

**MINUTES**  
**MEDICAL UNIVERSITY HOSPITAL AUTHORITY**  
**BOARD OF TRUSTEES MEETING**  
**December 9, 2011**

The Board of Trustees of the Medical University Hospital Authority convened Friday, December 9, 2011, with the following members present: Thomas L. Stephenson, Esquire, Chairman; Dr. James E. Wiseman, Jr., Vice Chairman; Mr. William H. Bingham, Sr.; Dr. Cotesworth P. Fishburne, Jr.; Mr. William B. Hewitt; Dr. Harold W. Jablon; Dr. Donald R. Johnson II; Dr. E. Conyers O'Bryan, Jr.; Dr. Thomas C. Rowland, Jr.; Mr. Charles W. Schulze ; The Honorable Robin M. Tallon; Dr. Charles B. Thomas, Jr.; Emeritus: Mrs. Claudia Peeples. Absent Dr. Stanley C. Baker, Jr.

The following administrative officials were present: Dr. Raymond S. Greenberg, President; Dr. Mark Sothmann, Vice President for Academic Affairs and Provost; Dr. Etta Pisano, Vice President for Medical Affairs, and Dean, College of Medicine; Ms. Lisa Montgomery, Vice President for Finance and Administration; Mr. Stuart Smith, Vice President for Clinical Operations and Executive Director, MUHA; Dr. Frank Clark, Vice President for Information Technology and CIO.

The following deans were present: Dr. Jack Sanders, College of Dental Medicine; Dr. Etta Pisano, College of Medicine; Dr. Philip Hall, College of Pharmacy; Dr. Gail Stuart, College of Nursing; Dr. Perry Halushka, College of Graduate Studies.

**Item 1. Call to Order-Roll Call.**

There being a quorum present, Chairman Stephenson called the meeting to order. Ms. Celeste Jordan called the roll.

**Item 2. Secretary to Report Date of Next Meeting.**

The date of the next regularly scheduled meeting is Friday, February 10, 2012.

**Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of October 21, 2011.**

Board Action: It was moved that the Minutes be approved. The motion was seconded, voted on and unanimously carried.

**RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT**

**OLD BUSINESS:** None.

**NEW BUSINESS:**

**Item 4. General Informational Report of the President.**

Dr. Greenberg introduced Dr. Lucian Del Priore, MD, PHD, the new chair of the Department of Ophthalmology. He comes to MUSC from Columbia University. He received his BS in physics from Cooper Union; an MS in physics from Cornell; an MD from University of Rochester and PHD in physics from Cornell. Dr. Del Priore is a retinal surgeon doing amazing work in cutting edge clinical trials. Dean Pisano welcomes Dr. Del Priore to the university. He has already recruited two people for the department and he has hit the ground running. He is a great recruitment for the University.

Dr. Del Priore reviewed his scientific work and discussed the cutting edge technology to help people see in the future. He talked about his vision for the Department of Ophthalmology and the Storm Eye Institute. He reported that there is an overwhelming demand for the residency program at MUSC and the quality of applicants is outstanding. He stated the department is undergoing a period of growth and he projects that growth to continue.

**Item 5. Other Business.**

**MEDICAL UNIVERSITY HOSPITAL AUTHORITY OPERATIONS, QUALITY AND FINANCE COMMITTEE. CHAIRMAN: DR. STANLEY C. BAKER, JR.**

**OLD BUSINESS:**

**NEW BUSINESS:** In Dr. Baker's absence, Dr. Thomas chaired the committee.

**Item 6. MUSC Medical Center Status Report.**

Statement: Mr. Stuart Smith had provided a report to committee.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: Received as information.

Board Action: Received as information.

**Item 7. Medical University Hospital Authority Financial and Statistical Report.**

Statement: Ms. Lisa Montgomery had provided a report to committee.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

**Item 8. Major Purchase.**

Statement: Dr. Thomas asked for approval of the following item:

- MUSC Children's Hospital purchase of additional gastrointestinal equipment in the amount of \$492,007.

Recommendation of Administration: That the purchase be approved.

Recommendation of Committee: That the purchase be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the purchase.

**Item 9. General Report from Dean Etta Pisano.**

Statement: Dr. Pisano gave an update on the College of Medicine activities to committee. Dr. Thomas stated everything in the COM seems to be progressing at a good pace.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

**Item 10. Report on Quality and Patient Safety.**

Statement: Dr. Pat Cawley provided a report to committee on quality and patient safety. Dr. Thomas commented that we continue to perform admirably in those areas.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

**Item 11. Report on Outreach Activity and MUSC Physicians.**

Statement: Dr. Costello gave a report on Outreach Activities and MUSC Physicians.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

**Item 12. Legislative Update.**

Statement: Dr. Thomas said the legislative update had been given by Representative White who reiterated there is no funding available from the state.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

**Item 13. Other Committee Business.** None.

**Item 14. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges (Consent Item).**

Statement: An updated list of appointments, reappointments and delineation of privileges to the medical staff were presented for approval.

Recommendation of Administration: That the appointments, reappointments and delineation of privileges to the medical staff be approved.

Recommendation of Committee: That the appointments, reappointments and delineation of privileges to the medical staff be approve.

Board Action: Dr. Thomas moved that the list of appointments, reappointments and delineation of privileges to the medical staff be approved. The motion was seconded, voted on and unanimously carried.

**Item 15. Revisions to the Medical Staff Bylaws (Consent Item).**

Statement: Dr. Pat Cawley presented revisions to the Medical Staff Bylaws for approval.

Recommendation of Administration: That the revisions to the Bylaws be approved.

Recommendation of Committee: That the revisions to the Bylaws be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the revisions to the Medical Staff Bylaws.

**Item 16. Plan for Provision of Care (Consent Item).**

Statement: Dr. Pat Cawley presented a Plan for Provision of Care for approval.

Recommendation of Administration: That the Plan be approved.

Recommendation of Committee: That the Plan be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the Plan for Provision of Care.

**Item 17. Update on Performance Improvement Plan (Consent Item).**

Statement: Dr. Pat Cawley presented an update on the Performance Improvement Plan for approval.

Recommendation of Administration: That the update on the Plan be approved.

Recommendation of Committee: That the update on the Plan be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the update on the Performance Improvement Plan.

**Item 18. Renewal of Ambulatory Patient Care Management Agreement (Consent Item).**

Statement: Ms. Annette Drachman presented the renewal of the Ambulatory Patient Care Management Agreement for approval.

Recommendation of Administration: That the renewal of the Ambulatory Patient Care Management Agreement be approved.

Recommendation of Committee: That the renewal of the Ambulatory Patient Care Management Agreement be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the renewal of the Ambulatory Patient Care Management Agreement.

**Item 19. Renewal of the Primary Care Agreement (Consent Item).**

Statement: Ms. Annette Drachman presented the renewal of the Primary Care Agreement for approval.

Recommendation of Administration: That the renewal of the Primary Care Agreement be approved.

Recommendation of Committee: That the renewal of the Primary Care Agreement be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the renewal of the Primary Care Agreement.

**Item 20. Medical Executive Committee Minutes (Consent Item).**

Statement: Minutes of the Medical Executive Committee were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: The minutes of the Medical Executive Committee for were received as information.

**Item 21. Medical Center Contracts and Agreements (Consent Item).**

Statement: Contracts and Agreements which have been signed since the last board meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

**MEDICAL UNIVERSITY HOSPITAL AUTHORITY PHYSICAL FACILITIES COMMITTEE.**  
**CHAIRMAN: MR. WILLIAM H. BINGHAM, SR. (Detailed committee minutes are attached to these minutes).**

**OLD BUSINESS:** None

**NEW BUSINESS:**

**Item 22. Facilities Procurements/Contracts Proposed.**

Statement: Mr. Bingham presented the Facilities Procurements/Contracts for approval:

- PT/OT Renovations/Improvements at Leeds Avenue – Estimated Budget of \$450,000.
- New Lease of 8,981 sq. ft. of space located at 4480 Leeds Avenue – Total Lease: \$669,221.20.
- New Lease of 8,051 sq. ft. of office space located at 261 Calhoun Street – Total Lease of \$405,790.56.
- Lease Amendment to increase the square footage from 3,459 to 10,511 located at 261 Calhoun Street. – Total Lease of \$397,271.12.
- Lease Renewal of 54,808 sq. ft. at 230 Albemarle Road – Total Lease: \$1,861,050.12.
- Lease Renewal for 4,274 sq. ft. at 735 Johnnie Dodds Boulevard – Total Lease: \$596,552.85.

Recommendation of Administration: That the Procurements/Contract be approved.

Recommendation of Committee: That the Procurements/Contracts be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the Procurements/Contracts as proposed.

**Item 23. Update on Projects.**

Statement: Mr. Bingham stated Mr. Dennis Frazier had provided an update on various Authority projects to committee and was received as information.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

**Item 24. Other Committee Business.** None.

**Item 25. Facilities Contracts Awarded (Consent Item).**

Statement: Facilities Contracts awarded since the last meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

**MEDICAL UNIVERSITY HOSPITAL AUTHORITY AUDIT COMMITTEE. CHAIRMAN: MR. WILLIAM B. HEWITT. (Detailed committee minutes are attached to these minutes).**

**OLD BUSINESS:** None

**NEW BUSINESS:**

**Item 26. External Audit Report from KPMG.**

Statement: Mr. Hewitt reported that Mr. Brad Benton, a Partner with KPMG Healthcare, provided the results of the 2011 external audit. He stated MUHA received an unqualified opinion. There had been no problems with management providing accurate and complete information in a timely manner and there were no disagreements with management.

Ms. Melanie Hammond-Trace, with Elliott Davis, presented the good results of the external audits for the MUSC Foundation and the MUSC Foundation for Research Development.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

**Item 27. Report of the Office of Internal Audit.**

Statement: Mr. Hewitt stated a report had been received from Ms. Susan Barnhart, the Internal Auditor and there were no questions from committee.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

**Item 28. Other Committee Business.** None.

**OTHER BUSINESS FOR THE BOARD OF TRUSTEES:**

**Item 29. Approval of Consent Agenda.**

Statement: Approval of the Medical University Hospital Authority consent agenda was requested.

Recommendation of Administration: That the consent agenda be approved.

Board Action: It was moved, seconded and unanimously voted that the consent agenda be approved.

**Item 30. New Business for the Board of Trustees.**

**Item 31. Report from the Chairman.**

There being no further business, the Hospital Authority meeting was adjourned and the University Board of Trustees meeting was convened.

Respectfully submitted,



Hugh B. Faulkner III  
Secretary

/wcj  
Attachments



**Medical University Hospital Authority  
Board of Trustees  
Committee on Hospital Operations, Quality and Finance  
December 8, 2011 Minutes**

Attendees:

Dr. Charles B. Thomas, Chair	Mr. Jim Fisher
Mr. William H. Bingham, Sr.	Mr. Thomas Anderson
Dr. Cotesworth P. Fishburne, Jr.	Dr. Patrick Cawley
Mr. William B. Hewitt	Dr. Phillip Costello
Dr. Harold Jablon	Dr. Steve Lanier
Dr. Donald R. Johnson, II	Annette Drachman, Esq.
Dr. E. Conyers O'Bryan, Jr.	Mr. Dennis Frazier
Dr. Thomas Rowland	Mr. Casey Liddy
Mr. Charles W. Schulze	Mr. Steve Hargett
Mr. Allan E. Stalvey	Mr. John Cooper
Thomas L. Stephenson, Esq.	Joseph Good, Esq.
Hon. Robin M. Tallon	Mr. Hugh B. Faulkner
Dr. James E. Wiseman, Jr.	Mr. Mark Sweatman
Dr. Raymond Greenberg	Ms. Susan Barnhart
Mr. Stuart Smith	Ms. Lauren Allen
Dr. Etta Pisano	Mr. Patrick Wamsley
Ms. Lisa Montgomery	Ms. Sarah King
Dr. Mark Lyles	

The committee was called to order by Dr. Charles Thomas, at 12:25 p.m. on behalf of Dr. Stanley Baker, Chair, who was not present at the December Board meeting.

**Item 6. MUSC Medical Center Status Report**

Stuart Smith presented on hospital statistics. He mentioned at the last Board meeting that we had a shift in past activity regarding whether a patient was in an observation versus or an inpatient status. We have used a company that provides physician consultations on these decisions and as a result observation cases are down 567 and discharges are up 531 which equates to increased revenue. Last year the trend was going the other way. OR cases are down by 1.3%. The new chair in Ophthalmology is actively recruiting new faculty which should help us see this number go back up. In addition, we are also looking at cases that are now done in procedure areas such as neuro-interventional radiology that used to be in the Operating Room. We are reviewing these trends and the value of these procedures that are being conducted outside the OR.

Mr. Smith also gave an update on the organization's pillar goals. He mentioned that the goals in green indicate goals met, yellow indicates progress. The people goals are white as they are only measured annually. The HCAHPS goal for FY12 is red. Mr. Smith mentioned that we performed well last year in our HCAHPS' goal. For FY12 all ten dimensions are included. While we are currently meeting 3 of the 10, we are optimistic that we will meet our goal of 7 out of 10 dimensions by year end. We are meeting our Hand Hygiene goal with 86.2% compliance through November.

Mr. Smith reported on the 5/5 plans. We rebased to a measure of Cost Per CMI Adjusted Discharge. FY11 base was \$9252. Our goal is reduce this cost by \$1,000 over the next two years which would put us at the 25<sup>th</sup> percentile. Mr. Smith shared a report card from the Oncology service line indicating that since FY09 Hollings has seen a growth of 49% which shows how important growth is to reducing cost per unit of service.

Action: Received as information

## **Item 7. MUSC Medical Center Financial and Statistical Report**

Ms. Montgomery briefed the committee on the financial status. For October we had an increase in net assets of \$600,000 over budget which gets us year to date closer to budget. We are still behind by \$2M but gaining ground. Ms. Montgomery reported that we finished the month of October with cash of \$59M. FTEs per adjusted occupied bed is at 6.44 which puts us close to the 25<sup>th</sup> percentile at UHC. Our labor expense is still above the median which has a lot to do with our employee mix and the cost of our retirement benefits. She shared the six metrics that are considered the top financial and operational indicators as defined by UHC. Ms. Montgomery mentioned that we are doing better than the 50<sup>th</sup> percentile in most areas. She reported that we are in compliance with all bond covenants as well as HUD requirements.

Action: Received as information

## **Item 8. Major Purchase**

Information was presented on a major purchase for gastrointestinal equipment to be used for pediatric patients by new GI physician, Dr. Antonio Quiros.

Action: Recommend Approval

## **Item 9. General Report from Dean Etta Pisano**

Dean Etta Pisano gave a report on College of Medicine Activities. She reported on the current clinical chair searches for the Department of Medicine, Department of OB/GYN and the Neurosciences/Neurology Co-Chair. Dr. Peter Zwerner accepted the Chief Medical Office for MUSC Physicians effective October 1. She also presented on clinical affairs activities related to GME programs, ART 7 Project and the Epic implementation. Education activities include bimonthly meetings with students and chief residents and the focus on LCME reaccreditation site visit in January 2013. She also reported on the chair searches in Research including the Director for the new Center for Genomic Medicine, Department of Public Health Sciences and Department of Biochemistry. She also gave an update on other activities around the implementation of the research strategic plan, finance, space management and faculty affairs.

Action: Received as information

## **Item 10. Report on Quality and Patient Safety**

Dr. Cawley gave the Quality and Patient Safety report. One component of the strategic plan is the strategic intent which is to be in the top 25 among AMCs by 2015. Two sources will be used to grade ourselves, UHC and *US News and World Report*. Dr. Cawley reported on the methodology UHC uses, which includes the national domains of quality broken into six areas including mortality, effectiveness, safety, equity, patient centeredness and efficiency. He reported on our current rankings within UHC and on the areas of opportunity including the IMPROVE plan to focus on mortality, including appropriate documentation and coding, effectiveness, safety and efficiency. In *US News & World Report*, the methodology is measured by structure, process, outcome and safety. He reported on our current rankings within US News and World Report, opportunities

and the IMPROVE plan to include a Children's task force for addressing gaps, work on physician documentation, work on reducing avoidable complications, Journey to Magnet and accuracy of data submitted. Dr. Cawley reported that the mortality index for the first quarter of FY12 was at .65.

#### **Item 11. Report on Outreach Activity and MUSC Physicians**

Dr. Phil Costello requested approval to increase East Cooper equipment budget by \$1M to replace MRI/DISC and purchase diagnostic mammography equipment for the MUSC Specialty Care in Mount Pleasant.

Action: Recommend Approval.

#### **Item 12. Legislative Update**

This report was given in an earlier committee.

Action: Received as information

#### **Item 13. Other Committee Business**

No other committee business.

Action: Received as Information

### **CONSENT AGENDA**

#### **Item 14. Medical University Hospital Authority Appointments, Reappointments, and Delineation of Privileges**

The committee reviewed the request for appointments, reappointments and delineation of privileges. These have been approved by the appropriate hospital committees, and have been recommended by the Medical Executive Committee.

Action: Recommend approval

#### **Item 15. Revisions to the Medical Staff Bylaws**

These documents were submitted to the committee and reviewed by all appropriate groups. The committee reviewed and recommended approval.

Action: Recommend approval

#### **Item 16. Plan for Provision of Care**

The committee reviewed and approved the updated Plan for Provision of Care for the Medical Center.

Action: Recommend Approval

#### **Item 17. Update on Performance Improvement Plan**

The updated performance improvement plan was presented and approved as presented.

Action: Approve as presented

**Item 18. Renewal of Ambulatory Patient Care Management Agreement**

The committee reviewed the updated Ambulatory Patient Care Management Agreement and recommended approval.

Action: Recommend Approval

**Item 19. Renewal of Primary Care Agreement**

The committee reviewed the updated Renewal of Primary Care Agreement and recommended approval.

Action: Recommend Approval

**Item 20. Medical Executive Committee minutes**

The minutes for July, September and October 2011 were presented. These were reviewed by the committee.

Action: Received as information

**Item 21. Medical Center Contracts and Agreements.**

The committee reviewed the contracts and agreements which have been entered into since the last meeting of the Board.

Action: Received as information

There being no further business, the committee adjourned at 1:35 p.m.

  
Jane L. Scutt

**Medical University Hospital Authority  
Physical Facilities Committee  
December 8, 2011  
Minutes**

**Attendees:**

Mr. William H. Bingham, Sr., Chair  
Dr. Cotesworth P. Fishburne, Jr.  
Mr. William B. Hewitt  
Dr. Harold Jablon  
Dr. E. Conyers O'Bryan, Jr.  
Dr. Thomas C. Rowland, Jr.  
Mr. Charles W. Schulze  
Thomas L. Stephenson, Esquire  
The Honorable Robin M. Tallon  
Dr. Charles B. Thomas, Jr.  
Dr. James E. Wiseman, Jr.  
Mr. Allan E. Stalvey  
Dr. Raymond S. Greenberg  
Ms. Jennifer Aldrich

Dr. Phillip Costello  
Ms. Annette Drachman  
Mr. Dennis Frazier  
Mr. Jim Fisher  
Mr. Chip Hood  
Ms. Sarah King  
Dr. Steve Lanier  
Mr. Mark Lyles  
Mr. John Malmrose  
Ms. Lisa Montgomery  
Dr. Etta Pisano  
Dr. Darlene Shaw  
Mr. Stuart Smith  
Dr. Mark Sothmann  
Mr. Patrick Wamsley

Mr. Bingham called the meeting to order.

**REGULAR Items**

**Item 22      Procurements/Contracts Proposed.**

Mr. Dennis Frazier presented the following for approval:

- PT/OT Renovations/Improvements at Leeds Avenue – Estimated Budget of \$450,000.
- New Lease of 8,981 sq. ft. of space located at 4480 Leeds Avenue – Total Lease: \$669,221.20.
- New Lease of 8,051 sq. ft. of office space located at 261 Calhoun Street – Total Lease of \$405,790.56.
- Lease Amendment to increase the square footage from 3,459 to 10,511 located at 261 Calhoun Street. – Total Lease of \$397,271.12.
- Lease Renewal of 54,808 sq. ft. at 230 Albemarle Road – Total Lease: \$1,861,050.12.
- Lease Renewal for 4,274 sq. ft. at 735 Johnnie Dodds Boulevard – Total Lease: \$596,552.85.

Recommendation of Committee: That these procurements/contracts be approved.

**Item 23**      **Update on Projects.**

No report.

Recommendation of Committee: That this report be received as information.

**Item 24**      **Other Committee Business**      None

**CONSENT Items for Information:**

**Item 25**      **Facilities Contracts Awarded**

The facilities contracts since the last board meeting were presented for information.

Recommendation of Committee: That this report be received as information.

With no further business, the meeting was adjourned.

Respectfully submitted,

Celeste Jordan

**Medical University Hospital Authority  
Audit Committee  
December 8, 2011  
Minutes**

**Attendees:**

Mr. William B. Hewitt, Chair  
Mr. William H. Bingham, Sr.  
Dr. Cotesworth P. Fishburne, Jr.  
Dr. Donald R. Johnson II  
Dr. Harold Jablon  
Dr. E. Conyers O'Bryan, Jr.  
Dr. Thomas C. Rowland, Jr.  
Mr. Charles W. Schulze  
Thomas L. Stephenson, Esquire  
The Honorable Robin M. Tallon  
Dr. Charles B. Thomas, Jr.  
Dr. James E. Wiseman, Jr.  
Mr. Allan E. Stalvey  
Dr. Raymond S. Greenberg  
Ms. Susan Barnhart  
Mr. Brad Benton

Dr. Frank Clark  
Mr. John Cooper  
Ms. Annette Drachman  
Ms. Susie Edwards  
Mr. Joe Good  
Mr. Steve Hargett  
Dr. Steve Lanier  
Mr. Mark Lyles  
Ms. Lisa Montgomery  
Ms. Gina Ramsey  
Dr. Darlene Shaw  
Mr. Stuart Smith  
Dr. Mark Sothmann  
Mr. Mark Sweatman  
Mr. Patrick Wamsley

Mr. Hewitt called the meeting to order.

