive Committee.

(d) The Chairperson of the Board may attend meetings of the Facility Medical Executive Committee and participate in its discussions, but without vote.

(e) The composition, duties, and meeting requirements of the Facility Medical Executive Committee of Carolinas Medical Center - Pineville are set forth in Article V, Part F of the Medical Staff bylaws.
ARTICLE III - PART H: MEDICAL RECORD AND UTILIZATION MANAGEMENT COMMITTEE:

Section 1. Composition:

(a) The Medical Record and Utilization Management Committee shall consist of at least the following:

(1) one (1) Medical Staff Appointee from each clinical department;
(2) one (1) representative from pathology;
(3) the President of the Hospital or a designee; and
(4) representatives from medical records, nursing service, social service, and other departments of the hospital who shall serve, ex officio, without vote.

(b) The President of the Medical Staff of Carolinas Medical Center - Pineville shall select one of the Physician members to serve as chairperson of this committee.

ARTICLE III - PART H:

Section 2. Duties:

(a) Medical Record Functions. The committee shall:

(1) determine that each medical record, or a representative sample of records, reflects the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge; and

(2) conduct periodic reviews of summary information regarding the timely completion of all medical records.

(b) Utilization Management Functions: Using the hospital’s Utilization Review Plan, the committee shall:

(1) monitor utilization to evaluate over-utilization, under-utilization, and the efficient use of the hospital’s resources; and

(2) evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations on the same to the attending Physician, the Facility Medical Executive Committee of Carolinas Medical Center - Pineville and the President of the Hospital. No Practitioner shall have review responsibility for any extended stay cases in which that Practitioner has been professionally involved.

(c) Blood Utilization Review Functions: The committee shall review blood transfusions for proper utilization, particular attention being given to the use
of whole blood versus component blood elements. Each actual or suspected transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the amount used, and the amount of wastage.

ARTICLE III - PART H:
Section 3. Meetings, Reports and Recommendations:

(a) The Medical Record and Utilization Management Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee of Carolinas Medical Center - Pineville and the President of the Hospital.

(b) The Medical Record and Utilization Management Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART I: CRITICAL CARE COMMITTEE:
Section 1. Composition:

(a) The Critical Care Committee shall consist of at least the following:

(1) not less than three (3) Medical Staff Appointees; and

(2) representatives from nursing service and cardiopulmonary service who shall serve, ex officio, without vote.

(b) The President of the Medical Staff of Carolinas Medical Center - Pineville shall select one of the Physician members to serve as chairperson of this committee.

ARTICLE III - PART I:
Section 2. Duties:

The Critical Care Committee shall:

(a) monitor and evaluate the appropriateness and quality of patient care provided in the Critical Care Unit and other special care areas;

(b) review utilization and patterns of use of the Critical Care Unit and other special care areas;

(c) develop, review, and recommend policies and procedures as appropriate concerning the functioning of the Critical Care Unit and other special care areas; and
(d) make recommendations regarding capital equipment.

ARTICLE III - PART I:
Section 3. Meetings, Reports and Recommendations:

The Critical Care Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee at Carolinas Medical Center - Pineville.

ARTICLE III - PART J: NOMINATING COMMITTEE:

The composition, duties, and meeting requirements of the Nominating Committee of Carolinas Medical Center - Pineville are set forth in Article III, Part B of the Medical Staff bylaws.

ARTICLE III – PART K: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE:
Section 1. Composition:

(a) Quality Assessment and Improvement Committee
1. Shall be multidisciplinary and consist of members of the various sections of the clinical departments
2. Members appointed by the President of the Medical Staff

(b) The chairperson of the Quality Assessment and Improvement Committee shall be the President-Elect of the Medical Staff, and the vice-chairperson shall be the Secretary of the Medical Staff.