**REGULAR Items**

**Item 26. External Audit Report from KPMG.**

Mr. Brad R. Benton, Partner with KPMG Healthcare provided an overview of the results of the 2011 external audit for MUHA as also presented in the material provided to the Board. He stated the Authority received an unqualified opinion. At the conclusion of the presentation, Mr. Hewitt asked if KPMG has experienced any problems with management providing accurate and complete information in a timely manner and the response from Mr. Benton was no. Mr. Hewitt asked if there were any disagreements with management and Mr. Benton said none at all. Mr. Hewitt asked if there were any reason to meet with Mr. Benton without management in the room and Mr. Benton replied no.

Recommendation of Committee: That the report be received as information.

**Item 27. Report of the Office of Internal Audit.**

Ms. Susan Barnhart had provided a report and there were no questions regarding the report.

Recommendation of Committee: Received as information.

**Item 28. Other Committee Business.** None

Respectfully Submitted,

Celeste Jordan

**MEDICAL UNIVERSITY HOSPITAL AUTHORITY  
MAJOR PURCHASES FOR  
BOARD OF TRUSTEES' APPROVAL  
(December, 2011)**

**Description of Purchase:** MUSC Children's Hospital is requesting to purchase additional gastrointestinal equipment to support the newly recruited GI physician, Antonio Quiros. Dr. Quiros will start on July 1<sup>st</sup> 2012, and has the capability of performing therapeutic endoscopic procedures, both Endoscopic Ultrasound (EUS) and ERCP, on pediatric patients. While the pediatric patient population needing an EUS or ERCP is small, he will be the only physician in the Southeastern United States with this ability. SG2 Intelligence data attached shows this is a growing service in the southern market of between 10-23% over the next 10 years. He can also perform General GI procedures which is a growing market.

**Estimated Cost of Purchase:** \$492,007

**Requisition Number:** Pending

**Department Name(s) and UDAK Number(s):** Pediatric Procedure Area- 96341

**Department Contact Person:** John Sanders, Administration MUSC Children's Hospital and Kellie Suggs, Director of Business Operations, MUSC Children's Hospital

**Method of Purchase:** Capital Sole Source Agreement Olympus

**Vendor Name:** Olympus

**New Purchase** ☒ Yes ☐ No

**Replacement of Existing Item(s)** ☐ Yes ☒ No

**Name of Item(s) Being Replaced:** N/A

**Name and Value of Equipment the Requested Purchase Will Be Used in Conjunction With:**

<u>NAME OF EQUIPMENT</u>	<u>VALUE</u>
Olympus Pediatric GI Video Tower and Scopes	\$142,774
Endoscopic Ultrasound System with Scope	\$349,233



**MEDICAL UNIVERSITY HOSPITAL AUTHORITY  
MAJOR PURCHASES FOR  
BOARD OF TRUSTEES' APPROVAL  
(December, 2011)**

**How this Purchase Will Benefit MUSC:**

This will give MUSC the ability to offer Therapeutic GI procedure to pediatric patients which will be the only hospital in the Southeast to offer this service. This will result in referrals of more commercial payers to the Children's Hospital.

**Source of Revenue/Savings:** Facility charges for procedures and clinic visits

**Financial Analysis:**

**Additional Hospital Procedure Revenue/Costs for Dr. Antonio Quiros**

	FY 2012	FY2013	FY 2014
Hospital Additional Procedure Revenue	\$ 675,509	\$ 730,009	\$ 784,038
Children's Hospital Fund Contribution	\$ 117,000	\$ -	\$ -
GI Equipment Cost/ Install of Axiom Artis	\$ 532,007	\$ -	\$ -
Operating Cost	\$ 501,450	\$ 542,030	\$ 593,038
<b>Profit/Loss</b>	<b>\$ (240,948)</b>	<b>\$ 187,979</b>	<b>\$ 191,000</b>

**Notes:**

- \*Only additional hospital (facility) revenue included
- \*Charges and Payment derived from adult GI procedures
- \* DSH Payments non included in Revenue Projection

**Assumptions:**

- \*10% growth for EUS and ERCP and no increase in growth for Gen GI in FY 2013, Reducing to 5% growth in all procedures for FY 2014.
- \*60/40 Commercial to Medicaid Payer Mix
- \*No increase in payments for FY2011-FY2014
- \*3% increase in cost starting in FY 2014

**Initial Cost:** \$492,007 (GI Equipment) + \$40,000 (Install of Axiom Artis)= **\$532,007**

**Physical Plant Requirements:** Installation of Axiom Artis for imaging which is currently in storage- approximately \$40,000.

**Personnel Cost (to include base salary, fringes, training, etc.):** Due to the decrease in the adult GI procedures, it is likely that we will be able to transition staff to the pediatric procedures with no net increase in FTEs for clinical support of Dr. Quiros.

**Facilities**

**Hospital Authority**

**Construction Project**

For Approval

December 9, 2011

**Project Title:** PT/OT Renovations/ Improvements, Leeds Avenue

**Budget:** \$450,000

**Source of Funds:** Hospital Generated Funds

**Scope:** Selective demolition and renovation of leased space for PT/OT patient care, relocating from on campus. The work includes revisions to casework, new finishes, modifications to the bathrooms for ADA compliance, and mechanical, electrical, plumbing and other work as needed. We will do the renovations in March and April, 2012.

**Justification:** the 9000 SF leased space will accommodate Sleep Lab, Peds Hearing Clinic, Peds PT/OT and the Wheelchair clinic.

**Funding:** The total project budget is \$450,000 and the current FY 12 budget is also \$450,000. The project will be paid for with operating cash flow.

**FACILITIES  
HOSPITAL AUTHORITY  
NEW LEASE  
FOR APPROVAL**

**DECEMBER 9, 2011**

DESCRIPTION OF NEW LEASE: This lease is for 8,981 square feet of space located at 4480 Leeds Place West in North Charleston. The purpose of this lease is to provide space for several Therapeutic Services Groups including Sleep Lab, Speech Pathology, a Wheelchair Clinic and Pediatric Occupational Therapy and Physical Therapy. These departments are relocating to accommodate approved renovation projects within the University Hospital. The cost per square foot for this lease is \$6.50. The monthly rental amount will be \$4,864.71 (rounded), resulting in an annual rent amount of \$58,376.50. Rent shall increase annually 3%.

In addition to the rent amount, MUHA shall pay an estimated \$450,000 for renovations at this property that will be paid separate from the lease agreement.

NEW LEASE AGREEMENT   X    
RENEWAL LEASE AGREEMENT       

LANDLORD: Essex Farms, LLC

LANDLORD CONTACT: Edith Dubose, Meyer Kapp & Associates, Broker, 971-8606

TENANT NAME AND CONTACT: Therapeutic Services, Sally Potts, Director, 792-4771

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

TERM: Five (5) years [4/1/2012-3/30/2017]

AMOUNT PER SQUARE FOOT: \$6.50

ANNUALIZED LEASE AMOUNT:

Year 1: \$58,376.50

Year 2: \$60,127.80

Year 3: \$61,931.63

Year 4: \$63,789.58

Year 5: \$65,703.27

TOTAL AMOUNT OF LEASE: \$309,928.78

EXTENDED TERM(S): One (1) term, five (5) years [4/1/2017-3/30/2022]

ANNUALIZED LEASE AMOUNT:

Year 1: \$67,674.37

Year 2: \$69,704.60

Year 3: \$71,795.74

Year 4: \$73,949.61

Year 5: \$76,168.10

TOTAL AMOUNT OF EXTENDED TERM: \$359,292.42

TOTAL AMOUNT INCLUDING EXTENDED TERMS: \$669,221.20

OPERATING COSTS:

FULL SERVICE       

NET   X

**FACILITIES  
HOSPITAL AUTHORITY  
NEW LEASE  
FOR APPROVAL**

**DECEMBER 9, 2011**

DESCRIPTION OF NEW LEASE: This lease is for 8,051 square feet of office space located on the 2<sup>nd</sup> floor of Cannon Park Place at 261 Calhoun Street. The purpose of this lease is to continue to provide office space for Ambulatory Care administration. In addition, MUHA will use office space to be vacated by the University Medical Associates (UMA) in January 2012 for swing space associated with the ART 7<sup>th</sup> floor relocation. This space has previously been under the UMA master lease agreement. The purpose for this tenant change is for MUHA to directly fund this space. The per square foot rent rate for this lease is \$18.90 (rounded). The total monthly rent shall be \$12,680.96 (rounded) resulting in an annual rent amount of \$152,171.46.

University Medical Associates holds the master lease for this space, in which 8,081 square feet is being further subleased to the Medical University Hospital Authority. The terms for this new lease coincide with the terms of the master lease.

NEW LEASE AGREEMENT   X    
RENEWAL LEASE AGREEMENT       

LANDLORD: University Medical Associates

LANDLORD CONTACT: Marty Phillips, 852-3109

TENANT NAME AND CONTACT: Hospital Facilities, Kim Duckworth, Director of Facilities Management, 792-1145

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

TERM: Two (2) years, eight (8) months [2/1/2012-9/30/2014]  
AMOUNT PER SQUARE FOOT: \$18.90  
ANNUALIZED LEASE AMOUNT: \$152,171.46  
TOTAL AMOUNT OF LEASE: \$405,790.56

EXTENDED TERM(S): N/A

OPERATING COSTS:

FULL SERVICE   X   (net utilities)  
NET

**FACILITIES  
HOSPITAL AUTHORITY  
LEASE AMENDMENT  
FOR APPROVAL**

**DECEMBER 9, 2011**

DESCRIPTION OF LEASE AMENDMENT: This lease amendment is to increase the square footage from 3,459 to 10,511 located on the 3<sup>rd</sup> floor of Cannon Park Place at 261 Calhoun Street. This lease will continue to provide office space for Ambulatory Care administration and the Ambulatory EMP Implementation Project (EPIC), which has previously been under a University Medical Associates (UMA) lease agreement. The purpose for this tenant change is for MUHA to directly fund this space. The per square foot rate for this lease is \$18.90 (rounded). The monthly rental rate will be \$16,552.96 (rounded), resulting in an annual rent amount of \$198,635.56.

University Medical Associates (UMA) holds the master lease for this space, in which 10,511 square feet is being further subleased to the Medical University Hospital Authority. The terms for this new lease coincide with the terms on the master lease.

NEW LEASE AGREEMENT \_\_\_\_\_  
RENEWAL LEASE AGREEMENT \_\_\_\_\_  
LEASE AMENDMENT   X  

LANDLORD: University Medical Associates

LANDLORD CONTACT: Marty Phillips, Financial Analyst, 852-3109

TENANT NAME AND CONTACT: Hospital Facilities, Kim Duckworth, Director of Facilities Management, 792-1145

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

AMENDED TERM: Two (2) Years [2/1/2012-1/31/2014]  
AMOUNT PER SQUARE FOOT: \$18.90  
ANNUALIZED LEASE AMOUNT: \$198,635.56  
TOTAL AMOUNT OF LEASE TERM: \$397,271.12

EXTENDED TERM(S): N/A

OPERATING COSTS:

FULL SERVICE   X   (net utilities)  
NET \_\_\_\_\_

**FACILITIES  
HOSPITAL AUTHORITY  
LEASE RENEWAL  
FOR APPROVAL**

**DECEMBER 9, 2011**

DESCRIPTION OF LEASE RENEWAL: This lease renewal is for 54,808 square feet of warehouse/office space located at 230 Albemarle Road. This lease renewal will continue to provide space for delivery of equipment and temporary storage for items as departments relocate throughout campus as well as the new mail order pharmacy. The per square foot rate for this lease is \$6.67 (rounded). The total monthly rent shall be \$30,469.06 resulting in an annual rent amount of \$365,628.72. The rent shall increase 3% the third year of the lease renewal.

NEW LEASE AGREEMENT \_\_\_\_\_  
RENEWAL LEASE AGREEMENT   X  

LANDLORD: The Porter Academy

LANDLORD CONTACT: Al Trivette, Property Manager, 402-4718

TENANT NAME AND CONTACT: Support Services, John Franklin, Director, 792-9526

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

RENEWAL TERM: Five Years [4/1/2012-3/31/2017]

AMOUNT PER SQUARE FOOT: \$6.67

ANNUALIZED LEASE AMOUNT:

Year 1 \$365,628.72

Year 2 \$365,628.72

Year 3 \$376,597.56

Year 4 \$376,597.56

Year 5 \$376,597.56

TOTAL AMOUNT OF LEASE: \$1,861,050.12

EXTENDED TERM(S): One (1) term, five (5) years, rate to be negotiated

OPERATING COSTS:

FULL SERVICE \_\_\_\_\_

NET   X

**FACILITIES  
HOSPITAL AUTHORITY  
LEASE RENEWAL  
FOR APPROVAL**

**DECEMBER 9, 2011**

DESCRIPTION OF LEASE RENEWAL: This lease renewal is for 4,274 square feet of clinical space located at 735 Johnnie Dodds Boulevard in Mount Pleasant. This lease renewal will continue to provide space for the East Cooper Ambulatory Procedure Center. The per square foot rate for this lease is \$26.29. The monthly rental rate will be \$9,363.62 (rounded), resulting in an annual rent amount of \$112,363.46. Rent shall increase annually 3%.

NEW LEASE AGREEMENT \_\_\_\_\_  
RENEWAL LEASE AGREEMENT   X  

LANDLORD: Holland Properties, LLC

LANDLORD CONTACT: Mason Holland, Owner, 284-1111

TENANT NAME AND CONTACT: Ambulatory Care, Margo Gangloff, Facilities Manager,  
792-4580

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

RENEWAL TERM: Three (3) Years [4/1/2012-3/31/2015]

AMOUNT PER SQUARE FOOT: \$26.29

ANNUALIZED LEASE AMOUNT:

Year 1 \$112,363.46

Year 2 \$115,734.36

Year 3 \$119,206.39

TOTAL AMOUNT OF LEASE: \$347,304.21

EXTENDED TERM(S): One (1) term, two (2) years

Year 1 \$122,782.58

Year 2 \$126,466.06

TOTAL AMOUNT OF EXTENDED TERM: \$249,248.64

TOTAL AMOUNT INCLUDING EXTENDED TERMS: \$596,552.85

OPERATING COSTS:

FULL SERVICE   X  

NET \_\_\_\_\_

## Board of Trustees Credentialing Subcommittee - September 2011

**The Medical Executive Committee reviewed the following applicants on September 21, 2011 and recommends approval by the Board of Trustees Credentialing Subcommittee effective September 28, 2011**

### Medical Staff Initial Appointment and Privileges

Cherrie Mae Hart M.D.	Family Medicine	Initial
Michelle Elaine Koski M.D.	Urology	Initial
Nicholas Peter Pietris M.D.	Pediatrics	Initial
	Oral & Maxillofacial	
Jeffrey Reitzel D.M.D.	Surgery	Initial
Rita Marie Ryan M.D.	Pediatrics	Initial
Dolores Yvonne Tetreault M.D.	Medicine	Initial
Kathleen Woschkolup M.D.	Neurosciences	Initial

### Medical Staff Reappointment and Privileges

Michelle Irene Amaya M.D.	Pediatrics	Active
James A. Amlicke M.D.	Orthopaedic Surgery	Active
Eric Bolin M.D.	Anesthesiology	Active
Keith Borg M.D. Ph.D.	Medicine	Active
		Affil CFC - Refer &
Jeanne Marie Campbell M.D.	Medicine	Follow
Ruth Campbell M.D.	Medicine	Active Prov
Rabiya Khalid Hasan M.D.	Psychiatry	Active
John Terrill Huggins M.D.	Medicine	Active
Samir Rameshchandra Karia M.D.	Neurosciences	Active
William Keith McKibbin M.D.	Orthopaedic Surgery	Active
Fred A. Michael M.D.	Family Medicine	Active
Abraham Herbert Moskow Jr. M.D.	Pediatrics	Affiliate
Leonard William Mulbry Jr. M.D.	Psychiatry	Active
Rick Olson M.D.	Pediatrics	Affiliate
Dorothea Rosenberger M.D.	Anesthesiology	Active
Natasha Ruth M.D.	Pediatrics	Active
Robert M. Sade M.D.	Surgery	Active
Heidi Sapp M.D.	ObGyn	Affiliate
J. Wade Strong M.D.	Pathology & Lab. Med.	Active
Rupalben H Trivedi M.D.	Ophthalmology	Active
Daniel B. Ward Jr. M.D.	Dermatology	Active

### Medical Staff Reappointment and Change in Privileges

Heidi D. Williams M.D.	Surgery	Affiliate	Switching to Refer & Follow
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### Medical Staff Change in Privileges

Cody G. Carpenter M.D.	Pediatrics	Active	Addition: Limited Emergency Ultrasound
George Cooper IV M.D.	Medicine	Active	Switching to Refer & Follow
Joseph V. Dobson M.D.	Pediatrics	Active	Addition: Limited Emergency Ultrasound
Constance Guille M.D.	Psychiatry	Active	Addition: ECT
Andrei Vedeniapiin M.D.	Psychiatry	Active	Addition: ECT



**Professional Staff Initial Appointment and Privileges**

Wendy E. Balliet Ph.D.	Psychiatry	Initial
Natalie Brown Dixon P.A.C.	Pediatrics	Initial
Sarah K. Galloway Ph.D.	Psychiatry	Initial
Jenna L. McCauley Ph.D.	Psychiatry	Initial
Amy Hardin Patton F.N.P.	Medicine	Initial
Susan Grace Sims F.N.P.	Medicine	Initial
Carrie Elizabeth Smith P.A.	Neurosciences	Initial
Blair Buck Turnage P.A.C.	Radiology	Initial

**Professional Staff Reappointment and Privileges**

Sarah Elizabeth Gay A.P.R.N.	Neurosciences	Allied Health
Susan Diane Groome C.R.N.A.	Anesthesiology	Allied Health
Susan Simons Heath C.R.N.A.	Anesthesiology	Allied Health
Jack Owens C.R.N.A.	Anesthesiology	Allied Health
Kerri Marie Presley P.A.C.	Medicine	Allied Health
Natalie Claire Vernon A.N.P.	Surgery	Allied Health
Amy Allen Williams P.N.P.	Pediatrics	Allied Health

**Professional Staff Change in Privileges**

Sameer Tipnis Ph.D.	Radiology	Prov Allied Health	Addition: Medical Physicist Specialty Privileges
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## Board of Trustees Credentialing Subcommittee - October 2011

The Medical Executive Committee reviewed the following applicants on October 19, 2011 and recommends approval by the Board of Trustees Credentialing Subcommittee effective October 28, 2011

### Medical Staff Initial Appointment and Privileges

Arias-Pandey, Ana Isabel	MD	Initial	Peds
Kuo, Jamie	MD	Initial	Medi
Ngo, Tue	MD	Initial	Medi
Turner, Ronald Coleman	MD	Initial	Medi

### Medical Staff Reappointment and Privileges

Brown, Tod Allen	MD	Active	Anes
Cotton, Petter	MBBCh	Active	Medi
Friedman, Richard	MD	Affil R&F	Ortho Surg
Gwynette, McLeod	MD	Active	Psyc
Hebbar, Latha	MBBS	Active	Anes
Hurray, David	MD	Active Prov	Path
Jaroscak, Jennifer	MD	Active Prov	Peds
Kraft, Andrew	MD	Active	Medi
Lynch, Cheryl	MD	Active	Medi
Mendelsohn, Andrea	MD	Active Prov	Fam Med
Mitsiev, Ivaylo	MD	Active Prov	Surg
Orak, John	MD	Active	Peds
Pisoni, Roberto	MD	Active Prov	Medi
Wong, Jeffrey	MD	Active	Medi

### Medical Staff Reappointment and Change in Privileges

DeMarco, James	MD	Affiliate	Ortho Surg	Switching to Affiliate Refer & Follow
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### Professional Staff Initial Appointment and Privileges

Ahring, Rachel	FNP	Initial	Medi
Baldino, Ellen	PAC	Initial	Medi
Bradsher, Sherrill	FNP	Initial	Inter HS
Davis, Kelley	FNP	Initial	Medi
Edmunds, Holly	FNP	Initial	Medi
Fuoto, Abby	APRN	Initial	Medi
Heyward, Dawn	APRN	Initial	Medi
Lewey, Jennifer	FNP	Initial	Inter HS
Prisciandaro, James	Ph.D	Initial	Psych
Sutton, Valerie	FNP	Initial	Inter HS
Walters, Megan	PAC	Initial	Surg
Wynne, Alison	APRN	Initial	Medi

**Professional Staff Reappointment and Privileges**

Adler, Mary	ANP	Prov AHP	Medi
Books, Rachelle	PAC	Prov AHP	Surg
Crosby, Brittany	PAC	Prov AHP	Otol
DesMarteau, Julie Anne	PAC	AHP	Neuro
Drechsler, Holly	PA	Prov AHP	Otol
Hamilton, Elizabeth	APRN	AHP	Neuro
Nissen, Allison	CNM	AHP	OBGYN
Owczarski, Stefanie	PAC	AHP	Surg
Roitzsch, John	Ph.D	AHP	Psyc
Sistino, Joseph	CCP	AHP	Surg

**Professional Staff Change in Privileges**

Brand, Elizabeth	CNM	AHP	OBGYN	Addition of Colposcopy
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Medical University of South Carolina  
Medical Center

Medical Staff Bylaws

~~February, 2010~~  
January 2011

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<b>Error! Hyperlink reference not valid.</b> Section 3.06 .... TEMPORARY and DISASTER PRIVILEGES	<b>255</b>



**Error! Hyperlink reference not valid.**(a) .... Temporary Privileges – Temporary privileges may be granted by the Executive Director of the Medical Center or his designee for a stated limited time upon the recommendation of the applicable Department Chairperson or the President of the Medical Staff, in all other circumstances, as detailed in the Credentials Policy Manual. ....255

**Error! Hyperlink reference not valid.**(b) Disaster Privileges – Disaster privileges may be granted by the Executive Director of the Medical Center or the President of the Medical Staff or the Medical Director of the Medical Center, according to Medical Center Policy C-35 “Disaster Privileges for Licensed Independent Practitioners, when the Emergency Management Plan for the Medical Center has been activated and when the Medical Center cannot handle the needs of patients with just the available credentialed staff. The Department Chairperson will be responsible for monitoring the professional performance of volunteer practitioners with disaster privileges. This monitoring will be accomplished through direct observation, staff feedback, and when appropriate, medical record review. The Department Chairperson is responsible for reviewing the continuation of disaster privileges within 72 hours of granting the disaster privileges.....255

**Error! Hyperlink reference not valid.**..... LEAVE OF ABSENCE –  
—266

**Error! Hyperlink reference not valid.**Section 3.07 ..... Any member may apply to the Credentials Committee for a leave of absence not to exceed one (1) year. Reinstatement of privileges may be requested from the Credentials Committee without formal re-application. Absence for a period longer than one (1) year will require formal re-application. In some special cases, (i.e., military service) a Department Chairperson through the Credentials Committee can recommend to the MEC that a leave of absence be extended beyond a year without the necessity for formal reappointment. At no time can a special circumstance leave of absence extend beyond a two-year re-appointment cycle. ....266

**Error! Hyperlink reference not valid.**Section 3.08 ..... RESPONSIBILITIES OF MEMBERSHIP  
—266

**Error! Hyperlink reference not valid.**(a) ..... Provide timely, appropriate and continuous care/treatment/services for his/her patients and supervise the work of any allied health professional or trainee under his/her direction when appropriate. ....276

**Error! Hyperlink reference not valid.**(b) ..... Assist the MUH in fulfilling its responsibilities by participating in the on-call coverage of the emergency room and other coverage as determined by the MEC. ....276

**Error! Hyperlink reference not valid.**(c)..... Assist other practitioners in the care of their patients when asked.....276

**Error! Hyperlink reference not valid.**(d) ..... Act in an ethical and professional manner.  
—276

**Error! Hyperlink reference not valid.**(e) ..... Treat employees, patients, visitors, and other physicians in a dignified and courteous manner. ....276

**Error! Hyperlink reference not valid.**(f) ... Actively participate in the measurement, assessment, and improvement of patient care processes. ....276

**Error! Hyperlink reference not valid.**(g) ..... Participate in peer review as appropriate.  
—276

**Error! Hyperlink reference not valid.**(h) Abide by the bylaws, rules and regulations, department rules, and other policies and procedures of the MUSC Medical Center.....276

**Error! Hyperlink reference not valid.**(i).. Participate in continuing education as directed by state licensure and the MEC.....276

<del>Error! Hyperlink reference not valid.</del> (j).....Speak as soon as possible with hospitalized patients who wish to contact the attending about their medical care in accordance with the South Carolina Lewis Blackman Hospital Patient Safety Act.....	<del>276</del>
<del>Error! Hyperlink reference not valid.</del> (k)....When required as a part of the practitioner well being program, comply with recommended actions.....	<del>276</del>
<del>Error! Hyperlink reference not valid.</del> (l)....Manage and coordinate their patients care, treatment, and services.....	<del>276</del>
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<del>Error! Hyperlink reference not valid.</del> Section 4.01 .....	<del>THE ACTIVE CATEGORY</del>
<del>286</del>	
<del>Error! Hyperlink reference not valid.</del> (a) .....	<del>Qualifications - Appointee to this category must:</del>
<del>286</del>	
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<del>307</del>	
<del>Error! Hyperlink reference not valid.</del> (b) .....	<del>Prerogatives - Appointees to this category may</del>
<del>318</del>	
<del>Error! Hyperlink reference not valid.</del> (c) .....	<del>Limitations - Appointees to the Affiliate Category do not have general Medical Staff voting privileges.....</del>
<del>318</del>	
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<del>318</del>	
<del>Error! Hyperlink reference not valid.</del> Section 4.03. This category is restricted to those individuals the Medical Staff wishes to honor or to those physicians who have only administrative positions and no clinical privileges.....	<del>318</del>
<del>Error! Hyperlink reference not valid.</del> ... Such staff appointees are not eligible to admit patients to the MUSC Medical Center, to vote, or to exercise .....	<del>318</del>
<del>Error! Hyperlink reference not valid.</del> (a) .. clinical privileges in the MUSC Medical Center. They may, however, attend Medical Staff and department meetings. This category is exempt from the malpractice insurance requirements and Board Certification requirements, unless required within their position description.....	<del>318</del>
<del>Error! Hyperlink reference not valid.</del> (b) ..... Physicians with the MUSC Medical Center whose duties include both administrative and clinical activities must be members of the Medical Staff, and must obtain clinical privileges in the same manner as any other Medical Staff member. When a contract exists, the contract of the physician who has both administrative and clinical duties shall clearly define the relationship between termination of the contract by the MUSC Medical Center and reduction or termination in privileges.....	<del>318</del>
<del>Error! Hyperlink reference not valid.</del> Section 4.04 .....	<del>OTHER / NON-MEDICAL STAFF MEMBERS</del>
<del>318</del>	
<del>Error! Hyperlink reference not valid.</del> (a) .....	<del>House Staff - The House Staff consists of those practitioners, who by virtue of a contract, are in the postgraduate training program at the Medical University of South Carolina.....</del>
	<del>328</del>

**Error! Hyperlink reference not valid.**(b) ..... Allied (affiliated) Health Professionals – Allied (affiliated) Health Professionals are those health practitioners, not a licensed MD, DO or Dentist, who, although not members of the Medical Staff are credentialed through the Medical Staff process as described in the Credentials Policy Manual.....**329**

**Error! Hyperlink reference not valid.**.....**CONTRACT SERVICES**—**329**

**Error! Hyperlink reference not valid.**..... The clinical privileges of any practitioner who has a .....**329**

**Error! Hyperlink reference not valid.**Section 4.05 ....contractual relationship with an entity that has a contractual relationship with MUSC Medical Center to provide professional services to patients shall be subject to those provisions contained in said contract with regard to the termination of Medical Staff membership and privileges upon the expiration, lapse, cancellation, or termination of the contract. If no provisions for termination of membership or privileges are contained in the contract, the affected practitioners' membership and clinical privileges will be terminated at the time of the contract termination, lapse, expiration or cancellation date. The affected practitioners shall have no right to a hearing regarding termination of Medical Staff membership or privileges.....**329**

Article V. OFFICERS .....**324010**

**Error! Hyperlink reference not valid.**.....**OFFICERS OF THE MEDICAL STAFF**—**3340**

**Error! Hyperlink reference not valid.**Section 5.01 ..... The officers of the Medical Staff shall be: .....**3340**

**Error! Hyperlink reference not valid.**(a) ..... President .....**3340**

**Error! Hyperlink reference not valid.**(b) ..... Vice President .....**3340**

**Error! Hyperlink reference not valid.**(c) ..... Secretary .....**3340**

**Error! Hyperlink reference not valid.**.....**QUALIFICATIONS OF OFFICERS**—**3340**

**Error! Hyperlink reference not valid.**Section 5.02 Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during their terms of office. Officers should possess some Medical Staff administrative experience. In addition, Medical Staff officers must be committed to put in the required time to assist the functioning of the organized Medical Staff.....**3340**

**Error! Hyperlink reference not valid.**.....**SELECTION OF OFFICERS**—**3340**

**Error! Hyperlink reference not valid.**Section 5.03 ..A nominating committee shall be appointed by the Medical Staff president at the meeting prior to biennial elections.....**3340**

**Error! Hyperlink reference not valid.**(a) ... This committee shall present a slate of officers to the Medical Staff at its annual meeting.....**3340**

**Error! Hyperlink reference not valid.**(b) ..... Medical Staff members may submit names for consideration to members of the nominating committee.....**3340**

**Error! Hyperlink reference not valid.**(c) ..... Only Active Staff shall be eligible to vote. A plurality vote of these Active Staff present at the annual meeting is required.....**3340**

**Error! Hyperlink reference not valid.**.....**TERM OF OFFICE**—**3410**

**Error! Hyperlink reference not valid.**Section 5.04 .... All officers shall take office on the first day of the calendar year and serve a term of two years.....**3410**

<b>Error! Hyperlink reference not valid.</b>	VACANCIES IN OFFICE
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	Section 5.05 Vacancies in office during the Medical Staff year, except the Office of President, shall be filled by the MEC of the Medical Staff. If there is a vacancy in the Office of the President, the Vice President shall serve the remainder of the term.
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	Section 5.06 DUTIES OF OFFICERS
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	(a) President The President shall serve as the chief administrative officer of the Medical Staff and will fulfill those duties as specified in the organization and functions manual.
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	(b) Vice President In the absence of the President, Vice President shall assume all the duties and have the authority of the President. He shall perform such further duties to assist the President as the President may, from time to time request, including the review and revision of bylaws as necessary, supervision of the Medical Center's quality, patient safety, and resource utilization programs, and the MEC liaison for medical staff peer review activities. The Vice President will serve as the President-Elect.
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	(c) Secretary The secretary shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all Medical Staff meetings.
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	Section 5.07 REMOVAL FROM OFFICE
<b>3410</b>	
<b>Error! Hyperlink reference not valid.</b>	(a) The Medical Staff and/or Board of Trustees may remove any Medical Staff officer for failure to fulfill his responsibilities, conduct detrimental to the interests of the MUSC.
<b>3514</b>	
<b>Error! Hyperlink reference not valid.</b>	Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that
<b>3514</b>	
<b>Error! Hyperlink reference not valid.</b>	(b) renders him incapable of fulfilling the duties of the office.
<b>3514</b>	
<b>Error! Hyperlink reference not valid.</b>	(c) Elected officers may be removed by 2/3 majority vote of the Medical Staff for the reasons stated in VII A above.
<b>3514</b>	
<b>Error! Hyperlink reference not valid.</b>	(d) Removal from elected office shall not entitle the practitioner to procedural rights.
<b>3514</b>	
<b>Error! Hyperlink reference not valid.</b>	(e) Any Medical Staff member has the right to initiate a recall election of a Medical Staff Officer. A petition to recall must be signed by at least 25% of the members of the active staff and presented to the MEC. Upon presentation, the MEC will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote.
<b>3514</b>	
Article VI. DEPARTMENTS	361214
<b>Error! Hyperlink reference not valid.</b>	ORGANIZATION OF DEPARTMENTS
<b>3614</b>	
<b>Error! Hyperlink reference not valid.</b>	Section 6.01 The Medical Staff shall be organized into departments, divisions, and or sections, in a manner as to best assure:
<b>3614</b>	
<b>Error! Hyperlink reference not valid.</b>	(a) the supervision of clinical practices within the Hospital;
<b>3614</b>	
<b>Error! Hyperlink reference not valid.</b>	(b) the conduct of teaching and training programs for students and House Staff;
<b>3614</b>	
<b>Error! Hyperlink reference not valid.</b>	(c) the discovery of new knowledge;
<b>3614</b>	

**Error! Hyperlink reference not valid.**(d) ..... the dissemination of new knowledge;  
 .....3611

**Error! Hyperlink reference not valid.**(e) the appropriate administrative activities of the Medical Staff; and an integrated quality management program to monitor objectively and systematically evaluate the quality and appropriateness of patient care, objectively establish and monitor criteria for the effective utilization of hospital and physician services, and pursue opportunities to improve patient care and resolve identified problems. ....3611

**Error! Hyperlink reference not valid.**(f) the active involvement in the measurement, assessment and improvement of patient care processes. ....3611

**Error! Hyperlink reference not valid.**Section 6-02 ..... QUALIFICATIONS AND SELECTION OF DEPARTMENT CHAIRPERSON .....3611

**Error! Hyperlink reference not valid.**(a)Each Chairperson shall be a member of the Active Category of the Medical Staff and be well qualified by training and experience and demonstrated ability for the position. The Chairperson must be certified in an appropriate specialty board, or have comparable competence that has been affirmatively established through the credentialing process. ....3611

**Error! Hyperlink reference not valid.**(b) The appointment and removal of Department Chairpersons shall be the responsibility of the Dean of the appropriate College in accordance with the Board of Trustees approved Rules and Regulations of the Faculty of the Medical University of South Carolina (Faculty Handbook). . Such appointment must then be submitted to the Board of Trustees for approval. —3742

**Error! Hyperlink reference not valid.**..... FUNCTIONS OF DEPARTMENT—  
 .....3742

**Error! Hyperlink reference not valid.**Section 6-03 ..... Through the department Chairperson each department shall: .....3742

**Error! Hyperlink reference not valid.**(a) ..... Recommend to the Medical Staff the objective and evidenced based criteria consistent with the policies of the Medical Staff and the Board of Trustees for the granting and renewal of clinical privileges related to patient care provided within the department—3742

**Error! Hyperlink reference not valid.**(b) ..... Recommend clinical privileges for each member of the Department. ....3742

**Error! Hyperlink reference not valid.**(c) ..... Develop and uniformly apply criteria for a focused time limited professional practice evaluation for all initially requested privileges of independent practitioners within their department. ....3742

**Error! Hyperlink reference not valid.**(d) ..... Develop and uniformly apply criteria for the on-going professional evaluation of all independent practitioners within their department.....3843

**Error! Hyperlink reference not valid.**(e) ... Assure the decision to deny a privilege(s) is objective and evidenced based. ....3843

**Error! Hyperlink reference not valid.**(f) . Establish policies and procedures and scope of practice for House Staff supervision. The character of supervision will depend upon the level of training and demonstrated competence of each House Staff member. ....3843

**Error! Hyperlink reference not valid.**(g) ..... Each department shall participate in a medical care evaluation program and/or quality improvement program as required by accrediting bodies, federal regulations and state statutes. This plan shall include a process that assures active participation in the ongoing measurement, assessment and improvement of the quality of care and treatment and include quality control processes as appropriate. ....3843

**Error! Hyperlink reference not valid.**(h) .. Shall establish standards and a recording methodology for the orientation and continuing education of its members. Such continuing education should (1) represent a balance between intra-institutional and outside activities, (2) be based, when applicable, on the findings of the quality improvement effort, (3) be appropriate to the practitioner's privileges and

will be considered as part of the reappointment process. Participation in the roles of both students and teachers is recognized as the means of continuously improving the services rendered by the Medical Staff.	3813
<b>Error! Hyperlink reference not valid.</b> (i). Coordinate clinical activities of the department and integrate all patient care and clinical activities with MUSC Medical Center.	3813
<b>Error! Hyperlink reference not valid.</b> (j)..... Monitor on a continuing basis, departmental activities and compliance with Medical Staff Bylaws or other accrediting bodies.	3813
<b>Error! Hyperlink reference not valid.</b> (k)..... Define the circumstances and implement the process of focused peer review activities within the department.	3813
<b>Error! Hyperlink reference not valid.</b> (l).. Assess and recommend off-site sources for needed patient care, treatment and service when not provided by the department.	3813
<b>Error! Hyperlink reference not valid.</b> (m).. Conduct administrative duties of the department when not otherwise provided by the hospital.	3913
<b>Error! Hyperlink reference not valid.</b> (n) ..... Coordinate and integrate all inter and intra departmental services.	3913
<b>Error! Hyperlink reference not valid.</b> (o)Develop and implement department policies and procedures that guide and support the provision of safe quality care, treatment, and services.	3913
<b>Error! Hyperlink reference not valid.</b> (p) ..... Recommend sufficient qualified and competent staff to provide care within the department and with Clinical Services and MUSC Medical Center leaders determine the qualifications and competencies of non LIP's within the department who provide patient care, treatment, and services.	3913
<b>Error! Hyperlink reference not valid.</b> (q) Recommend space and resource needs of the department.	3913
<b>Error! Hyperlink reference not valid.</b> (r) ..... Ensure the timely and appropriate completion of MUSC Medical Center administrative responsibilities assigned to departmental physicians.	3913
<b>Error! Hyperlink reference not valid.</b> (s). Supervise the completion of the assigned responsibilities of departmental members who serve as MUSC Medical Center Medical Directors.	3913
<b>Error! Hyperlink reference not valid.</b> (t) ..... Assess and improve on a continuing basis the quality of care, treatment, and services provided in the department.	3914
<b>Error! Hyperlink reference not valid.</b> ..... ASSIGNMENT TO DEPARTMENTS	3914
<b>Error! Hyperlink reference not valid.</b> Section 6.04 ..... All members of the Medical Staff shall be assigned to a department as part of the appointment process.	3914
Article VII. COMMITTEES AND FUNCTIONS	4014
<b>Error! Hyperlink reference not valid.</b> Section 7.01 ..... MEDICAL EXECUTIVE COMMITTEE	4014
<b>Error! Hyperlink reference not valid.</b> (a) ... Composition: The Medical Executive Committee (MEC) is the executive committee of the organized Medical Staff. The majority of members are physicians. Other hospital and University leaders shall have membership in order to allow the committee to have an integrated leadership role within MUSC Medical Center. The MEC shall include:	4014
<b>Error! Hyperlink reference not valid.</b> (b) ..... The Medical Executive Committee will be chaired by the Vice President for Medical Affairs (or his/her designee) and co-chaired by the Medical Staff President.	4115
<b>Error! Hyperlink reference not valid.</b> (c)..... All members will have voting rights.	4115
<b>Error! Hyperlink reference not valid.</b> (d) ..... Duties - The duties of the MEC shall be to:	4115
<b>Error! Hyperlink reference not valid.</b> (e) ..... Delegated Authority	4216



**Error! Hyperlink reference not valid.**(f) . Meetings – The MEC shall meet at least six (6) times a year or as often as necessary to fulfill its responsibility and maintain a permanent record of its proceedings and actions. Special meetings of the MEC may be called at any time by the Chairperson.....**4246**

**Error! Hyperlink reference not valid.**(g) . Removal from MEC – The Medical Staff and/or the Board of Trustees may remove any member of the MEC for failure to fulfill his responsibilities, conduct detrimental to the interests of the MUSC Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the committee. Any Medical Staff member has the right to initiate a recall of a Medical Executive Committee member. A petition to recall must be signed by at least 25% of the members of the Active staff and presented to the MEC or to the Board of Trustees if the recall is for the majority or all of the MEC members. Upon presentation, the MEC or Board of Trustees will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote. Removal of an MEC member shall require a 2/3 majority vote of voting members. Removal from the MEC shall not entitle the practitioner to procedural rights.....**4246**

**Error! Hyperlink reference not valid.**Section 7.02 ..... OTHER MEDICAL STAFF FUNCTIONS  
.....**4316**

**Error! Hyperlink reference not valid.**(a) .... Peer Review – All members of the MUSC Medical Center Medical Staff, House Staff, and Professional Staff will be included in the Medical Staff's peer review process. ....**4316**

**Error! Hyperlink reference not valid.**The accomplishment of the following functions may or may not require the existence of separate, established committees. The functions consist of collection of relevant information (monitoring), and presentation to the appropriate Clinical Departments, discussion, and action (evaluation and problem-solving). Evidence that these functions are being effectively accomplished at the departmental level is included in departmental .....**4317**

**Error! Hyperlink reference not valid.**....reports to the MEC, and in MEC reports to the Board: These functions can be carried out.....**4317**

**Error! Hyperlink reference not valid.**(b) .....by a Medical Staff Committee, a MUSC Medical Center interdisciplinary committee, a responsible group, or individual. These functions include, but are not limited to: ....**4317**

Article VIII. HISTORY AND PHYSICAL REQUIREMENTS .....**441818**

**Error! Hyperlink reference not valid.**..... Comprehensive History and Physical-  
.....**4418**

**Error! Hyperlink reference not valid.**..... A comprehensive history and physical (H&Ps) shall be completed no later than twenty-four (24) hours after admission (includes inpatient or observation status) or at the initial visit to an ambulatory clinic, or prior to any operative, invasive, high risk ....**4518**

**Error! Hyperlink reference not valid.**.... diagnostic or therapeutic procedure, or procedures requiring moderate or deep sedation .....**4518**

**Error! Hyperlink reference not valid.**Section 8.01 ..... or anesthesia regardless of setting.  
.....**4518**

**Error! Hyperlink reference not valid.**..... A complete H&P (except in circumstances  
.....**4518**

**Error! Hyperlink reference not valid.**(a) .....allowing a focused H&P) must include (as information is available): ....**4518**

**Error! Hyperlink reference not valid.**..... Focused History and Physical – For other non-inpatients procedures, a focused history and physical may be completed .....**4518**

**Error! Hyperlink reference not valid.**Section 8.02 based on the presenting problem. A focused H&P must include at a minimum: .....**4518**

**Error! Hyperlink reference not valid.**(a) ..... present illness  
.....**4518**

**Error! Hyperlink reference not valid.**(b) .....past medical/surgical history  
4518

**Error! Hyperlink reference not valid.**(c) .....medications  
4518

**Error! Hyperlink reference not valid.**(d) .....allergies  
4518

**Error! Hyperlink reference not valid.**(e) .....focused physical exam to include the presenting problem and heart and lungs, .....4518

**Error! Hyperlink reference not valid.**(f) .impression and plan including the reason for the procedure.  
4518

**Error! Hyperlink reference not valid.**.....Primary Care Clinics – H&Ps are required in all primary care clinics. On subsequent primary care visits .....4619

**Error! Hyperlink reference not valid.**and in specialty clinics, the H&P can be focused, based on the presenting problem(s). .....4619

**Error! Hyperlink reference not valid.**Section 8.03 The focused H&P must meet the requirements for a focused H&P. ....4619

**Error! Hyperlink reference not valid.**.....H&P Not Present–  
4619

**Error! Hyperlink reference not valid.**..... When the H&P examination is not on the chart prior to the surgery or high risk diagnostic or therapeutic procedure, the said procedure shall be delayed until the H&P is .....4619

**Error! Hyperlink reference not valid.**Section 8.04 ..... completed unless it is an emergency.  
4619

**Error! Hyperlink reference not valid.**..... Updating an H&P–  
4619

**Error! Hyperlink reference not valid.**.. When using an H &P that was performed within 30 days prior to admission or a procedure, and that H&P is in the patient's medical record, an update to the H&P must be completed within 24 hours for inpatients or prior to the procedure whichever comes .....4619

**Error! Hyperlink reference not valid.**..first . This includes intra-campus admissions from the Medical Center. (i.e., TCU, IOP) For all surgeries and other procedures requiring an H&P this update may be completed in.....4619

**Error! Hyperlink reference not valid.**Section 8.05 ..combination with the preanesthesia assessment.  
4619

**Error! Hyperlink reference not valid.**Section 8.06 ..... H&P Responsibility:  
4619

**Error! Hyperlink reference not valid.**(a) ...Dentists are responsible for the part of their patient's H&P that relates to dentistry.....4619

**Error! Hyperlink reference not valid.**... Oral and maxillofacial surgeons may perform a medical H&P examination in order to .....4619

**Error! Hyperlink reference not valid.**(b) .....assess the status and risk of the proposed surgery or procedures. 4619

**Error! Hyperlink reference not valid.**(c).... Podiatrists are responsible for the part of his/her patient's H&P that relates to podiatry. ....4619