ARTICLE III – PART K: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE:
Section 2. Duties:

The Quality Assessment and Improvement Committee shall:

(a) Oversee all quality assessment and improvement systems for the Medical Staff, evaluate and review such systems with respect to comprehensiveness, consistent operation, timeliness and function in accordance with defined procedures for all cases meeting the Hospital definition of reviewable circumstances;

(b) review and evaluate the quality and appropriateness of care rendered;

(c) review and evaluate quality assessment and improvement initiatives for planning and utilization, objective, written criteria and that conclusions reached through the process are supported by a rationale that specifically addresses the issues for which the Peer Review Activity was conducted, including, as appropriate, reference to the professional literature and relevant clinical practice guidelines;
(d) provide to the Practitioner whose performance is being reviewed an opportunity for participation in the Peer Review Activity;

(e) review and evaluate actions taken on quality assessment and improvement findings, the documentation of findings and conclusions and the effectiveness of remedial action. The results of Peer Review Activities will be considered in (i) Practitioner-specific credentialing, reappointment and privileging decisions at the Hospital and at all other CHS Hospitals as contemplated by the CREDENTIALS POLICY and by the reporting and sharing of such results through the CMC-C Medical Executive Committee, and (ii) as appropriate, in the Hospital’s and other CHS Hospitals' performance improvement activities;

(f) track Peer Review Actions over time, and monitor for effectiveness.

ARTICLE III – PART K: QUALITY ASSESSMENT AND IMPROVEMENT COMMITTEE:
Section 3. Meetings, Reports, And Recommendations:

(a) The Quality Assessment and Improvement Committee shall meet as often as necessary to fulfill their duties, but at least quarterly; shall maintain a permanent record of findings, proceedings, and actions; and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

(b) The Quality Assessment and Improvement Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies, or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

COMMITTEES SERVING CAROLINAS MEDICAL CENTER - MERCY AND CAROLINAS MEDICAL CENTER – PINEVILLE:

ARTICLE III – PART L: CMC-C CANCER COMMITTEE:

Section 1: The CMC-C Cancer Committee of Carolinas HealthCare System is a committee established for the purpose of overseeing and coordinating the cancer program. The CMC-C Cancer Committee shall be responsible and accountable for setting goals, planning, initiating, implementing, evaluating and improving all cancer program activities within Carolinas HealthCare System in accordance with the standards set forth by the American College of Surgeons’ Commission on Cancer Approvals Program (the Accreditation Standards”) and for ensuring that all cancer program activities fully comply with the Accreditation Standards.

Section 2: When requested, the CMC-C Cancer Committee shall review and evaluate, in accordance with guidelines—set forth by the American College of Surgeons (ACOS), the quality of Hospital or health care services provided in the treatment of cancer patients, as
Section 3: The CMC-C Cancer Committee shall meet as often as necessary to fulfill its duties, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

Section 4: The CMC-C Cancer Committee will report to the respective Hospital Quality Assessment and Improvement Committee regarding the appropriate clinical management of individual cancer patients only when asked to do so by a member of the Medical Staff, Risk Management, or the Chairman of the Quality Assessment and Improvement Committee. The Cancer Committee will serve a support role to the Quality Assessment and Improvement Committee in this regard.

ARTICLE III - M: FACILITY CREDENTIALS COMMITTEE:

The composition, duties, and meeting requirements of the Facility Credentials Committee are set forth in Article V, Part E of the Medical Staff bylaws.

ARTICLE III - PART N: INFECTION PREVENTION COMMITTEE:
Section 1. Composition:

The Infection Prevention Committee shall consist of at least the following:

(a) five (5) Medical Staff Appointees, including representatives from medicine, surgery, gynecology, and pathology;

(b) representatives from housekeeping, laundry, central services, dietetic, engineering and maintenance, pharmacy and the operating room, on a consulting basis, to serve, ex officio, without vote; and

(c) the nurse epidemiologist from Carolinas Medical Center - Mercy and Carolinas Medical Center - Pineville, representatives from nursing services, and a representative from Administration, as appointed by the President of the hospital.

ARTICLE III - PART N:
Section 2. Duties:

The Infection Prevention Committee shall:

(a) be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities;

(b) establish a system for documenting all hospital acquired infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;
(c) monitor the standards and the bacteriological services available to the hospital; and

(d) recommend an infection control prevention program and a continuing education program for Medical Staff Appointees and hospital personnel on infectious disease control.

ARTICLE III - PART N:
Section 3. Meetings, Reports and Recommendations:

(a) The Infection Prevention Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Facility Medical Executive Committee, the President of the Hospital, and the Vice President of Nursing.