**Error! Hyperlink reference not valid.**(d) ....Optometrists are responsible for the part of their patient's H&P that relates to optometry. ....4619

**Error! Hyperlink reference not valid.**Section 8.07 ..... The attending physician is responsible for the complete H&P. ....4719

**Error! Hyperlink reference not valid.**.... Residents, advanced nurse practitioners and in some cases physicians assistants, .....4719



<b>Error! Hyperlink reference not valid.</b> (a)..... appropriately privileged, may complete the H&P with the attending physician's counter signature.....	<b>4719</b>
<b>Error! Hyperlink reference not valid.</b> (b) ..In lieu of a signature the attending physician may complete an additional attestation sheet to confirm or change the initial history and physical.....	<b>4719</b>
<b>Error! Hyperlink reference not valid.</b> .....The co-	<b>4719</b>
<b>Error! Hyperlink reference not valid.</b> (c)..... signature by the attending or the attestation must be completed by the attending within 48 hours of admission or prior to any procedure requiring H&P's.....	<b>4719</b>
Article IX. MEDICAL STAFF MEETINGS .....	<b>472019</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.01 .....	<b>REGULAR MEETINGS</b>
<b>Error! Hyperlink reference not valid.</b> (a) . The Medical Staff shall meet at least quarterly or more often, as needed. Appropriate action will be taken as indicated.....	<b>4719</b>
<b>Error! Hyperlink reference not valid.</b> (b) ... An Annual Medical Staff Meeting shall be held during the last quarter of each year. Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted.....	<b>4719</b>
<b>Error! Hyperlink reference not valid.</b> (c).The primary objective of the meetings shall be to report on the activities of the staff, elect officers if necessary, and conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.....	<b>4819</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.02 .....	<b>SPECIAL MEETINGS</b>
<b>Error! Hyperlink reference not valid.</b> .....	<b>QUORUM—</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.03 The quorum requirements for all meetings shall be those present and voting, unless otherwise indicated in these Bylaws.....	<b>4820</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.04 .....	<b>ATTENDANCE REQUIREMENTS</b>
<b>Error! Hyperlink reference not valid.</b> .....PARTICIPATION BY EXECUTIVE DIRECTOR OF THE MUSC MEDICAL CENTE.....	<b>4920</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.05 .... The Executive Director of the MUSC Medical Center or his/her designee may attend any Committee, Department, or Section meeting of the Medical Staff.....	<b>4920</b>
<b>Error! Hyperlink reference not valid.</b> .....	<b>ROBERT'S RULES OF ORDER—</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.06 ..... The latest edition of ROBERT'S RULES OF ORDER shall prevail at all meetings of the General Staff, MEC, and Department Meetings unless waived by the Chairperson.....	<b>4920</b>
<b>Error! Hyperlink reference not valid.</b> .....	<b>NOTICE OF MEETINGS—</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.07 .. Written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee or department not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.....	<b>4920</b>
<b>Error! Hyperlink reference not valid.</b> .....	<b>ACTION OF COMMITTEE/DEPARTMENT—</b>
<b>Error! Hyperlink reference not valid.</b> Section 9.08 The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department.....	<b>5020</b>

~~Error! Hyperlink reference not valid.~~.....MINUTES-  
~~—5020~~

~~Error! Hyperlink reference not valid.~~Section 9.09. Minutes of each regular and special meeting of a Committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes from the Departments and Credentials Committee Meetings shall be signed, electronically or physically, by the presiding officer and copies thereof submitted to the MEC. The minutes from other committee meetings shall be signed by the presiding officer and copies thereof submitted to the appropriate departments. ....5020

Article X. TERMINATION, REDUCTION, AND SUSPENSION OF PRIVILEGES .....512224  
SUSPENSION— .....512224

~~Error! Hyperlink reference not valid.~~Section 10.01..... In the event that an individual practitioner's action may pose a danger to patients, other Medical Staff members, or the Hospital or its personnel, then either the President of the Medical Staff or Executive Medical Director or the Chairperson of the clinical department to which the practitioner is a member, shall each have the authority, as independent action, to suspend all or any portion of the Clinical Privileges of the Medical Staff member in question. ....5124

~~Error! Hyperlink reference not valid.~~(a) Such precautionary suspension does not imply final findings of fact or responsibility for the situation that caused the suspension. ....5124

~~Error! Hyperlink reference not valid.~~(b) . Such precautionary suspension is immediately effective, is immediately reported to all the individuals named above, and the Medical Staff Office, and remains in effect until a remedy is effected following the provision of this Article of the Medical Staff Bylaws. ....5124

~~Error! Hyperlink reference not valid.~~(c).....Immediately upon the imposition of a suspension, the appropriate Department Chairperson or the Chief of Staff assigns to another Medical Staff member the responsibility for care of any hospitalized patients of the suspended individual. ....5124

~~Error! Hyperlink reference not valid.~~(d) ..... As soon as practical, but in no event later than three (3) days after a precautionary suspension, the Medical Executive Committee shall convene to review the action. The affected practitioner may request to be present at this meeting, which is not a hearing and is not to be construed as such. The MEC may continue the suspension, or take another action pursuant to this Article. If the action taken entitles the affected practitioner to a hearing, then the Hearing and Appeals Procedure Fair Hearing Plan shall apply .....5124

~~Error! Hyperlink reference not valid.~~Section 10.02... EFFECT OF OTHER ACTIONS ON MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES.....5124

~~Error! Hyperlink reference not valid.~~(a) ..Failure to Complete Medical Records— All portions of each patient's medical record shall be completed within the time period after the patient's discharge as stated in Medical Staff Rules and Regulations. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in (a) the record being defined as delinquent and (b) notification of the practitioner. ....5122

~~Error! Hyperlink reference not valid.~~(b) Failure to Complete Education Requirements—The Medical Staff recognizes the need to mandate certain education requirements for all Medical Staff in order to ensure ongoing success of quality improvement. ....5222

~~Error! Hyperlink reference not valid.~~(c).....Actions Affecting State License to Practice— If a practitioner's state license to practice or DEA registration is revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, suspended, or limited to at least the same extent, subject to re-application by the practitioner when or if his/her license or DEA registration is reinstated, or limitations are removed, whatever is the case. ....5222

~~Error! Hyperlink reference not valid.~~(d) ...Lapse of Malpractice Coverage— If the MEC and Board of Trustees have established a requirement for liability coverage for practitioners with clinical privileges, and if a staff member's malpractice coverage lapses without renewal, then the practitioner's clinical

privileges are automatically suspended until the effective date of his/her new malpractice coverage, unless otherwise determined by the Board.....	5322
<b>Error! Hyperlink reference not valid.</b> (e) Governmental Sanction or Ban—Imposition of governmental sanction or ban as outlined by Medicare and the DHHS—Office of the Inspector General is cause for immediate loss of all clinical privileges.....	5322
<b>Error! Hyperlink reference not valid.</b> (f) ... Felony Conviction—conviction of a felony offense is cause for immediate loss of all clinical privileges.....	5322
<b>Error! Hyperlink reference not valid.</b> (g) .. Loss of Faculty Appointment—Loss of faculty appointment shall result in immediate revocation of clinical privileges and appointment to the Medical Staff. ....	5322
<b>Error! Hyperlink reference not valid.</b> (h) ..... Failure to Meet Application Requirements—Failure to comply with deadlines or other application requirements will result in loss of appointment and privileges as outlined in the Credentials Policy Manual. ....	5323
<b>Error! Hyperlink reference not valid.</b> ..... FAIR HEARING PLAN—	5323
<b>Error! Hyperlink reference not valid.</b> Section 10.03 .....Any physician has a right to a hearing/appeal pursuant to the institution's Fair Hearing Plan in the event any of the following actions are taken or recommended:—	5323
<b>Error! Hyperlink reference not valid.</b> (b) ..... PROFESSIONAL REVIEW ACTION	5423
<b>Error! Hyperlink reference not valid.</b> (c)....STANDARDS FOR PROFESSIONAL REVIEW ACTIONS	5524
<b>Error! Hyperlink reference not valid.</b> (d) .....ADEQUATE NOTICE AND RIGHT TO HEARING	5625
<b>Error! Hyperlink reference not valid.</b> .....NOTICE AND REQUEST FOR HEARING—	5726
<b>Error! Hyperlink reference not valid.</b> (e) .. If a hearing is requested on a timely basis, the practitioner involved shall be given additional notice state: .....	5726
<b>Error! Hyperlink reference not valid.</b> (f) ..... CONDUCT OF HEARING AND NOTICE	5726
<b>Error! Hyperlink reference not valid.</b> .....RIGHTS OF THE PARTIES—	5827
<b>Error! Hyperlink reference not valid.</b> (g) .....In the hearing, the practitioner involved has the right: .....	5827
<b>Error! Hyperlink reference not valid.</b> .....COMPLETION OF HEARING—	5827
<b>Error! Hyperlink reference not valid.</b> (h) .... Upon completion of the hearing, the practitioner involved shall the right:.....	5827
<b>Error! Hyperlink reference not valid.</b> (i)..... CONDUCT OF HEARING	5927
<b>Error! Hyperlink reference not valid.</b> (j)..... EVIDENTIARY MATTERS IN CONTESTED CASES	5928
<b>Error! Hyperlink reference not valid.</b> .....BURDEN OF PROOF—	6028
<b>Error! Hyperlink reference not valid.</b> (k).....When a hearing relates to the following: .....	6028
<b>Error! Hyperlink reference not valid.</b> .....REPORT AND FURTHER ACTION—	6029
<b>Error! Hyperlink reference not valid.</b> (l). At the conclusion of the final hearing, the Arbitrator, Hearing Officer or the ad hoc Hearing Committee shall: .....	6029

<del>Error! Hyperlink reference not valid.</del> (m).....	NOTICE OF DECISION
<del>6029</del>	
<del>Error! Hyperlink reference not valid.</del> (n) .....	NOTICE OF APPEAL
<del>6129</del>	
<del>Error! Hyperlink reference not valid.</del> (o) .....	APPELLATE REVIEW PROCEDURE
<del>6129</del>	
<del>Error! Hyperlink reference not valid.</del> (p) .....	FINAL DECISION BY THE BOARD OF TRUSTEES
<del>6230</del>	
<del>Error! Hyperlink reference not valid.</del> (q) .....	ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES
<del>6230</del>	
<del>Error! Hyperlink reference not valid.</del> (r)....	REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HOSPITALS
<del>6331</del>	
Article XI. CONFLICT MANAGEMENT AND RESOLUTION .....	633131
<del>Error! Hyperlink reference not valid.</del> Section 11.01 .....	MEC and Medical Staff
<del>6431</del>	
<del>Error! Hyperlink reference not valid.</del> Section 11.02 .....	MEC and BOARD of TRUSTEES
<del>6432</del>	
Article XII. OFFICIAL MEDICAL STAFF DOCUMENTS .....	643132
<del>Error! Hyperlink reference not valid.</del> Section 12.01 .....	BYLAWS
<del>6432</del>	
<del>Error! Hyperlink reference not valid.</del> (a)...	Methods Of Adoption And Amendment- Amendments to these bylaws may be on recommendation from the MEC approved by the voting members of the Medical Staff or after notification to the MEC on a proposal directly from a two thirds (2/3) majority of voting Medical Staff to the Board of Trustees, The Bylaws may be amended or revised after submission of the proposed amendment at any regular or special meeting of the Medical Staff or by email or US mail submission to all Active Medical Staff members. To be adopted, an amendment or revisions shall require a majority vote of the Active members. Voting can be completed either in person at a Medical Staff meeting or by electronic ballot vote of those who are eligible to vote on the Bylaws. Amendments so made shall be effective only when approved by the Board of Trustees.
<del>6532</del>	
<del>Error! Hyperlink reference not valid.</del> (b).....	The Executive Committee is authorized to make minor changes/corrections when necessary due to spelling, punctuation and/or grammar.
<del>6532</del>	
<del>Error! Hyperlink reference not valid.</del> (c).....	These Bylaws shall be reviewed at least every two (2) years by the Officers of the Medical Staff. Findings shall be reported at a regular meeting of the Medical Staff or at a special meeting called for such purpose or by email to active Staff members. Any recommended changes shall be amended in accordance with these Bylaws.
<del>6532</del>	
<del>Error! Hyperlink reference not valid.</del> Section 12.02 .....	Rules and Regulations and Other Related Documents
<del>6633</del>	
<del>Error! Hyperlink reference not valid.</del> The MEC will provide to the Board of Trustees a set of Medical Staff Rules and Regulations, a Credentials Policy Manual, and a Fair Hearing Plan that further defines the general policies contained in these Bylaws	
<del>6633</del>	
<del>Error! Hyperlink reference not valid.</del> .....	These manuals will be incorporated by reference and become part of these Medical
<del>6633</del>	
<del>Error! Hyperlink reference not valid.</del> Staff Bylaws. The MEC has the delegated authority to make amendments to the	
<del>6633</del>	
<del>Error! Hyperlink reference not valid.</del> Rules and Regulations of the Medical Staff, the Credentials Manual of the Medical	
<del>6633</del>	
<del>Error! Hyperlink reference not valid.</del> Staff, the Fair Hearing Plan and other Medical Staff policies as outlined in Article VII	
<del>6633</del>	

Error! Hyperlink reference not valid.(a).....E-2.

6633

Error! Hyperlink reference not valid....Alternatively the Medical Staff may propose an amendment to the Rules and .....6633

Error! Hyperlink reference not valid...... Regulations and other afore mentioned associated documents directly to the Board of .....6633

Error! Hyperlink reference not valid...... Trustees. Such a proposal shall require a two-thirds (2/3) majority vote of the Active .....6633

Error! Hyperlink reference not valid...... Medical Staff and shall require notification to the MEC. —6633

Error! Hyperlink reference not valid.(b).....6633

Error! Hyperlink reference not valid.When there is a documented need for an urgent amendment to rules and regulations .....6633

Error! Hyperlink reference not valid.... to comply with the a law or regulation, the voting members of the organized medical .....6633

Error! Hyperlink reference not valid.staff delegate the authority to the MEC to by a majority vote of the MEC members .....6633

Error! Hyperlink reference not valid.... provisionally adopt such amendments and seek provisional Board of Trustees approval without prior notification to the medical staff. The MEC will immediately notify the .....6633

Error! Hyperlink reference not valid.Medical Staff of such provisional approval by the Board. The Medical Staff at its next .....6633

Error! Hyperlink reference not valid...... meeting, or at a called meeting or through electronic communication will retrospectively review the provisional amendment. If there is no conflict between the .....6633

Error! Hyperlink reference not valid...... organized medical staff and the MEC regarding the amendment, the provisional amendment stands. If there is a conflict over the provisional amendment(s) the Conflict Management process as outlined in Article X of these bylaws will be implemented. If .....6633

Error! Hyperlink reference not valid.(c) .. necessary a revised amendment is then submitted to the Board of Trustees for action. ....6633

Error! Hyperlink reference not valid...... The Rules and Regulations of the Medical Staff, the Credentials Manual, the Fair .....6733

Error! Hyperlink reference not valid.(d) .....Hearing Plan and the Policies of the Medical Staff are intended to provide the associated details necessary to implement these Bylaws of the MUSC Medical Staff, .....6733

Error! Hyperlink reference not valid...... RULE CHALLENGE —6733

Error! Hyperlink reference not valid.Section 12.03 .....6733

Error! Hyperlink reference not valid.Any practitioner may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate, any physician may .....6733

Error! Hyperlink reference not valid.submit a petition signed by 25% of the members of the Active Staff. When such petition has been received by the MEC, it will either: .....6733

Error! Hyperlink reference not valid.(a) ...Provide the petitions with information clarifying the intent of such rule, regulation, or policy and/or .....6733

Error! Hyperlink reference not valid.(b) ... Schedule a meeting with the petitioners to discuss the issue. —6733

## PARTICLE I

### Article I. PURPOSE AND RESPONSIBILITIES

Section 1.01 *The purpose of the organized Medical Staff of the MUSC Medical Center is to bring the professionals, who practice at the Medical Center together into a self governing cohesive body to:*

- ~~1.(a) provide~~Provide oversight of quality of care, treatment and services to patients of the MUSC Medical Center.
- ~~2.(b) determine~~Determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership.
- ~~3.(c) determine~~Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities for non-member practitioners with independent privileges.
- ~~4.(d) review~~Review new and on-going privileges of members and non-member practitioners with independent privileges.
- ~~5.(e) approve~~Approve and amend medical staff bylaws, and rules and regulations.
- ~~6.(f) provide~~Provide a mechanism to create a uniform standard of care, treatment, and service.
- ~~7.(g) evaluate~~Evaluate and assist in improving the work done by the staff, provide education, and offer advice to the Vice President for Clinical Operations/Executive Director of the MUSC Medical Center.

Section 1.02 *The organized medical staff is also responsible for:*

- ~~1.(a) the O-~~ongoing evaluation of the competency of practitioners who are privileged.
- ~~2.(b) delineating~~Delineating the scope of privileges that will be granted to practitioners.
- ~~3.(c) providing~~Providing leadership in performance improvement activities within the organization.
- ~~(d) assuring~~Assuring that practitioners practice only within the scope of their privileges.
- ~~4.(e) selecting~~Selecting and removing medical staff officers.

Section 1.03 *The Medical University Hospital Authority, that includes the Medical University hospitals, clinics, and other health care related facilities, shall hereinafter be referred to in the body of this document as the Medical University of South Carolina Medical Center (MUSC Medical Center).*

ARTICLE II

BILL OF RIGHTS

Article II. ~~I~~ Member Staff Rights



Section 2.01 Members of the Medical Staff are afforded the following rights:

~~A.~~ Right of Notification- Any matter of performance or conduct that could result in denial,

~~\_\_\_\_\_~~ suspension, or reduction of privileges will cause the Department Chairperson to notify the

~~(a)~~ ~~\_\_\_\_\_~~ affected member before formal activity commences.

~~B.~~ Access to Committees - Members of the Medical Staff are entitled to be present at ~~any~~

~~(b)~~ ~~\_\_\_\_\_~~ ~~committees~~ committee meeting except during peer review proceedings. Members present for a specific agenda item shall be recognized by the Chairperson as time permits. Members can petition the Medical Executive Committee (MEC) for a specific agenda item or issue.

~~C.~~~~(c)~~ Right of Information - Activities of the various committees (with the exception of peer review proceedings) may be reviewed by the Medical Staff members in the Medical Staff office. The MEC will provide to the active membership all changes to the Rules & Regulations, Credentials Policy Manual, and the Fair Hearing DocumentPlan.

~~D.~~~~(d)~~ Fair Hearing - Members are entitled to a fair hearing as described in the Fair Hearing DocumentPlan.

~~E.~~ Access to Credentials File - Each member shall be afforded an opportunity to review his/her own credentials file before submission for approval. This review will occur at the time of initial appointment and at the time of reappointment as specified in the Credentials Policy Manual.

~~(e)~~ \_\_\_\_\_

~~(f)~~ Physician Health and Well-Being - Any member may call upon the resources of the Medical Staff in personal, professional, and peer matters to seek help and improvement.

~~F.~~ \_\_\_\_\_

~~\_\_\_\_\_~~ Medical Staff in personal, professional, and peer matters to seek help and improvement.

~~G.~~~~(g)~~ Confidentiality - Matters discussed in committee and otherwise undertaken in the performance of Medical Staff duties and privileges are strictly confidential. Violation of this provision is grounds for expulsion from the Medical Staff.



## ARTICLE III

### Article III. MEDICAL STAFF MEMBERSHIP & STRUCTURE

#### MEDICAL STAFF APPOINTMENT

Section 3.01 Appointment to the Medical Staff of the MUHMUSC Medical Center is a privilege that shall be extended only to competent professionals, who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies of the Medical Staff and MUSC Medical Center ~~MUH~~.

#### II QUALIFICATIONS FOR MEMBERSHIP

##### Section 3.02

A. (a) Only physicians with Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degrees, or Dentists or podiatrists holding a current, valid unrestricted license to practice in the State of South Carolina shall be qualified for appointment to the Medical Staff. Additional requirements include:

- (i) documentation of background, experience, training, judgment, individual character and demonstrated competence, and physical and mental capabilities, with sufficient adequacy to assure the Medical Staff and Board Board of Trustees that any patient treated by them in the hospitals will be given a high quality of patient care,

- (ii) ~~demonstrated~~ Demonstrated adherence to the ethics of ~~their~~ his/her profession, and ability to work with others

(b) No professional may be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges at the MUSC Medical Center merely by virtue of licensure to practice in this or any other state, or of membership in any professional organization, or of privileges at another Medical Center.

B. Must be free from government sanctions and bans as outlined by Medicare and the

(c) Department of Health and Human Services - Office of the Inspector General (DHHS-OIG).

(d) Must meet appointment requirements as specified in the Credentials Policy Manual.

C. (e) An MD, DO or Dentist member, appointed after December 11, 1992, shall be eligible for or have obtained board certification and comply with individual board requirements in his/her respective medical or dental specialty board. This Board must have been approved by the American Medical Association, the American Osteopathic Association, or the American Board of Medical Specialties. A five (5) year grace period may be allowed an applicant from the time of completion of his/her residency or fellowship to obtain initial board certification. Newly hired physicians who are not board certified or are more than 5 years out from initial eligibility are required to

attain Board Certification within two (2) years, or reappointment will not be granted. In special cases where a need exists, an exception to these qualifications can be made, only after the applicant has demonstrated competency to the satisfaction of the Department Chairperson in the department in which they are assigned and the Department Chairperson has attested either in a written or oral format to the ~~Medical Executive Committee~~ MEC for approval. Waiver of board certification requirement can be granted when no board specialty exists and the Department Chairperson attests (in written and oral format) to adequacy of training and competency. ~~or when Waiver of the board certification requirement can be granted when the practitioner is not eligible for board certification.~~ Should the practitioner become eligible for board certification, s/he will be required to attain Board Certification within two (2) years, or reappointment will not be granted. Foreign Board Certification may be an appropriate substitute for United States Board approval. The delegated committee (Credentials Committee) may choose to accept or reject such certification. In the event the certification is rejected by the Credentials Committee, the Department Chairperson may petition the ~~Medical Executive Committee~~ MEC for approval.

~~D.~~(f) A member of the Medical Staff must be a member of the faculty of the Medical University of South Carolina.

(g) Maintain malpractice insurance as specified by the MEC, ~~MU~~ MUSC Medical Center and Board of Trustees.

(h) Follow the associated details for qualifications for Medical Staff membership outlined in the Credentials Manual.

### ~~III~~ NON-DISCRIMINATION

~~Section 3.03~~ The ~~MUSC Medical Center~~ ~~Medical University Hospital~~ will not discriminate in granting staff appointment and/or clinical privileges on the basis of age, sex, race, creed, color, or nationality.

### ~~Section 3.04~~ ~~IV~~ CONDITIONS AND DURATION OF APPOINTMENT

~~A.~~(a) Initial appointments and reappointments to the Medical Staff shall be made by the Board ~~of Trustees~~.

~~The~~ ~~Board~~ ~~Board of Trustees~~ shall act on appointments and reappointments only after

~~there has been a recommendation from the Credentials Committee and MEC~~ ~~as outlined~~

(b) ~~with associated details in the Credentials Manual.~~

~~B.~~(c) All initial appointments shall be for a provisional period of one year.

~~C.~~(d) Appointments to the staff will be for no more than 24 calendar months.

(e) Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

~~D.~~(f) Only those practitioners assigned to the Active Medical Staff have general Medical Staff voting privileges.

~~E.~~ Medical Staff membership, clinical privileges and prerogatives will be terminated immediately if the practitioner is under government sanctions as listed by the Department of Health and Human Services ~~HHS~~ –

(g) Office of the Inspector General.

#### V PRIVILEGES AND PRACTICE EVALUATION -

Section 3.05 *The privileging process is described as a series of activities designed to collect verify, and evaluate data relevant to a practitioner's professional performance and focuses on objective, evidence-based decisions regarding appointment and reappointment.*

Initial requests for privileges are made simultaneously with the filing of the application for

(a) Medical Staff membership. Following procedures and the associated details stated in the Credentials Policy Manual, and with a recommendation of the appropriate Department Chairperson, the Medical Staff organization will evaluate and make recommendations to the Board. Privileges will only be granted or renewed, after applicant meets the criteria related to current licensure, relevant education, training and experience, demonstrated current competence, physical ability and the clinical ability to perform the requested privileges. For new procedures and at the time of reappointment, members' requests for privileges will be subject again to the procedures and procedures and associated details outlined in the Credentials Policy Manual.

(b) When considering privileges for a new practitioner, current data should be collected during the provisional time period for those privileges selected by the Department Chairperson

Prior to the granting of a privilege, the Department Chairperson determines the resources needed for each requested privileges and must assure the resources necessary to support the requested privilege are currently available or define the timeframe for availability.

(c) These availability. These resources include sufficient space, equipment, staffing, and financial. The Chairperson will work with hospital to ensure resources are available

—At the time of appointment and reappointment each candidate applying for privileges will

(d) —be evaluated using the following six areas of general competence as a reference:

- ~~a.~~(i) Patient Care
- ~~b.~~(ii) Medical/Clinical Knowledge
- ~~c.~~(iii) Practice-based learning and improvement
- ~~d.~~(iv) Interpersonal and communication skills
- ~~e.~~(v) Professionalism
- ~~f.~~(vi) System-based practices

—A Focused Professional Practice Evaluation (FPPE) allows the medical staff to focus

(e) on specific aspects of a practitioner's performance. This evaluation is used when:

- ~~a.~~(i) A practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organizations' setting.
- ~~b.~~(ii) Questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation
- ~~c.~~(iii) For all initially requested privileges (Effective January 2008)
- (f) Ongoing Professional Practice Evaluation (OPPE) is designed to continuously evaluate a practitioner's professional performance. It allows potential problems to be identified and also fosters a more efficient, evidence-based privilege renewal process. The type of data to be collected is approved by the organized medical staff but is determined by individual departments and is uniformly applied to all members within the department. The frequency of data collection is determined by the organized Medical Staff in collaboration with the Executive Medical Director and the Center for Clinical Effectiveness and Patient Safety. Information from ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges.

### Section 3.06 ~~VI~~ — *TEMPORARY and DISASTER PRIVILEGES*

~~A.~~ Temporary Privileges - Temporary privileges may be granted by the Executive Director of the Medical Center or ~~his/her~~ designee for a stated limited time upon the recommendation of the applicable Department Chairperson or the President of the Medical Staff, in all other circumstances, as detailed in the Credentials Policy Manual.

(a) —

~~B.~~(b) Disaster Privileges - Disaster privileges may be granted by the Executive Director of the Medical Center or the President of the Medical Staff or the Executive Medical Director of the Medical Center, according to Medical Center Policy C-35 "Disaster Privileges for Licensed Independent Practitioners, when the Emergency Management Plan for the Medical Center has been activated and when the Medical Center cannot handle the needs of patients with just the available credentialed staff. The Department Chairperson will be responsible for monitoring the professional performance of volunteer practitioners with disaster privileges. This monitoring will be accomplished through direct observation, staff feedback, and when appropriate, medical record review. The

Department Chairperson is responsible for reviewing the continuation of disaster privileges within 72 hours of granting the disaster privileges.

## VII LEAVE OF ABSENCE -

*Any member may apply to the Credentials Committee for a leave of absence not to exceed one (1) year. Reinstatement of privileges may be requested from the Credentials Committee without formal re-application. Absence for a period longer than one (1) year will require formal re-application. In some special cases, (i.e., military service) a Department Chairperson through the Credentials Committee can recommend to the MEC that a leave of absence be extended beyond a year without the necessity for formal reappointment. At no time can a special circumstance leave of absence extend beyond a two year re-appointment cycle.*

### Section 3.07

## VIII RESPONSIBILITIES OF MEMBERSHIP -

Section 3.08 Each staff member will:

\_\_\_\_\_  
A.(a) PP Provide timely, appropriate and continuous care/treatment/services for his/her patients and supervise the work of any allied health professional or trainee under his/her direction when appropriate.

\_\_\_\_\_  
B.(b) Assist the MUH MUSC Medical Center in fulfilling its responsibilities by participating in the on-call coverage of the emergency room and other coverage as determined by the MEC.

\_\_\_\_\_  
C.(c) Assist other practitioners in the care of their/his/her patients when asked.

\_\_\_\_\_  
D.(d) Act in an ethical and professional manner.

\_\_\_\_\_  
E.(e) Treat employees, patients, visitors, and other physicians in a dignified and courteous manner.

\_\_\_\_\_  
F.(f) Actively participate in the measurement, assessment, and improvement of patient care processes.

\_\_\_\_\_  
G.(g) Participate in peer review as appropriate.

\_\_\_\_\_  
H.(h) Abide by the bylaws, rules and regulations, department rules, and other policies and procedures of the MUSC Medical Center.

\_\_\_\_\_  
I.(i) Participate in continuing education as directed by state licensure and the MEC.

\_\_\_\_\_  
J.(j) Speak as soon as possible with hospitalized patients who wish to contact the attending about their/his/her medical care in accordance with the South Carolina Lewis Blackman Hospital Patient Safety Act.

\_\_\_\_\_  
K.(k) When required as a part of the practitioner well being program, comply with recommended actions.

\_\_\_\_\_  
L.(l) Manage and coordinate their/his/her patients care, treatment, and services.

## **ARTICLE IV**

### **Article IV. \_\_\_\_\_ CATEGORIES OF THE MEDICAL STAFF**

#### **Section 4.01 | \_\_\_\_\_ THE ACTIVE CATEGORY**

**A. (a) \_\_\_\_\_** Qualifications - Appointee to this category must:

4. \_\_\_\_\_ Be involved on a regular basis in patient care delivery at the MUSC Medical Center ~~Medical University~~  
\_\_\_\_\_ hospitals\_ and clinics and annually, providing the majority of ~~their~~his/her  
services/activities

(i) \_\_\_\_\_ ~~within~~within the MUSC Medical Center.

2.~~(ii)~~ \_\_\_\_\_ Have completed at least one (1) year of satisfactory performance on the Medical Staff. (See Provisional  
Status MUSC Credentials Policy Manual)

B.~~(b)~~ \_\_\_\_\_ Prerogatives - Appointees to this category may:

4. \_\_\_\_\_ Exercise the privileges granted without limitation, except as otherwise provided in

(i) \_\_\_\_\_ the Medical Staff Rules and Regulations, or by specific privilege restriction.

2.~~(ii)~~ \_\_\_\_\_ V~~V~~ote on all matters presented at general and special meetings of the Medical Staff, and of the  
Department and Committees on which he is appointed.

3.~~(iii)~~ \_\_\_\_\_ Hold office, sit on or be chairperson of any committee, unless otherwise specified elsewhere in these  
Bylaws.

4.~~(iv)~~ \_\_\_\_\_ Admit patients to the MUSC Medical Center.

(c) C. \_\_\_\_\_ Responsibilities - ÷ Appointee to this category must:



~~4.~~(i) \_\_\_\_\_ Contribute to the organizational and administrative affairs of the Medical Staff.

\_\_\_\_\_

~~2.~~(ii) \_\_\_\_\_ Actively participate in recognized functions of staff appointment, including performance improvement and other monitoring activities, monitoring initial appointees during ~~the~~his/her provisional period, and in discharging other staff functions as may be required from time to time.

\_\_\_\_\_

~~3.~~(iii) \_\_\_\_\_ Accept ~~the~~his/her individual responsibilities in the supervision and training of students and House Staff members as assigned by ~~the~~his/her respective department, division or section head and according to Medical Center Policy C-74 "Resident Supervision".

\_\_\_\_\_

~~4.~~(iv) \_\_\_\_\_ Participate in the emergency room and other specialty coverage programs as scheduled or as required by the MEC or Department Chairperson.

\_\_\_\_\_

~~D.~~ \_\_\_\_\_ Removal ~~-~~ ÷

\_\_\_\_\_

\_\_\_\_\_ Failure to satisfy the requirements for activity for the MUSC Medical Center, as deemed by the Chairperson of the department, during the appointment period will result in automatic transfer to Affiliate Category. The practitioner shall have the rights afforded by Article ~~IX~~, ~~Section IV~~X, ~~Section 10~~.03.

\_\_\_\_\_

(d) \_\_\_\_\_

## ~~II~~ \_\_\_\_\_ AFFILIATE CATEGORY

### Section 4.02

~~A.~~ \_\_\_\_\_ Qualifications - ~~Appointees~~Appointee to this category must:

(a) \_\_\_\_\_

~~4.~~(i) \_\_\_\_\_ Participate in the clinical affairs of the MUSC Medical Center.

\_\_\_\_\_

~~2.~~(ii) \_\_\_\_\_ Be involved in the care or treatment of at least six (6) patients of the MUSC Medical Center hospitals or clinics during his/her appointment period, or

\_\_\_\_\_

~~3-(iii)~~ Refer patients to other physicians on staff of the MUSC Medical Center or those who order diagnostic or therapeutic services at the MUSC Medical Center

(b) ~~B.~~ Prerogatives - ~~Appointees~~Appointee to this category may

~~4-(i)~~ Exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege restriction.

~~2-(ii)~~ Attend meetings of the Staff and Department to which she is appointed and any staff or MUSC Medical Center education programs.

~~3-(iii)~~ Request admitting privileges.

(c) ~~C.~~ Limitations - ~~Appointees~~Appointee to the Affiliate Category do not have general Medical Staff voting privileges.

~~III~~ HONORARY / ADMINISTRATIVE CATEGORY -

Section 4.03 *This category is restricted to those individuals the Medical Staff wishes to honor or to those physicians who have only administrative positions and no clinical privileges.*

— Such staff appointees are not eligible to admit patients to the MUSC Medical Center, ~~to~~ vote, or ~~to~~ exercise clinical privileges

(a) ~~clinical privileges in the MUSC Medical Center.~~ They may, however, attend Medical Staff and department meetings. This category is exempt from the malpractice insurance requirements and Board Certification requirements, unless required within ~~their~~his/her position description.

(b) Physicians with the MUSC Medical Center whose duties include both administrative and clinical activities must be members of the Medical Staff, and must obtain clinical privileges in the same manner as any other Medical Staff member. When a contract exists, the contract of the physician who has both administrative and clinical duties shall clearly define the relationship between termination of the contract by the MUSC Medical Center and reduction or termination in privileges.

Section 4.04 ~~IV~~ OTHER / NON-MEDICAL STAFF MEMBERS

(a) House Staff - The House Staff consists of those practitioners, who by virtue of a contract, are in the postgraduate training program at the Medical University of South Carolina.

(i) They are not eligible to hold a Medical Staff office and are not eligible to vote unless otherwise indicated in these Bylaws.

Only practitioners who are graduates of an approved, recognized medical, osteopathic or dental school, who are legally licensed to practice in the State of South Carolina and who, continue to perform and develop appropriately in ~~their~~his/her training are qualified for assignment to

(ii) the House Staff.

The Chairperson of the House Staff member's department and Associate Dean for Graduate Medical Education will be responsible for monitoring performance and will notify the

(iii) Chairperson of the Executive Committee of any status changes.

(b) Allied (affiliated) Health Professionals - Allied (affiliated) Health Professionals are those health practitioners, not a licensed MD, DO or Dentist, who, although not members of the Medical Staff are credentialed through the Medical Staff process as described in the Credentials Policy Manual.

#### ~~V~~ CONTRACT SERVICES -

~~Medical staff membership and~~ The clinical privileges of any practitioner who has a

contractual relationship with an entity that has a contractual relationship with MUSC Medical Center to provide professional services to patients shall be subject to those provisions contained in said contract with regard to the termination of Medical Staff membership and privileges upon the expiration, lapse, cancellation, or termination of the contract. If no provisions for termination of membership or privileges are contained in the contract, the affected practitioners' membership and clinical privileges will be terminated at the time of the contract termination, lapse, expiration or cancellation date. The affected practitioners shall have no right to a hearing regarding termination of Medical Staff membership or privileges.

#### Section 4.05 ~~ARTICLE V~~

#### Article V. OFFICERS

## OFFICERS OF THE MEDICAL STAFF -

Section 5.01 *The officers of the Medical Staff shall be:*

A.(a) President

\_\_\_\_\_

B.(b) Vice President

\_\_\_\_\_

C.(c) Secretary

## II QUALIFICATIONS OF OFFICERS -

Section 5.02 *Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during ~~their~~his/her terms of office. Officers should possess some Medical Staff administrative experience. In addition, Medical Staff officers must be committed to put in the required time to assist the functioning of the organized Medical Staff.*

## III SELECTION OF OFFICERS -

Section 5.03 *A nominating committee shall be appointed by the Medical Staff president at the meeting prior to biennial elections.*

A.(a) This committee shall present a slate of officers to the Medical Staff at its annual meeting.

\_\_\_\_\_

B.(b) Medical Staff members may submit names for consideration to members of the nominating committee.

C.(c) Only Active Staff shall be eligible to vote. A plurality vote of those Active Staff present at the annual meeting is required.

IV TERM OF OFFICE -

Section 5.04 All officers shall take office on the first day of the calendar year and serve a term of two years.

V VACANCIES IN OFFICE -

Section 5.05 Vacancies in office during the Medical Staff year, except the Office of President, shall be filled by the MEC of the Medical Staff. If there is a vacancy in the Office of the President, the Vice President shall serve the remainder of the term.

Section 5.06 VI DUTIES OF OFFICERS

A.(a) President -The President shall serve as the chief administrative officer of the Medical Staff and will fulfill those duties as specified in the organization and functions manual.

B.(b) Vice President - In the absence of the President, Vice President shall assume all the duties and have the authority of the President. He shall perform such further duties to assist the President as the President may, from time to time request, including the review and revision of bylaws as necessary, supervision of the Medical Center's quality, patient safety, and resource utilization programs, and the MEC liaison for medical staff peer review activities The Vice President will serve as the President-Elect.

C.(c) Secretary -The secretary shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all Medical Staff meetings.

Section 5.07 VII REMOVAL FROM OFFICE

A.(a) \_\_\_\_\_ The Medical Staff and/or Board of Trustees may remove any Medical Staff officer for failure to fulfill his/his/her responsibilities, conduct detrimental to the interests of the MUSC

\_\_\_\_\_ Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that \_\_\_\_\_

(b) \_\_\_\_\_ renders him incapable of fulfilling the duties of the office.

\_\_\_\_\_

B.(c) \_\_\_\_\_ Elected officers may be removed by 2/3 majority vote of the Medical Staff for the reasons stated in VII A above.

\_\_\_\_\_

C.(d) \_\_\_\_\_ Removal from elected office shall not entitle the practitioner to procedural rights.

\_\_\_\_\_

D.(e) \_\_\_\_\_ Any Medical Staff member has the right to initiate a recall election of a Medical Staff Officer. A petition to recall must be signed by at least 25% of the members of the active staff and presented to the MEC. Upon presentation, the MEC will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no ~~confidence note~~ confidence vote.

**Article VI. DEPARTMENTS**

**ORGANIZATION OF DEPARTMENTS**

A. Section 6.01 The Medical Staff shall be organized into departments, divisions, and or sections, in a manner as to best assure:

1.(a) the supervision of clinical practices within the Hospital;

\_\_\_\_\_

2.(b) the conduct of teaching and training programs for students and House Staff;

\_\_\_\_\_

3.(c) the discovery of new knowledge;

\_\_\_\_\_

4.(d) the dissemination of new knowledge;

\_\_\_\_\_

5.(e) the appropriate administrative activities of the Medical Staff; and an integrated quality management program to monitor objectively and systematically evaluate the quality and appropriateness of patient care, objectively establish and monitor criteria for the effective utilization of hospital and physician services, and pursue opportunities to improve patient care and resolve identified problems.

\_\_\_\_\_

6.(f) the active involvement in the measurement, assessment and improvement of patient care processes.

Section 6.02 ~~II~~ QUALIFICATIONS AND SELECTION OF DEPARTMENT CHAIRPERSON

A.(a) Each Chairperson shall be a member of the Active Category of the Medical Staff and be well qualified by training and experience and demonstrated ability for the position. The Chairperson ~~should~~ must be certified in an appropriate specialty board, or have comparable competence that has been affirmatively established through the credentialing process.

~~B.(b)~~ The appointment and removal of Department Chairpersons shall be the responsibility of the Dean of the appropriate ~~College,~~ College, in accordance with the Board of Trustees approved Rules and Regulations of the Faculty of the Medical University of South Carolina (Faculty Handbook), in accordance with Article IV of the General Rules and Regulations of the Faculty of the Medical University of South Carolina. Such appointment must then be submitted to the Board of Trustees for approval.

### III FUNCTIONS OF DEPARTMENT

Section 6.03 Through the department Chairperson each department shall:

A.(a) Recommend to the Medical Staff the objective and evidenced based criteria consistent with the policies of the Medical Staff and the Board of Trustees for the granting and renewal of clinical privileges related to patient care provided within the department.

B.(b) Recommend clinical privileges for each member of the Department.

C.(c) Develop and uniformly apply criteria for a focused time limited professional practice evaluation for all initially requested privileges of independent practitioners within ~~their~~ this/her department.



~~D.~~(d) \_\_\_\_\_ Develop and uniformly apply criteria for the on-going professional evaluation of all independent practitioners within ~~their~~his/her department.

\_\_\_\_\_

~~E.~~(e) \_\_\_\_\_ Assure the decision to deny a privilege(s) is objective and evidenced based.

\_\_\_\_\_

~~F.~~(f) Establish policies and procedures and scope of practice for House Staff supervision. The character of supervision will depend upon the level of training and demonstrated competence of each House Staff member.

\_\_\_\_\_

~~G.~~(g) \_\_\_\_\_ ~~As required by the Board of Trustees through the Performance Improvement Plan, e~~Each department shall participate in a medical care evaluation program and/or quality improvement program as required by accrediting bodies, federal regulations and state statutes. This plan shall include a process that assures active participation in the ongoing measurement, assessment and improvement of the quality of care and treatment and ~~may~~include quality control processes as appropriate.

\_\_\_\_\_

(h) \_\_\_\_\_ Shall establish standards and a recording methodology for the orientation and continuing education of its members. Participation in the roles of both students and teachers is recognized as the means of continuously improving the services rendered by the Medical Staff. Such continuing education should:

(i) \_\_\_\_\_ ~~(1) R~~represent a balance between intra-institutional and outside activities.

(ii) \_\_\_\_\_ ~~(2) Be be~~-based, when applicable, on the findings of the quality improvement effort.

~~H.~~(iii) \_\_\_\_\_ ~~(3) Be~~ appropriate to the practitioner's privileges and will be considered as part of the reappointment process. Participation in the roles of both students and teachers is recognized as the means of continuously improving the services rendered by the Medical Staff.

~~I.~~(i) \_\_\_\_\_ Coordinate clinical activities of the department and integrate all patient care and clinical activities with MUSC Medical Center.

~~J.~~(j) \_\_\_\_\_ Monitor on a continuing basis, departmental activities and compliance with Medical Staff Bylaws or other accrediting bodies.

\_\_\_\_\_

~~K.~~(k) \_\_\_\_\_ Define the circumstances and implement the process of focused peer review activities within the department.

\_\_\_\_\_

~~L.~~(l) \_\_\_\_\_ Assess and recommend off-site sources for needed patient care, treatment and service when not provided by the department.

\_\_\_\_\_

M.(m) Conduct administrative duties of the department when not otherwise provided by the hospital.

N.(n) Coordinate and integrate all inter and intra departmental services.

O.(o) Develop and implement department ~~polices~~policies and procedures ~~for the provision of safe and quality~~  
that guide and support the provision of safe quality care, treatment, and services.

P.(p) Recommend sufficient qualified and competent staff to provide care within the department and with  
Clinical Services and MUSC Medical Center leaders determine the qualifications and competencies of non LIP's  
within the department who provide patient care, treatment, and services.

Q.(q) Recommend space and resource needs of the department.

R.(r) Ensure the timely and appropriate completion of MUSC Medical Center administrative responsibilities  
assigned to departmental physicians.

S.(s) Supervise the completion of the assigned responsibilities of departmental members who serve as MUSC  
Medical Center Medical Directors.

(t) ~~With MUSC Medical Center leaders determine the qualifications and competence of department or service  
personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.~~  
Assess and improve on a continuing basis the quality of care, treatment, and services provided in the  
department[pjc1].