ARTICLE III - PART O: CMC-C PERIPHERAL ENDOVASCULAR COMMITTEE:
Section 1. Composition:

(a) The CMC-C Peripheral Endovascular Committee shall consist of Medical Staff Appointees representing various specialties, including, but not limited to, Appointees from the Departments of Internal Medicine (Cardiology), General Surgery, Neurosurgery and Radiology whose specialty relates, at least in part, to peripheral endovascular surgery.

(b) The President of the Medical Staff shall appoint one member of the Committee to serve as chairperson of this Committee.

ARTICLE III - PART O: CMC-C PERIPHERAL ENDOVASCULAR COMMITTEE:
Section 2. Duties:

The Committee shall:

(a) endeavor to improve the quality of patient care by sharing knowledge, ideas, and information pertaining to peripheral endovascular surgery, and to provide coordination of activities relating to peripheral endovascular care; and

(b) review and evaluate the quality of Hospital or health care services provided in the treatment of peripheral endovascular patients in accordance with criteria/quality indicators;

(c) develop new policies and evaluate submitted revisions and/or changes of policies and procedures for peripheral endovascular care;

(d) be responsible for reviewing the credentials of all Applicants and Appointees seeking specialized privileges in peripheral endovascular surgery; and

(e) review and recommend criteria for procedures performed in peripheral endovascular surgery.
ARTICLE III - PART O:
Section 3. Meetings, Reports and Recommendations:

(a) The CMC-C Peripheral Endovascular Committee shall meet as often as necessary to fulfill its duties, but at least quarterly; shall maintain a permanent record of its findings, proceedings and actions; and shall make a written report thereof after each meeting to the Facility Medical Executive Committee and the President of the Hospital.

(b) The CMC-C Peripheral Endovascular Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies, or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART P: PHARMACY AND THERAPEUTICS COMMITTEE:
Section 1. Composition:

(a) The Pharmacy and Therapeutics Committee shall be multi-disciplinary, consisting of Appointees of the Medical Staff;

(b) The President of the Medical Staff shall appoint one (1) member of the Committee to serve as chairperson of this committee.

ARTICLE III - PART P:
Section 2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) be responsible for the development and surveillance of the pharmacy and therapeutic policies and procedures and shall recommend new or changed policies to the Facility Medical Executive Committee of the Medical Staff; and

(b) assist in the formulation of programs designated to meet the educational needs of the professional staff regarding the selection, distribution, and safe administration of drugs;

(c) recommend additions and deletions from the Hospital’s formulary based upon patient efficacy, safety and cost effectiveness;

(d) review reported medication related incidents, including adverse drug reactions; review and advise on therapeutic nutritional matters, including diet and nourishment content, tube feedings and patient/family education as requested.
ARTICLE III - PART P:
Section 3. Meetings, Reports and Recommendations:

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

(b) The Pharmacy and Therapeutics Committee shall also report (with or without recommendation) to the Facility Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III - PART Q: BYLAWS COMMITTEE:
Section 1. Composition:

(a) The Bylaws Committee shall consist of at least three (3) to five (5) persons appointed from the Active Staff representing both hospitals.

(b) The President of the Medical Staff shall select one of the Physician members to serve as chairperson of this committee.

ARTICLE III - PART Q:
Section 2. Duties:

The Bylaws Committee shall review the bylaws of the Medical Staff, the Credentials Policy, and other associated documents at least annually and recommend amendments, as appropriate, to the Facility Medical Executive Committee. This review shall also include, but not be limited to, the Medical Staff rules and regulations. The Committee shall also receive and consider all recommendations for changes in these documents made by any committee or department of the Medical Staff, any individual appointed to the Medical Staff, the President of the Hospital or the Board.

ARTICLE III - PART Q:
Section 3. Meetings, Reports and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, but at least annually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report of its recommendations after each meeting to the Facility Medical Executive Committee and the President of the Hospital.
ARTICLE IV
OTHER PARTICIPANTS IN COMMITTEE MEETINGS

Other individuals, such as Hospital employees, administrative staff, members of the community, etc. may also be appointed as committee members. These members shall serve without vote, except those members who are appointed in accordance with State or federal regulations, or unless specific voting privileges are delineated in the ORGANIZATIONAL MANUAL.

ARTICLE V
ADOPTION

This Manual is adopted and made effective upon approval by the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations or hospital policies pertaining to the subject matter thereof, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the hospital shall be taken under and pursuant to the requirements of this Manual.