#### IV ASSIGNMENT TO DEPARTMENTS \_

Section 6.04 All members of the Medical Staff shall be assigned to a department as part of the appointment process.

## ARTICLE VII

### Article VII. COMMITTEES AND FUNCTIONS

#### Section 7.01 ~~1.~~ MEDICAL EXECUTIVE COMMITTEE (MEC)

(a) Composition: ~~The Medical Executive Committee (MEC) is the executive committee of the organized Medical Staff. The majority of whose members are physicians. Other hospital and University leaders shall have membership in order to allow the committee to have an integrated leadership role within MUSC Medical Center.~~ The MEC shall include:

- 1) ~~the~~ elected officers of the Medical Staff,
- 2) ~~Past~~ Past President of the Medical Staff,
- 3) ~~the~~ Vice President for Clinical Operations/Executive Director of MUSC Medical Center,
- 4) ~~Senior~~ Senior Associate Dean for Clinical Affairs,
- 5) ~~the~~ Executive Medical Director,
- 6) ~~Associate Executive Medical Directors,~~
- 7) ~~and/or designee,~~ Administrator of Clinical Services/Chief Nursing Executive,
- 8) ~~Department of Medicine~~ Chairperson,
- 9) ~~Department of Surgery~~ Chairperson,
- 10) ~~the~~ Director of Quality,
- 11) ~~the~~ Director of Strategic Planning,
- 12) ~~the~~ Director of Pharmacy,
- 13) ~~Administrator of Ambulatory Care,~~
- 14) ~~the~~ Vice President for Medical Affairs,
- 15) ~~the~~ CEO of UMA,
- 16) ~~A,~~ President of the House Staff (voting),
- 17) ~~Chairperson of Credentials Committee,~~
- 18) ~~Physician Director of Children's Health Services,~~
- 19) ~~the~~ Senior Associate Dean for Medical Education,
- 20) ~~the~~ Director for Graduate Medical Education,
- 21) ~~the~~ President of UMA,
- 22) ~~the~~ Director/Division Chief of Emergency Medicine,
- 23) ~~and a designee appointed by the~~ Chairpersons (or designee) of the Departments of Laboratory Medicine & Pathology, Anesthesiology and Peri-operative Medicine, and Radiology,
- 24) ~~Three (3) elected Medical Staff representatives: one (1) each to represent the Institute of Psychiatry, primary care and surgical specialties to be elected by the Medical Staff members of those represented departments,~~
- 25) ~~Three~~ Three elected Medical Directors from service lines,

~~26)~~ ~~T, and two~~ (-2) Department Chairpersons not already assigned~~1.~~

~~A.(b)~~ Membership for elected members and unassigned Department Chairpersons will be for a two year period.

~~B.(c)~~ The ~~Medical Executive Committee~~ MEC will be chaired by the Vice President for Medical Affairs (or his/her designee) and ~~c~~Co-chaired by the Medical Staff President.

~~C.(d)~~ All members will have voting rights.

~~D.(e)~~ Duties - The duties of the MEC shall be to:

~~1.(i)~~ Ensure high quality cost-effective patient care across the continuum of the MUSC Medical Center

~~2.(ii)~~ Represent and to act on behalf of the Medical Staff

~~3.(iii)~~ Coordinate the activities and general policies of the Medical Staff;

~~4.(iv)~~ Determine and monitor committee structure of the Medical Staff;

~~5.(v)~~ Receive and act upon reports and recommendations from departments, committees, and officers of the Medical Staff;

~~6.(vi)~~ Implement Medical Staff policies not otherwise the responsibility of the departments;

~~7.(vii)~~ Provide a liaison between the Medical Staff and the Executive Director of the MUSC Medical Center;

~~8.(viii)~~ Recommend action to the Executive Director of the MUSC Medical Center on medico-administrative matters;

~~9.(ix)~~ Make recommendations to the Board of Trustees regarding: the Medical Staff structure, membership, delineated clinical privileges, appointments, and reappointments to the Medical Staff, and performance improvement activities;

~~10.(x)~~ Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the MUSC Medical Center

~~11.(xi)~~ Fulfill the Medical Staff organization's accountability to the ~~Board~~ Board of ~~for~~ Trustees for the medical care of patients in the MUSC Medical Center;

~~42.(xii)~~ Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges;

~~43.(xiii)~~ Conduct such other functions as are necessary for effective operation of the Medical Staff;

~~44.(xiv)~~ Report at each general staff meeting; and

~~45.(xv)~~ Ensure that Medical Staff is involved in performance improvement and peer review activities.

~~16. The organized medical staff delegates the authority to the Medical Executive Committee the ability to act on its behalf in between organized meetings of the medical staff.~~

~~—Delegated Authority-~~

~~(f) —~~

~~4.(i) The Medical Staff delegates the authority to the Medical Executive Committee MEC the ability to act on its behalf in between organized meetings of the medical staff.~~

~~—The Medical Staff delegates authority to the MEC to make amendments and submit directly to the Board of Trustees for adoption those associated details of processes defined in these bylaws that reside in the Credentials Manual of the Medical Staff, the Rules and Regulations of the Medical Staff, and the Fair Hearing Plan of the Medical Staff or other Medical Staff policies. Such detail changes/amendments shall not require Medical Staff approval prior to submission to the Board. The MEC shall however notify the Medical Staff of said changes prior to Board of Trustees submission. The associated details are defined as those details for the processes of qualifications of the Medical Staff, appointment and re-appointment to the Medical Staff, credentialing/privileging and re-credentialing/ re-privileging of licensed independent practitioners and other practitioners credentialed by the Medical Staff, the processes and indications for automatic and or summary suspension of medical staff membership or privileges, the processes or indications for recommending termination or suspension of a medical staff membership and/or termination, suspension or reduction of clinical privileges and other processes contained in these bylaws where the details reside either in The Rules and Regulations of the Medical Staff, the Credentials Manual of the Medical Staff, the Fair Hearing Plan, or other Medical staff policies. The Medical Staff, after notification to the MEC and the Board, by a two thirds vote of voting members shall have the ability to remove this delegated authority of the MEC.~~

~~(ii) —~~

~~—The authority to amend these bylaws cannot be delegated.~~

~~(iii) —~~

~~(g) Meetings - The MEC shall meet at least six (6) times a year or as often as necessary to fulfill its responsibility and maintain a permanent record of its proceedings and actions. Special meetings of the MEC may be called at any time by the Chairperson.~~

~~E.(h) Removal from MEC - The Medical Staff and/or the Board of Trustees may remove any member of the MEC for failure to fulfill his/her responsibilities, conduct detrimental to the interests of the MUSC~~

Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the committee. Any Medical Staff member has the right to initiate a recall of a ~~Medical Executive Committee~~ MEC member. A petition to recall must be signed by at least 25% of the members of the ~~A~~active staff and presented to the MEC or to the Board of Trustees if the recall is for the majority or all of the MEC members. Upon presentation, the MEC or Board of Trustees will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote. Removal of an MEC member shall require a 2/3 majority vote of voting members. Removal from the MEC shall not entitle the practitioner to procedural rights.

## Section 7.02 ~~II~~ — OTHER MEDICAL STAFF FUNCTIONS

(a) Peer Review - —All members of the MUSC Medical Center Medical Staff, House Staff, and Allied Health Professional Staff will be included in the Medical Staff's peer review process.

(i) Peer Review is initiated as outlined in the Medical Center Policy "Peer Review Policy." A peer review committee for the Medical Staff will be maintained by the ~~Medical Executive Committee~~ MEC. This committee will be chaired by the Vice President of the Medical Staff, as will a subcommittee for Professional Staff peer review. A subcommittee for House Staff peer review will be chaired by the Secretary of the Medical Staff. Members of each of these committees will be appointed by the MEC.

(ii) All peer review activities whether conducted as a part of a department quality plan or as a part of a medical staff committee will be considered medical staff quality activities and fall under the protection of SC Code Section 40-71-10 and 40-71-20.

### Other Functions -

—The accomplishment of the following functions may or may not require the existence of separate, established committees. The functions consist of collection of relevant information (monitoring), and presentation to the appropriate Clinical Departments, discussion, and action (evaluation and problem solving). Evidence that these functions are being effectively accomplished at the departmental level is included in departmental

—reports to the MEC, and in MEC reports to the Board. —These functions can be carried out

(b) by a Medical Staff Committee, a MUSC Medical Center interdisciplinary committee, a responsible group, or individual. These functions include, but are not limited to:

A.(i) \_\_\_\_\_ Conduct or coordinate quality, appropriateness, and improvement activities, including but not limited to operative, invasive, and high risk procedures review, tissue review, blood usage review, drug usage review, medical record review, mortality and morbidity review, autopsy review, sentinel event and other reviews;

\_\_\_\_\_

B.(ii) \_\_\_\_\_ Conduct or coordinate utilization activities;

\_\_\_\_\_

C.(iii) \_\_\_\_\_ Conduct or coordinate credentials investigations for staff membership and granting of clinical privileges;

\_\_\_\_\_

D.(iv) \_\_\_\_\_ Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments, and other perceived needs;

\_\_\_\_\_

E.(v) \_\_\_\_\_ Develop and maintain surveillance over drug utilization policies and practices;

\_\_\_\_\_

F.(vi) \_\_\_\_\_ Investigate and control nosocomial infections and monitor the MUSC Medical Center infection control program;

\_\_\_\_\_

G.(vii) \_\_\_\_\_ Plan for response to fire and other disasters;

\_\_\_\_\_

H.(viii) \_\_\_\_\_ Direct staff organizational activities, including staff Bylaws, review and revision, Staff officer and committee nominations, liaison with the ~~Board~~ Board of Trustees and MUSC Medical Center administration, and review and maintenance of MUSC Medical Center accreditation

#### ARTICLE VIII

### Article VIII. HISTORY AND PHYSICAL REQUIREMENTS[pjc2]

Comprehensive History and Physical -

~~\_\_\_\_\_ A. \_\_\_\_\_ A Complete comprehensive history and physical (H&Ps) shall be completed no later than twenty-four (24) hours after admission (includes inpatient or observation status) or at the initial visit to an ambulatory clinic, or prior to any operative, invasive, high \_\_\_\_\_ risk \_\_\_\_\_~~

~~\_\_\_\_\_ diagnostic or therapeutic procedure, or procedures requiring moderate or deep sedation –~~

~~Section 8.01 \_\_\_\_\_ or anesthesia regardless of setting.~~

~~\_\_\_\_\_ A complete H&P (except in circumstances \_\_\_\_\_~~

~~(a) \_\_\_\_\_ allowing a focused H&P must include (as \_\_\_\_\_ information is available):~~

~~(i) \_\_\_\_\_ chief complaint,~~

~~(ii) \_\_\_\_\_ details of present illness (history),~~

~~(iii) \_\_\_\_\_ past history (relevant - includes illnesses, injuries, and operations),~~

~~(iv) \_\_\_\_\_ social history,~~

~~(v) \_\_\_\_\_ allergies and current medications,~~

~~(vi) \_\_\_\_\_ family history,~~

~~(vii) \_\_\_\_\_ review of systems pertinent to the diagnosis,~~

~~(viii) \_\_\_\_\_ physical examination pertinent to the diagnosis,~~

~~(ix) \_\_\_\_\_ pertinent normal and abnormal findings, and~~

~~\_\_\_\_\_ conclusion or a planned course of action.~~

~~(x) \_\_\_\_\_~~

~~\_\_\_\_\_ Focused History and Physical - B. \_\_\_\_\_ For other non-inpatients procedures, a focused history and physical may be completed \_\_\_\_\_~~

~~Section 8.02 \_\_\_\_\_ based on the presenting problem. A focused H&P must include at a minimum:~~

~~(a) present illness,~~

~~(b) past medical/surgical history,~~

~~(c) medications,~~

~~(d) allergies,~~

~~(e) focused physical exam to include the presenting problem and heart and lungs,~~

~~•(f) impression and plan including the reason for the procedure.~~



\_\_\_\_\_ Primary Care Clinics - G. \_\_\_\_\_ H&Ps are required in all primary care clinics. On subsequent primary care visits

\_\_\_\_\_ and in specialty clinics, the H&P can be focused, based on the presenting problem(s). \_\_\_\_\_

Section 8.03 \_\_\_\_\_ The focused H&P must meet the requirements for a focused H&P.

H&P Not Present -

\_\_\_\_\_ D. \_\_\_\_\_ When the H&P examination is not on the chart prior to the surgery or high risk \_\_\_\_\_ diagnostic or therapeutic procedure, the said procedure shall be delayed until the H&P is \_\_\_\_\_

Section 8.04 \_\_\_\_\_ completed unless it is an emergency.

\_\_\_\_\_ Updating an H&P -

\_\_\_\_\_ E. \_\_\_\_\_ When using an H&P that was performed within 30 days prior to admission or a \_\_\_\_\_ procedure, and that H&P is in the patient's medical record, an update to the H&P must be \_\_\_\_\_ completed within 24 hours for inpatients or prior to the procedure whichever comes \_\_\_\_\_

\_\_\_\_\_ first ~~it~~. This includes intra campus admissions from the Medical \_\_\_\_\_ Center. (i.e., TCU, IOP). For \_\_\_\_\_ all surgeries and other procedures requiring an H&P, this update may be completed in \_\_\_\_\_

Section 8.05 \_\_\_\_\_ combination with the preanesthesia assessment.

Section 8.06 H&P Responsibility:

(a) F. \_\_\_\_\_ Dentists are responsible for the part of ~~their~~his/her patient's H&P that relates to dentistry.

\_\_\_\_\_ G. \_\_\_\_\_ Oral and maxillofacial surgeons may perform a medical H&P examination in order to \_\_\_\_\_

(b) \_\_\_\_\_ assess the status and risk of the proposed surgery or procedures.

(c) H. \_\_\_\_\_ Podiatrists are responsible for the part of ~~their~~his/her patient's H&P that relates to podiatry.

(d) I. \_\_\_\_\_ Optometrists are responsible for the part of ~~their~~his/her patient's H&P that relates to \_\_\_\_\_ optometry.

Section 8.07 J. — The attending physician is responsible for the complete H&P.

—

— K. — Residents, advanced nurse practitioners and in some cases physicians assistants,

(a) — appropriately privileged, may complete the H&P with the attending physician's —counter  
signature.

(b) In lieu of a signature, the attending physician may complete an —additional attestation sheet to confirm or  
change the initial history and physical.

— The co-

(c) — signature by the attending or the attestation must be completed by the attending within 48  
—hours of admission or prior to any procedure requiring H&P's.

## ARTICLE IXVIII

### Article IX. — MEDICAL STAFF MEETINGS

#### Section 9.01 — REGULAR MEETINGS

(a) — A. — The Medical Staff shall meet at least quarterly or more often, as needed. Appropriate  
action will be taken as indicated.

(b) — B. — An aAnnual Medical Staff Meeting shall be held during the last quarter of each year.  
Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted.

C.(c) The primary objective of the meetings shall be to report on the activities of the staff, elect officers if necessary, and conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

## II SPECIAL MEETINGS

-

Section 9.02 The President of the Medical Staff, the Executive Medical Director, the Dean of the College of Medicine, the Vice President of Academic Affairs or the ~~Medical Executive Committee~~ MEC may call a special meeting after receipt of a written request for same signed by not less than five (5) members of the Active and Affiliate Staff and stating the purpose for such meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, including electronic mail, to each member of the Active Category of the Medical Staff not less than 48 hours before the date of such meeting, by or at the direction of the President of the Medical Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited in the Campus Mail addressed to each Staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to members in other Medical Staff categories who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

## IV QUORUM -

The quorum requirements for all meetings shall be those present and voting, unless otherwise indicated in these Bylaws.

Section 9.03

V ATTENDANCE REQUIREMENTS

Section 9.04

A.(a) Although attendance at regular Medical Staff meetings is encouraged, Medical Staff members are not required to attend general staff meetings. Medical staff meeting attendance will not be used as a reappointment measurement.

B.(b) Attendance requirements for department meetings are at the discretion of the Department Chairpersons.

C. Members of the MEC and Credentials Committee are required to attend fifty percent (50%) of the committee meetings during each year unless otherwise excused.

VI

(c)

VII PARTICIPATION BY EXECUTIVE DIRECTOR OF THE MUSC MEDICAL CENTER R - R

Section 9.05 *The Executive Director of the MUSC Medical Center or his/her designee may attend any Committee, Department, or Section meeting of the Medical Staff.*

VIII ROBERT'S RULES OF ORDER -

Section 9.06 *The latest edition of ROBERT'S RULES OF ORDER shall prevail at all meetings of the General Staff, MEC, and Department Meetings unless waived by the Chairperson.*

IX NOTICE OF MEETINGS -

Section 9.07 *Written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee or department not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.*

~~X~~ ACTION OF COMMITTEE/DEPARTMENT -

Section 9.08 *The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department.*

~~XI~~ MINUTES -

Section 9.09 *Minutes of each regular and special meeting of a Committee or Department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes from the Departments and Credentials Committee Meetings shall be signed, electronically or physically, by the presiding officer and copies thereof submitted to the MEC. The minutes from other committee meetings shall be signed by the presiding officer and copies thereof submitted to the appropriate departments.*

~~ARTICLE X~~

## Article X. ———TERMINATION, REDUCTION, AND SUSPENSION OF PRIVILEGES

### —————|—————SUSPENSION -

Section 10.01 *In the event that an individual practitioner's action may pose a danger to patients, other Medical Staff members, or the Hospital or its personnel, then either the President of the Medical Staff, ~~or Executive~~ Medical Director or the Chairperson of the clinical department to which the practitioner is a member, shall each have the authority, as independent action, to suspend all or any portion of the Clinical Privileges of the Medical Staff member in question.*

- (a) Such precautionary suspension does not imply final findings of fact or responsibility for the situation that caused the suspension.
- (b) Such precautionary suspension is immediately effective, is immediately reported to all the individuals named above, and the Medical Staff Office, and remains in effect until a remedy is effected following the provision of this Article of the Medical Staff Bylaws.
- (c) Immediately upon the imposition of a suspension, the appropriate Department Chairperson or the Chief of ~~Staff~~Service assigns to another Medical Staff member the responsibility for care of any hospitalized patients of the suspended individual.
- (d) As soon as practical, but in no event later than three (3) days after a precautionary suspension, the ~~Medical Executive Committee~~MEC shall convene to review the action. The affected practitioner may request to be present at this meeting, which is not a hearing and is not to be construed as such. The MEC may continue the suspension, or take another action pursuant to this Article. If the action taken entitles the affected practitioner to a hearing, then the Hearing and Appeals Procedure Fair Hearing Plan shall apply

### Section 10.02 ||—————EFFECT OF OTHER ACTIONS ON MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

- (a) Failure to Complete Medical Records - All portions of each patient's medical record shall be completed within the time period after the patient's discharge as stated in Medical Staff Rules and Regulations. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in ~~(a)~~ the record being defined as delinquent and ~~(b)~~ notification of the practitioner.
  - (i) A temporary suspension in the form of withdrawal of admitting privileges, scheduling of clinic appointments, or scheduling of elective surgical cases, effective until the medical records are complete, shall be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such medical records within a seven (7) day period after delivery of such warning to him/her either orally or in writing.
  - (ii) Having three (3) suspensions in one (1) consecutive 12 month period will be reason for removal from the Medical Staff. Re-application for reinstatement to the staff is allowed immediately upon completion of the delinquent record(s).

(b) Failure to Complete Education Requirements – The Medical Staff recognizes the need to mandate certain education requirements for all Medical Staff in order to ensure ongoing success of quality improvement.

(i) The MEC will regularly review and approve the education requirements, including time periods, for Medical Staff members. All education requirements for Medical Staff members shall be completed within the time period. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in an education delinquency and notification to the practitioner of temporary suspension.

(ii) A temporary suspension in the form of withdrawal of admitting privileges, scheduling of clinic appointments, or scheduling of elective surgical cases, effective until the education requirements are complete, shall be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such education requirement within a seven (7) day period after delivery of such warning to him/her either orally or in writing.

(iii) Having three (3) suspensions in one (1) consecutive 12 month period will be reason for removal from the Medical Staff. Re-application for reinstatement to the staff is allowed immediately upon completion of the delinquent education requirements.

(c) Failure to Perform Appropriate Hand Hygiene – The Medical Staff recognizes the need to ensure a high level of hand hygiene compliance for all Medical Staff in order to ensure ongoing success of the infection control and prevention plan of the Medical Center

(i) Understanding that noncompliance with hand hygiene is often the result of distraction or simple forgetfulness, rather than a blatant disregard for patient safety, medical staff will be reminded in a positive manner when not compliant with the hand hygiene policy. Medical staff are expected to readily respond in a positive manner to a reminder and adjust their actions accordingly.

(ii) Medical staff who fail to respond in a positive manner to a reminder are subject to the medical staff Peer Review Process.

(iii) Medical staff who have recurrent hand hygiene noncompliance will be subject to an MEC approved progressive education and discipline process.

(iv) Medical staff having four (4) hand hygiene noncompliance events in one (1) consecutive 12 month period will be reason for suspension from the Medical Staff. Re-application for reinstatement is allowed immediately upon completion of a MEC approved process.

(v) Medical staff having two (2) suspensions in a consecutive 12 month period will result in removal of Medical Staff membership and clinical privileges.

(vi) Medical staff may formally respond to each noncompliance event with subsequent adjudication by the peer review committee

(d) Actions Affecting State License to Practice - If a practitioner's state license to practice or DEA registration is revoked, suspended, limited for disciplinary reasons, not renewed by the relevant agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, suspended, or limited to at least the same extent, subject to re-application by the practitioner when or if his/her license or DEA registration is reinstated, or limitations are removed, whatever is the case.

(e) Lapse of Malpractice Coverage - If the MEC and ~~Board~~ Board of Trustees have established a requirement for liability coverage for practitioners with clinical privileges, and if a staff member's malpractice coverage lapses without renewal, then the practitioner's clinical privileges are automatically suspended until the effective date of his/her new malpractice coverage, unless otherwise determined by the Board.

(f) Governmental Sanction or Ban - Imposition of governmental sanction or ban as outlined by Medicare and the DHHS -Office of the Inspector General is cause for immediate loss of all clinical privileges.

—Felony Conviction - conviction of a felony offense is cause for immediate loss of all clinical privileges.

(g) —————

(h) Loss of Faculty Appointment - Loss of faculty appointment shall result in immediate revocation of clinical privileges and appointment to the Medical Staff.

(i) Failure to Meet Application Requirements - Failure to comply with deadlines or other application requirements will result in loss of appointment and privileges as outlined in the Credentials Policy Manual.

#### ~~III~~V HEARING/APPEAL FAIR HEARING PLAN -

Section 10.03 Any physician has a right to a hearing/appeal pursuant to the institution's Fair Hearing Plan in the event any of the following actions are taken or recommended:



(i) \_\_\_\_\_ A. \_\_\_\_\_ Denial of initial staff appointment,  
\_\_\_\_\_

(ii) \_\_\_\_\_ B. \_\_\_\_\_ Denial of reappointment,  
\_\_\_\_\_

(iii) \_\_\_\_\_ C. \_\_\_\_\_ Revocation of staff appointment,  
\_\_\_\_\_

(iv) \_\_\_\_\_ D. \_\_\_\_\_ Denial or restriction of requested clinical privileges,  
\_\_\_\_\_

(v) \_\_\_\_\_ E. \_\_\_\_\_ Reduction in clinical privileges,  
\_\_\_\_\_

(vi) \_\_\_\_\_ F. \_\_\_\_\_ Revocation of clinical privileges,  
\_\_\_\_\_

(vii) \_\_\_\_\_ G. \_\_\_\_\_ Individual application of, or individual changes in, the mandatory consultation requirement, and  
\_\_\_\_\_

\_\_\_\_\_ H. \_\_\_\_\_ Suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.  
\_\_\_\_\_

(viii) \_\_\_\_\_

## (b) PROFESSIONAL REVIEW ACTION[pjc3]

### \_\_\_\_\_ DEFINITIONS

(i) \_\_\_\_\_

- 1) \_\_\_\_\_ The term “professional review action” means an action or recommendation of the professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual practitioner which affects (or could affect) adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges of the practitioner or the practitioner’s membership. Such term includes a formal decision of the professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to professional review action.

2) An action not considered to be based on the competence or professional conduct of a practitioner if the action taken is primarily based on:

- (i) The practitioner's association or lack of association with a professional society or association;
- (ii) The practitioner's fees or the practitioner's advertising or engaging in other competition acts intended to solicit or retain business;
- (iii) The practitioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;
- (iv) A practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with a member of members of a particular class of health care practitioner or professional; or
- (v) Any other matter that does not related to the competence or professional conduct of a practitioner.

3) The term "professional review activity" means an activity of the Hospital with respect to an individual practitioner.

- (i) To determine whether the practitioner may have clinical privileges with respect to or membership;
- (ii) To determine the scope or conditions of such clinical privileges or membership; or
- (iii) To change or modify such clinical privileges or membership.

4) The term "Professional Review Body" means the Hospital and the Hospital's governing body or the committee of the Hospital which conducts the professional review activity and includes any committee of the Medical Staff of the Hospital when assisting the governing body of the Hospital in a professional review activity.

5) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership.

6) The term "Board of Medical Examiners", "Board of Dental Examiners", and Board of Nursing are those bodies established by law with the responsibility for the licensing of physicians, dentists, and Affiliated Health Care Professionals respectively.

7) The term "clinical privileges" includes privileges, membership, and the other circumstances pertaining to the furnishing of medical care under which a practitioner is permitted to furnish such care in the Hospital.

8) The term "medical malpractice action or claim" means a written claim of demand for payment based on a health care provider's furnishing (or failure to furnish) health care services including the filing of a cause of action, based on the law of tort, brought in any court of the State or the United States seeking monetary damages.

#### (c) STANDARDS FOR PROFESSIONAL REVIEW ACTIONS

(i) For the purposes of the protection provided by Section 411(a) of the Health Care Quality Improvement Act of 1986 and in order to improve the quality of medical care, a professional review action shall be taken:

1) In the reasonable belief that the action was in the furtherance of quality health care;

2) After a reasonable effort to obtain the facts of the matter;

3) After adequate notice and hearing procedures are afforded to the practitioner involved or after such other procedures are fair to the practitioner under the circumstances; and

4) In the belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after adequate notice and hearing procedures are afforded.

(ii) A professional review action shall be presumed to have met the preceding standards unless the presumption is rebutted by a preponderance of evidence.

(iii) Impaired Practitioners: The MUSC Medical Center subscribes to and supports the South Carolina Medical association's policies and procedures on impaired practitioners. The staff will support and follow procedures of the South Carolina Medical Association Impaired Physician Committee in dealing with any practitioner who has an addiction to drugs and/or alcohol which impairs his/her ability to function or otherwise disables him from the practice of medicine.

(d) -ADEQUATE NOTICE AND RIGHT TO HEARING

— Notice of Proposed Action – the practitioner shall be given a notice stating:

a. —

—[1] that a professional review action has been proposed to be taken against the practitioner;

—[2] the practitioner; the reasons for the proposed action; and

— b. [1] that the practitioner has a right to request a hearing on the proposed action; and

— [2] that the practitioner has thirty (30) days within which to request such

1) —hearing; and

2) The Notice of Right to Hearing to the practitioner shall also state that the request for hearing shall be delivered to the Chair of the Executive Committee personally or by certified, registered mail, restricted delivery.

3) The Notice of Right to Hearing shall additionally state that a failure on the part of the practitioner to make a written request for hearing within the thirty (30) day time period shall constitute a waiver of the practitioner's right to hearing and to any further appellate review on the issue.

4) The Executive Medical Director shall be responsible for giving the prompt written notice to the practitioner or any affected party who shall be entitled to participate in the hearing.

5) The Notice shall also state that, upon the receipt of Request for Hearing, the practitioner shall be notified of the date, time, and place and shall be provided with written charges against him or the grounds upon which the proposed adverse action is based.

#### — NOTICE AND REQUEST FOR HEARING -

-

(e) If a hearing is requested on a timely basis, the practitioner involved shall be given additional notice state:

(i) The time, place and date of a pre-hearing conference in order to review or clarify procedures that will be utilized;

(ii) The place, time and date of hearing, which date shall not be less than thirty (30) days after the date of the notice;

(iii) A list of witnesses (if any) expected to testify at the hearing on behalf of the Professional Review Body;

(iv) A statement of the time, place and nature of the hearing;

(v) A statement of the authority under which the hearing is to be held;

(vi) Reference to any rules, regulations or statutes in issue; and

(vii) A short and plain statement of the charges involved and the matters to be asserted.

(f) CONDUCT OF HEARING AND NOTICE

(i) If a hearing is requested on a timely basis, the hearing shall be held as determined by the Executive Medical Director of the Hospital:

1) Before an Arbitrator mutually acceptable to the practitioner and the Hospital;

2) Before a Hearing Officer who is appointed by the Executive Medical Director of the Hospital and who is not in direct economic competition with the practitioner involved; or

3) Before an ad hoc Hearing Committee of not less than five (5) MEMBERS OF THE Medical Staff appointed by the Chair of the Hospital Executive Committee. One of the members so appointed shall be designated as chair. No Medical Staff member who has actively participated in the consideration of any adverse recommendation or action shall be appointed a member of this committee.

(ii) The Hearing Committee, the Arbitrator, or the Hearing Office may issue subpoenas for the attendance and testimony of witnesses and the production and examination of books, papers, and records on its own behalf or upon the request of any other party to the case. Failure to honor an authorized subpoena may be grounds for disciplinary action against the subpoenaed party including, but not limited to, a written reprimand, suspension, or termination.

(iii) The personal presence of the affected party shall be required by the Arbitrator, Hearing Officer, or Committee. Any party who fails, without good cause, to appear and proceed at the hearing shall be deemed to have waived his/her rights to the hearing and to have accepted the adverse action, recommendations, or decision or matter in issue, which shall then remain in full force and effect.

(iv) Postponement of hearing shall be made only with the approval of the Arbitrator, Hearing Officer, or ad hoc Hearing Committee. Granting of such postponement shall be only for good cause shown and shall be at the sole discretion of the decision maker.

(v) The right to the hearing shall be forfeited if the practitioner fails, without good cause, to appear.

#### RIGHTS OF THE PARTIES -

(g) In the hearing, the practitioner involved has the right:

(i) To representation by an attorney or any other person of the practitioner's choice;

(ii) To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;

(iii) To call, examine, and cross-examine witnesses;

(iv) To present evidence determined to be relevant by the Arbitrator, Hearing Officer, or Committee regardless of its admissibility in a court of law;

(v) To submit a written statement at the closing of the hearing.

(vi) The hearing and all proceedings shall be considered confidential and all proceedings shall be in closed session unless requested otherwise by the affected practitioner. Witnesses and parties to the hearing shall not discuss the case except with the designated parties' attorneys or other authorized individuals and shall not discuss the issue outside of the proceedings.

#### COMPLETION OF HEARING -

(h) Upon completion of the hearing, the practitioner involved shall the right:

(i) To receive the written recommendations of the Arbitrator, Officer or ad hoc Hearing Committee, including a statement of the basis for the recommendation, including findings of the fact and conclusions of law; and

(ii) To receive a written decision of the Hospital, including a statement of the basis for that decision.

(i) CONDUCT OF HEARING

\_\_\_\_\_If the Hospital, in its sole discretion, chooses to utilize an ad hoc Hearing Committee, a majority of the Hearing Committee must be present throughout the hearing and deliberations. If a Committee member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision.

(i) \_\_\_\_\_

(ii) The Chair of the Hearing Committee, or his/her designee, shall preside over the hearing to determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present and respond to relevant oral and documentary evidence and to present arguments on all issues involved.

(iii) The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

(iv) A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record, such as the court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. The minutes shall be transcribed at the request of any party.

(v) All oral evidence shall be taken only after an Oath of Affirmation.

(i) EVIDENTIARY MATTERS IN CONTESTED CASES

(i) Evidence determined to be relevant by the Hearing Officer, Arbitrator, or ad hoc Hearing Committee, regardless of its admissibility in a court of law, shall not be excluded.

(ii) Documentary evidence may be received in the form of copies or excerpts, if the original is not readily available. Upon request, parties shall be given an opportunity to compare the copy with the original.

(iii) Notice may be taken of judicially cognizable facts. In addition, the Hearing Officer, Arbitrator or ad hoc Hearing Committee may take notice of generally recognized technical or scientific facts within the Committee's specialized knowledge. Parties shall be notified either before or during the hearing of

the material noticed, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material noticed. The Committee's experience, technical competence and specialized knowledge shall be utilized in the evaluation of the evidence.

~~BURDEN OF PROOF - The practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefore are either arbitrary, unreasonable, or capricious, w~~

(k) ~~When a hearing relates to the following:~~

(i) ~~Denial of staff appointment;~~

(ii) ~~Denial of requested advancement in staff category;~~

(iii) ~~Denial of department, service, or section affiliation; or~~

(iv) ~~Denial of requested clinical privileges.~~

~~The practitioner who requested the hearing shall have the burden of proving, by clear and convincing evidence, that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn therefore are either arbitrary, unreasonable, or capricious.~~

~~REPORT AND FURTHER ACTION -~~

(l) ~~At the conclusion of the final hearing, the Arbitrator, Hearing Officer or the ad hoc Hearing Committee shall:~~

(i) ~~Make a written report of the conclusions and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chair of the Executive Committee. All findings and recommendations by the Arbitrator, Hearing Officer or ad hoc Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it; and~~

(ii) ~~After receipt of the report, conclusions and recommendations of the Arbitrator, Hearing Officer or ad hoc Hearing Committee, the Executive Committee shall consider the report, conclusions and recommendations and shall issue a decision affirming, modifying or reversing those recommendations received.~~

(m) NOTICE OF DECISION

- (i) The Chair of the Executive Committee shall promptly send a copy of the decision by written notice to the practitioner, the practitioner's chair, the Vice President for Academic Affairs, the Vice President for Medical Affairs, the Vice President for Clinical Operations and CEO and the President of the University.
- (ii) This notice shall inform the practitioner of his/her right to request an appellate review by the Board of Trustees.

(n) NOTICE OF APPEAL

- (i) Within ten (10) days after receipt of notice by a practitioner or an affected party of an adverse decision, the practitioner or affected party may, by written notice to the Executive Medical Director (by personal service or certified mail, return receipt requested), request an appellate review by the Board of Trustees. The Notice of Appeal and Request for Review, with or without consent, shall be presented to the Board of Trustees at its next regular meeting. Such notices requesting an appellate review shall be based only on documented record unless the Board of Trustees, within its sole discretion, decides to permit oral arguments.
- (ii) If such appellate reviews not requested within ten (10) days, the affected practitioner shall have deemed to have waived his/her right to appellate review and the decision on an issue shall become final.

(o) APPELLATE REVIEW PROCEDURE

- (i) Within five (5) days after receipt of Notice of Appeal and Request for Appellate Review, the Board of Trustees shall, through the Executive Committee, notify the practitioner, and other affected parties in writing by certified mail, return receipt requested, or by personal service, of the date of such review, and shall also notify them whether oral arguments will be permitted.
  - (ii) The Board of Trustees, or its appointed Review Committee, shall act as an appellate body. It shall review the records created in the proceedings.
- 1) If an oral argument is utilized as part of the review procedure, the affected party shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the Appellate Review Body.
  - 2) If oral argument is utilized, the Executive Committee and other affected parties shall also be represented and shall be permitted to speak concerning the recommendation or decision and shall answer questions put to them by any member of the Appellate Review Body.



(iii) New or additional matters not raised during the original hearings and/or reports and not otherwise reflected in the record shall only be considered during the appellate review upon satisfactory showing by the affected practitioner or party that substantial justice cannot be done without consideration of these new issues and further giving satisfactory reasons why the issues were not previously raised. The Appellate Review Body shall be the sole determinant as to whether such new information shall be accepted.

(iv) The Board of Trustees may affirm, modify, or reverse the decision in issue or, in its discretion, may refer the matter back to the Executive Committee for further review or consideration of additional evidence. Such referral may include a request that the Executive Committee arrange for further hearing to resolve specified disputed issues.

(v) If the appellate review is conducted by a committee of the Board of Trustees, such committee shall:

1) Make a written report recommending that the Board of Trustees affirm, modify, or reverse the Decision in issue, or

2) Refer the matter back to the Executive Committee for further review and recommendations. Such referral may include a request for a hearing to resolve the disputed issues.

#### —FINAL DECISION BY THE BOARD OF TRUSTEES -

4. —

(p) After the Board of Trustees makes its final decision, it shall send notice to the President of the Medical University, the Executive Committee, the Executive Medical Director, and to the affected practitioner and other affected parties, by personal service or by certified mail, return receipt requested. This decision shall be immediately effective and final.

#### —ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES -

(q) Nothing in this section shall be construed as:

(i) Requiring the procedures under this section where there is no adverse professional review action taken;

(ii) In the case of a suspension or restriction of clinical privileges for a period of not longer than fourteen (14) days during which an investigation is being conducted to determine the need for professional review action; or

(iii) Precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

(r) REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HOSPITALS

In the event the Hospital:

- (i) Takes a professional review action that adversely affects the clinical privileges of a practitioner for a period of longer than thirty (30) days;
- (ii) Accepts the surrender of clinical privileges of a practitioner:
  - 1) While the practitioner is under investigation by the Hospital relating to possible incompetence or improper professional conduct; or
  - 2) In return for not conducting such an investigation or proceeding; or
- (iii) In the case where action is taken by the Hospital adversely affecting the membership of the practitioner, it is agreed and understood that the Hospital shall report to the appropriate State Board the following information:
  - 1) The name of the practitioner involved;
  - 2) A description of the acts or omissions or other reasons for the action or, if known, for the surrender of the privileges; and
  - 3) Such other information respecting the circumstances of the action or surrender as deemed appropriate.

~~Pursuant to Federal and State Statutes such reports to the State Boards will be reported to the National Practitioner Data Bank.~~

**ARTICLE XI**

**Article XI. CONFLICT MANAGEMENT AND RESOLUTION**

## MEC and Medical Staff -

Section 11.01 ~~\_\_\_\_\_If a conflict arises between the Medical Executive Committee~~MEC and the voting members of ~~\_\_\_\_\_the Medical Staff regarding issues pertaining to the Medical Staff including but not limited to proposals for adoption or amendment of bylaws, rules and regulations, or medical staff \_\_\_\_\_policies and when MUSC Medical Center Policy A-115 Conflict Management does not \_\_\_\_\_apply, the voting members of the medical staff by a 2/3rds vote may appoint a Conflict \_\_\_\_\_Management Team consisting of six (6) aActive~~ members of the staff who are not on the MEC. In such an event, the action or recommendation of the MEC at issue shall not go ~~\_\_\_\_\_into effect until thirty (30) days after the -appointment of the Conflict Management Team, \_\_\_\_\_during which time the MEC and the Conflict Management Team shall use their best \_\_\_\_\_efforts to resolve or manage the conflict. If the conflict is not resolved, the Medical Staff, \_\_\_\_\_by a two-thirds (2/3) vote of the Active members may make a recommendation directly to \_\_\_\_\_the Board of Trustees for action.~~

## // MEC and BOARD of TRUSTEES -

Section 11.02 ~~\_\_\_\_\_If a conflict arises between the MEC and the Board of Trustees regarding a matter \_\_\_\_\_pertaining to the quality or safety of care or to the adoption or amendment of Medical Staff \_\_\_\_\_Bylaws, Rules and Regulations, or Medical Staff Policies and when MUSC Medical \_\_\_\_\_Center Policy A-115 Conflict Management does not apply, the Executive Director may \_\_\_\_\_convene an ad-hoc committee of MUSC Medical Center, Board of Trustees and Medical \_\_\_\_\_Staff leadership to manage or resolve the conflict. This committee shall meet as early as \_\_\_\_\_possible and within 30 days of its appointment shall report its work and report to the MEC \_\_\_\_\_and the Board of Trustees its recommendations for resolution or management of the \_\_\_\_\_conflict.~~

## ARTICLE XII

### REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS

#### Article XII. OFFICIAL MEDICAL STAFF DOCUMENTS

~~\_\_\_\_\_The official governing documents of the Medical Staff shall be these B-bylaws, the Rules and Regulations of the Medical Staff, the Medical Staff Credentials Manual, the Fair Hearing Plan, and other Medical Staff policies pursuant to these bylaws. Adoption and aAmendment of these documents shall be as provided below.:~~

## | MEDICAL STAFF RESPONSIBILITYBYLAWS -

Section 12.01 ~~The Medical Staff shall have the responsibility to formulate, review, adopt, and recommend to the Board, Medical Staff Bylaws and Amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. Neither the Medical Staff nor the Board of Trustees may unilaterally amend these bylaws and the authority to adopt or~~

*amend them may not be delegated to any group. If a conflict exists between the Bylaws and other documents as outlined in this section, the Bylaws will ~~supercede~~<sup>supersede</sup>.*

(a) ~~A.~~ Methods Of Adoption And Amendment- Amendments to these bylaws may be on recommendation from the MEC approved by the voting members of the Medical Staff or after notification to the MEC on a proposal directly from a two thirds (2/3) majority of voting Medical Staff to the Board of Trustees, The Bylaws may be amended or revised after submission of the proposed amendment at any regular or special meeting of the Medical Staff or by email or US mail submission to all Active Medical Staff members. To be adopted, an amendment or revisions shall require a majority vote of the Active members. Voting can be completed either in person at a Medical Staff meeting or by electronic ballot vote of those who are eligible to vote on the Bylaws. Amendments so made shall be effective only when approved by the Board of Trustees.

~~1. All proposed amendments, whether originated by the MEC, another standing committee, or by a member of the Active Category of the Medical Staff, must be reviewed and discussed by the MEC prior to a MEC vote. Such amendments may be recommended to the Board:~~

~~A. The Bylaws may be amended or revised after submission of the proposed amendment [L Korr 4] at any regular or special meeting of the Medical Staff or by email or US mail submission to all Active Medical Staff members. To be adopted, an amendment or revisions shall require a majority vote of the Active members. Voting can be completed either in person at a Medical Staff meeting or by electronic ballot vote of those who are eligible to vote on the Bylaws. Amendments so made shall be effective when approved by the Board of Trustees.~~

~~B.~~ (b) The Executive Committee is authorized to make minor changes/corrections when necessary due to spelling, punctuation and/or grammar.

~~C.~~ (c) These Bylaws shall be reviewed at least every two (2) years by the Officers of the Medical Staff. Findings shall be reported at a regular meeting of the Medical Staff or at a special meeting called for such purpose or by email to active Staff members. Any recommended changes shall be amended in accordance with these Bylaws.

Section 12.02 ~~II~~ Rules and Regulations and Other Related Documents - ~~The MEC will provide to the Board of Trustees a set of Medical Staff Rules and Regulations, a Credentials Policy Manual, and a Fair Hearing Plan that further defines the general policies contained in these Bylaws.~~

~~A. These manuals will be incorporated by reference and become part of f-these Medical - Staff Bylaws. The MEC has the delegated authority to make amendments to the - Rules -and Regulations of the Medical Staff, the Credentials Manual of the Medical - Staff, the -Fair Hearing Plan and other Medical Staff policies as outlined in Article VII -~~

(a) ~~E-2~~ Section 7.02b.

~~B. Alternatively the Medical Staff may propose an amendment to the Rules and - Regulations and other afore mentioned associated documents directly to the Board of - Trustees. Such a proposal shall require a two-thirds (2/3) majority vote of the Active - Medical Staff and shall require notification to the MEC.~~

(b)

~~C. When there is a documented need for an urgent amendment to the Rrules and Rregulations - to comply with the a law -or regulation, the voting members of the -organized medical - staff -delegate the authority to the MEC whole by a majority vote of the MEC members - provisionally adopt such amendments and seek provisional Board of Trustees approval -without prior notification to the medical staff. The MEC will immediately notify the - Medical Staff of such provisional approval by the Board. The Medical Staff at its next - meeting, or-at a called meeting, -or through -electronic communication will -retrospectively review the provisional amendment. If there is no conflict between the -~~

(c) ~~organized medical staff and the MEC regarding the amendment, the provisional- amendment stands. If there is a conflict over the provisional amendment(s) the Conflict -Management process as outlined in Article XI -of these bylaws will be implemented.~~

~~If If~~

(d) ~~necessary-a, a revised amendment is then submitted to the Board of Trustees for action.~~

~~\_\_\_\_\_D. The Rules and Regulations of the Medical Staff, the Credentials Manual, the Fair –~~

~~\_\_\_\_\_Hearing Plan and the Policies of the Medical Staff are intended to provide the \_\_\_\_\_associated details necessary to implement these Bylaws of the MUSC Medical Staff, \_\_\_\_\_~~

~~(e) \_\_\_\_\_~~

### ~~\_\_\_\_\_III\_\_\_\_\_~~ **RULE CHALLENGE**

#### Section 12.03

Any practitioner may raise a challenge to any rule or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate, any physician may

submit a petition signed by 25% of the members of the Active Staff. When such petition has been received by the MEC, it will either:

~~A. (a) \_\_\_\_\_~~ Provide the petitions with information clarifying the intent of such rule, regulation, or policy and/or

~~B. \_\_\_\_\_~~

~~C. (b) \_\_\_\_\_~~ Schedule a meeting with the petitioners to discuss the issue.

### ~~IV \_\_\_\_\_~~ **RELATED PROTOCOLS AND MANUALS**

~~The MEC will provide to the Board a set of Medical Staff Rules and Regulations, a Credentials Policy Manual, a Fair Hearing Plan that further defines the general policies contained in these Bylaws. These manuals will be incorporated by reference and become part of these Medical Staff Bylaws.~~

Approved by the Medical Executive Committee on January 19, 2011 ~~January 20, 2010~~, and by majority vote of the Medical Staff on January 25, 2011 ~~January 26, 2010~~.

~~\_\_\_\_\_~~ Revisions approved by the Board of Trustees on February <date>, 2011 ~~as of this February 12, 2010.~~

## **Hospital Plan for Provision of Patient Care Services for MUSC Medical Center**

### **I. INTRODUCTION**

The Medical University of South Carolina has a distinguished heritage that began in 1824 with the founding of the College of Medicine by the Medical Society of South Carolina. The Medical College, the first in the Southeast, was set up to provide medical students with a clinical teaching environment. Except for the years during the Civil War, the College of Medicine has operated continually since its founding.

In 1913, the Medical College, which included the Pharmacy School (founded in 1881), became a state owned institution. By 1969, the institution had grown to include many professional and graduate programs, and had added four (4) more schools; Nursing (1919), Graduate Studies (1965), Health Professions (1966), and Dental Medicine (1967). In 1969, the South Carolina Legislature voted to consolidate the professional schools and programs in the Medical University of South Carolina (MUSC).

Patient care services at the MUSC Medical Center are based on its mission, vision and values as well as the needs of the community it serves.

### **II. MISSION STATEMENT**

The mission of the Medical Center of the Medical University of South Carolina is to provide excellence in patient care, teaching, and research in an environment that is respectful of others, adaptive to change and accountable for outcomes.

### **III. VISION STATEMENT**

The clinical enterprise of MUSC will be a leading academic health care organization that is part of a geographically dispersed patient care delivery system. The clinical enterprise will offer a full range of services, including nationally and internationally recognized specialty services.

MUSC will establish strategic alliances to serve the state of South Carolina and will provide an educational environment that is at the forefront of academic health sciences and supports MUSC's role in cutting-edge scientific discoveries. MUSC's clinical enterprise will include:

- A flexible structure that allows MUSC to achieve its vision
- Excellent and safe patient-centered care
- A broad based provider network
- Integrated decision-making
- A commitment to health promotion and illness prevention

### **IV. ORGANIZATIONAL VALUES**

In the development and operation of the State's premier integrated delivery system, the Medical Center relies upon a core set of values to achieve its stated mission. These values are as follows:

**Accountability** - Accepting responsibility for actions and using resources prudently to ensure the success of the organization. Each Medical Center employee is dedicated to the collaborative effort of providing health services in a manner which maximizes

operational efficiency, demonstrates quality through teamwork, assures a safe environment, and thrives in a competitive market.

**Respect** - Relationships with all customers, both external and internal, are vital assets. Satisfaction with the ability to serve patient needs in a respectful and caring manner determines the success of the Medical Center.

**Excellence** - Success is measured by the ability to be recognized for excellence in clinical outcomes within a setting which maintains high ethical standards and is sensitive to the importance of patient rights.

**Adaptability** - Services are focused on the needs of customers. The ability to be collaborative, creative, and flexible in a changing market is a trait which positions the Medical Center as the premiere provider of health services in the community and region.

## **V. LEADERSHIP**

The leadership of MUSC Medical Center takes responsibility for providing the foundation and support necessary for planning, directing, coordinating, providing and improving health care services. This foundation includes:

- Providing a culture that fosters safety as a priority for everyone who works in the organization
- Providing the necessary resources, financial, human, and physical for providing care, treatment, and services.
- Insuring that all staff are competent
- Evaluating performance on an on-going basis

Leadership's role at MUSC is to provide for the effective functioning of patient care services in order to achieve and improve patient health outcomes with a focus on safety and quality. MUSC Medical Center leadership embraces the five key systems identified by the Joint Commission that influence the effective performance of patient care services. These systems include:

- Effective Use of Data
- Planning
- Communicating
- Changing performance
- Staffing

## **VI. PATIENT CARE SERVICES**

The Plan for Patient Care Services is organized, developed and implemented in order to maximize participation in the provision of patient care from all levels of staff. The plan for patient care services considers the following:

- The areas of the organization in which care is provided
- The mechanism(s) used in each area to identify patient care needs
- The environment that establishes an integrated quality and patient safety program
- The number and mix of staff members in each area to provide for patient needs
- The process used for assessing and acting on staffing variances
- The interdisciplinary plan for improving the quality of care.
- The organization's commitment to improve patient safety and reduce risks to patients.



This plan has been linked to the organization's planning process and considers the following:

- Patient/customer needs, expectations, and satisfaction
- Patient requirements and their implications for staffing
- The organization's determination of the essential services necessary to meet the needs of its patient population
- The planning for the provision of those essential services, either directly, through referral, or through a contract
- The organization's ability to recruit and/or develop appropriate staff
- Relevant information from staffing variance
- Information from quality and performance improvement activities
- The provision of a uniform level of care throughout the organization
- Opportunities to improve processes in the design and delivery of patient care
- National benchmarks and best practices

## **VII. STAFFING FOR PATIENT CARE**

Patient care services are organized, directed and staffed in a manner commensurate with the scope of services offered. Staff members are assigned clinical and managerial responsibilities based upon educational preparation, applicable licensing laws and regulations and assessment of current competence. Classifications of personnel providing patient care are identified in specific Department Scope of Services statements. In support of improvement and innovation in the delivery of patient care, staffing levels are adequate to support patient care, participation of patient care providers, as assigned, in committees, meetings or activities such as performance improvement teams and continuing professional education.

Staffing plans for patient care services are developed based on the level and scope of care that meets the needs of the patient population, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately provide the type of care needed.

## **VIII. SCOPE OF SERVICES**

The MUSC Medical Center has 709 beds, over 6500 hospital employees. 895 physicians, and 617 residents, providing a full continuum of inpatient and outpatient care including:

### **Acute Inpatient Services:**

Children's (including a Level III Neonatal ICU)  
Digestive Disease  
Heart and Vascular  
Medicine – acute and critical  
Musculoskeletal  
Oncology  
Mental Health  
Neuroscience  
Women's Care  
Surgery – acute, critical, Level I Trauma, and subspecialty  
Transplant

### **Emergency Services:**

Emergency Services – adult and pediatric  
Level I Trauma - adult and pediatric  
Air and Ground Transport

**Outpatient Services:**

Hospital Ancillaries

Physician and Other Clinician Services as defined in Acute Inpatient Services

**Partial Hospitalization Services:**

Mental Health

Patient Care Services are provided at the following locations:

<b>EMERGENCY DEPARTMENTS</b>	
Pediatric Emergency	1 CSB/1W
Adult ED	1 UH
Chest Pain Center	1 ART
<b>PROCEDURAL AREAS</b>	
6 Echo and Vascular Lab	6 UH
5 Procedure Area	5 CH
6 Peds Cath Lab	6 CH
5 Interventional Radiology	5 CH
5 Prep & Recovery	5 CH
3 Adult Cath Lab	3 ART
3 Electrophysiology Lab	3 ART
3 Prep & Recovery	3 ART
3 Interventional Radiology	3 ART
ART Patient Tower - Endoscopy	2 ART
1 Adult Echo Lab	1 ART
1 Vascular Lab	1 ART
1 EKG	1 ART
Sleep Lab	1 CSB
Bronch/PICC Lab	1 CSB
Clinical Neurophysiology Lab	1 CSB
3 Neuro-Interventional Radiology	3 UH
<b>SURGICAL SERVICES</b>	
PACU Main Hospital - Adult and Pediatrics	4 UH
Holding Main OR	4 UH
Main OR	4 UH
PACU ART Hospital	4 ART
ART OR	4 ART
Ambulatory Surgery	1 RT
<b>INPATIENT SITES</b>	
8 Special Care Nursery (Level II)	8 CH
8 NNICU	8 CH
6 Same Day Observation	6 CH
7A Infant Care	7 CH
7B Peds Medicine	7 CH

7C Peds Intermediate Care	7 CH
7E Peds Surgery	7 CH
8D Peds Cardiology	8 CH
8F Peds ICU	8 CH
6E Bariatric Surgery	6E ART
6W Digestive Disease	6W ART
5W Heme/Onc	5W ART
5E Gen Cardiology	5E ART
4E Thoracic Surgery	4E ART
CCU	4W ART
CTICU	4W ART
3W Cardiology	3W ART
MSICU	3E ART
10W Orthopedics	10W UH
9W Neuro Surgery	9W UH
9E Neuro	9E UH
NSICU	9C UH
8E Gen Med	8E UH
8W Med/ Surg Admissions	8W UH
7W Surgical Oncology & ENT	7W UH
6E University Hospital	6E UH
6 MICU	6SW UH
6W General Surgery	6W UH
5W Ante partum	5W UH
5 SW Labor and Delivery	5SW UH
5E Postpartum OB/GYN	5E UH
5E Nursery (Level II)	5E UH
PCICU Children's	4 UH
4 West STICU	4W UH
4 STICU	4SW UH
2 Transitional Care Unit	2C UH
2 Joint Replacement Unit (JRU)	2E UH
5 North STAR (Youth PHP)	5 IOP
5 Electro Convulsive Treatment (ECT)	5 IOP
4 North Alcohol/Drug Rehab/Addictions	4 IOP
3 North Adult Mental Health	3 IOP
2 North Youth Mental Health	2 IOP
1 North - SCU (Seniors)	1 IOP
1 North	1 IOP
<b>OUTPATIENT SITES</b>	
Gamma Knife	1 UH
ART Patient Tower - GI Surgery clinic	1 ART
ART Patient Tower - GI Medicine Clinic	2 ART

ART Patient Tower 1 - Cardiovascular Clinics	1 ART
6 Peds Echo	6 CH
SEI 4 Ophthalmology (Adult)	4 SEI
SEI 2 Ophthalmology (Adult)	2 SEI
SEI 1 Ped Ophthalmology	1 SEI
SEI 1 Ophthalmology (General)	1 SEI
HCC 3 Radiation Oncology	3 HCC
HCC 3 Adult Oncology Clinics (Head & Neck)	3 HCC
HCC 2 Adult Oncology Clinics (GYN, BMT, & Thoracic)	2 HCC
HCC 2 Infusion	2 HCC
HCC BMT	2 HCC
RT 10 Dermatology Surgery	10 RT
RT 10 Dermatology	10 RT
RT 10 Denistry/Maxillofacial/Prosthodontics	10 RT
RT 9 Pain Management	9 RT
RT 9 Clinical Neurophysiology Lab	9 RT
RT 9 Transplant	9 RT
RT 8 University Internal Medicine	8 RT
RT 7 Surgical Centers	7 RT
RT 7 Endocrine Clinic	7 RT
RT 6 Children's Oncology & Hematology	6 RT
CH 6 Peds Cardiology Clinic	6 CH
6 Peds EKG	6 CH
RT 6 Neurosurgery/Spine/Physical Medication & Rehab	6 RT
RT 5 Rheumatology	5 RT
RT 5 Urology	5 RT
RT 5 Pulmonary	5 RT
RT 4 Children's Brain Tumor	4 RT
RT 4 Children's Craniofacial	4 RT
RT 4 Children's Neurosurgery	4 RT
RT 4 Children's Pulmonary/Asthma	4 RT
RT 4 Children's Spina Bifida	4 RT
RT 4 Children's Surgery/Burn	4 RT
RT 4 Children's Urology	4 RT
RT 3B Children's Development Peds	3 RT
RT 3 Children's Sickle Cell / Day Services	3 RT
RT 3 Children's Primary Care	3 RT
RT 3 Children's Adolescent Medicine	3 RT
RT 3B Children's Endocrinology	3 RT
RT 3B Children's Genetics	3 RT
RT 3B Children's Psychology/Psychiatry	3 RT
RT 2 ENT Otolaryngology	2 RT
RT 2 Children's Infectious Disease	2 RT

RT 2B Children's GI	2 RT
RT 1 Sinus Clinic	1 RT
RT 1 Children's Nephrology	1 RT
RT 1 Children's Neurology	1 RT
RT 1 Children's Orthopedics	1 RT
RT 1 Children's Rheumatology	1 RT
RT 4 Children's Spasticity	1 RT
RT 1 Children's Transplant	1 RT
RT 1 Children's OPEC	1 RT

### SCOPE OF SERVICES TEMPLATE FOR CLINICAL AREAS

INTRODUCTION	
Description & Location	
Patient Population	
Procedures, Activities, and Processes Performed	
Operating Hours	
CRITERIA FOR SERVICE – INPATIENT AND OUTPATIENT	
Entry/Admission	
Alternate Units	
Discharge	
PLAN OF CARE	
Assessment	
Treatment	
Continuum of Care	
STAFFING	
Staffing Plan	
Staffing Variances	
STAFF QUALIFICATIONS	
Level of Staff or Required Qualifications	
Orientation Program	
Competency Assessment	
Continuing Education	
Employee Educational Records	
RELATIONS WITH OTHER DEPARTMENTS/SERVICES	
Communication Methods	
Collaborative/functional relationships with others	
GOALS & PERFORMANCE IMPROVEMENT	
Goals	
Current PI Activities	
Past PI Activities	
PATIENT SAFETY INITIATIVES	

Description	
<b>ADDITIONAL STANDARDS OF PRACTICE ADOPTED/ADAPTED</b>	
Description	

**SCOPE OF SERVICES TEMPLATE FOR NON-CLINICAL AREAS**

INTRODUCTION	
Description & Location	
Customer Identification	
Significant Activities/ Processes Performed	
Operating Hours	
STAFFING	
Staffing Plan	
Staffing Variances	
STAFF QUALIFICATIONS	
Required Qualifications	
Orientation Program	
Competency Assessment	
Continuing Education	
Employee Educational Records	
RELATIONS WITH OTHER DEPARTMENTS/SERVICES	
Communication Methods	
Collaborative/functional relationships with others	
GOALS & PERFORMANCE IMPROVEMENT	
Goals	
Current PI Activities	
Past PI Activities	
PATIENT SAFETY INITIATIVES	
Description	

Note: Detailed and current Scopes of Services are completed annually and are the attachments to this plan.

**MUSC MEDICAL CENTER**  
**PERFORMANCE IMPROVEMENT PLAN**  
**2011 - 2012**

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The Medical University of South Carolina Medical Center is committed to fostering an environment that promotes high quality care in all its domains: safety, effectiveness, equitable, efficient, patient-centered, and timely. This commitment has developed into an institutional strategy that aligns governance, managerial and clinical support functions and personnel to continually assess our performance and proactively identify opportunities for enhancing quality of care and patient safety by preventing medical errors before they occur. Recognizing the inevitability of adverse events and some medical errors in complex healthcare settings, we stand committed to learning from these events, developing safeguards to prevent their recurrence, and addressing the impact of adverse events on patients and families.

This Performance Improvement Plan establishes a network for continually and systematically planning, designing, measuring, assessing and improving performance of hospital wide key functions and processes that support high quality and safe patient care. Central components of this network are as follows:

- Incorporate quality planning throughout the Medical Center;
- Create an organizational structure that allows personnel and clinical units to integrate their efforts in performance improvement and collaborate across departmental boundaries;

- Communicate performance improvement efforts throughout the Medical Center to foster institutional learning and encourage innovation and problem solving at the clinical unit level;
- Assure project prioritization, process design and redesign are consistent with the Medical Center's mission, vision and values;
- Foster institutional self-assessment exercises that benchmark our performance against the "dimensions of performance" that direct care to be safe, effective, efficient, patient-centered, timely, and equitable.
- Reduce unexplained practice variation by promoting best clinical practices that are consistent with current professional knowledge as defined by evidence-based reports, practice guidelines, information from relevant systematic reviews and high-quality clinical investigations, and professional standards;
- Integrate error reduction procedures in healthcare processes; and
- Integrate the utilization of performance improvement principles in the daily activities of the work place.
- Link the education of our trainees to the science of performance improvement.
- Foster clinical research that examines processes of care and performance improvement.

This plan follows the "structure-process-outcome paradigm" of performance assessment and monitoring first described by Avedis Donabedian (1979, National Center for Health Services Research; 1983, Evaluation & the Health Professions). This paradigm provides the network for describing the MUSC Medical Center's plan for continuously improving the safety and quality of our care processes.

## I. **SCOPE OF SERVICES**

The MUSC Medical Center provides a full continuum of inpatient and outpatient care including:

### **Acute Inpatient Services:**

Children's (including a Level III Neonatal ICU)  
Digestive Disease  
Heart and Vascular  
Medicine – acute and critical  
Musculoskeletal  
Oncology  
Mental Health  
Neuroscience  
Women's Care  
Surgery – acute, critical, Level I Trauma, and subspecialty  
Transplant

### **Emergency Services:**

Emergency Services – adult and pediatric  
Level I Trauma - adult and pediatric



Air and Ground Transport

**Outpatient Services:**

Hospital Ancillaries  
Physician and Other Clinician Services as defined in Acute Inpatient Services

**Partial Hospitalization Services:**

Mental Health

**II. MISSION STATEMENT**

The mission of the Medical Center of the Medical University of South Carolina is to provide excellence in patient care, teaching, and research in an environment that is respectful of others, adaptive to change, and accountable for outcomes.

**III. VISION STATEMENT**

*To be a leading academic Medical Center*

The clinical enterprise of MUSC will be a leading academic health care organization that is part of a geographically dispersed patient care delivery system. The clinical enterprise will offer a full range of services, including nationally and internationally recognized specialty services. MUSC will establish strategic alliances to serve the state of South Carolina and will provide an educational environment that is at the forefront of academic health sciences and supports MUSC's role in cutting-edge scientific discoveries.

MUSC's clinical enterprise will include:

- a flexible structure that allows MUSC to achieve its vision.
- excellent and safe patient-centered care.
- a broad based provider network.
- integrated decision-making.
- a commitment to health promotion and illness prevention.

**IV. ORGANIZATIONAL VALUES**

In the development and operation of the State's premier integrated delivery system, the Medical Center relies upon a core set of values to achieve its stated mission. These values are as follows:

**Accountability** - Accepting responsibility for actions and using resources prudently to ensure the success of the organization. Each Medical Center employee is dedicated to the collaborative effort of providing health services in a manner, which maximizes operational efficiency,

demonstrates quality through teamwork, assures a safe environment, and thrives in a competitive market.

**Respect** - Relationships with all customers, both external and internal, are vital assets.

Satisfaction with the ability to serve patient needs in a respectful and caring manner determines the success of the Medical Center.

**Excellence** - Success is measured by the ability to be recognized for excellence in clinical outcomes within a setting, which maintains high ethical standards and is sensitive to the importance of patient rights.

**Adaptability** - Services are focused on the needs of customers. The ability to be collaborative, creative, and flexible in a changing market is a trait which positions the Medical Center as the premiere provider of health services in the community and region.

## **V. QUALITY DEFINITION**

MUSC Medical Center formally adopts the Institute of Medicine's definition of quality, which is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". Additionally, all domains of quality as noted by the IOM are adopted: safety, effectiveness, efficiency, equity, patient centeredness, and timely. (Committee on Quality of Health Care in America *Crossing the Quality Chasm*, Washington, DC, National Academy Press, 1999, p. 232).

## **VI. ORGANIZATION**

The MUSC Medical Center Quality Network is the interdisciplinary structure that drives and coordinates the performance improvement activities of the domains of quality within the medical center. This structure represents a systematic organization-wide approach to planning for quality results.

The Quality Network focuses on the patient and organizational functions that promote positive patient outcomes by standardizing processes of care across the medical center. Through the committees and communication channels of the Quality Network, improvement efforts within these functions are identified, prioritized, and quantified. This Network represents a transition from an approach in which performance improvement is a distinct set of activities to one in which performance improvement is integrated into the operational structure of each service as well as across the organization. This cross-organizational approach ensures that monitoring and evaluation of important functions occur within existing operational and medical staff committees.

In general, there are two types of performance improvement projects. The first are the large-scale, organization-wide performance improvement projects. These projects are initiated by senior management to support key strategic and operational objectives. Progress on these projects is reported to Hospital Operations Committee. The second types of projects are the smaller-scale, service projects. These smaller projects are initiated from within any component of the organization and are reported in the component's operational committees.

More specifically, the quality agenda is monitored extensively by the Hospital Quality Operations Committee and the Medical Executive Committee. The Hospital Quality Operations Committee agenda is separated into three sections:

1. Event Reviews
2. Quality Monitoring Reports
3. Performance Measures Reports

#### **1. Event Reviews**

All significant events are investigated by hospital risk management and then reviewed by an Administrative Review Group (ARG) which determines whether the events is deemed sentinel or serious as defined in medical center policy C-49. The ARG consists of the Vice President Clinical Operations & Executive Director, Executive Medical Director, Applicable Medical Leadership or designee, Applicable Service Line Administrator or designee, Chief Nursing Executive, and the Clinical Services Director of the affected area. The Manager of Risk Management and the Critical Interventions Managers also attend but are nonvoting members. If the event is deemed sentinel, a root cause analysis procedure is performed as described in policy C-49. All sentinel event action plans are reviewed and approved by both the Medical Executive Committee and the Hospital Operations Quality Committee. If serious, then they are assigned as a Quality Monitoring Report.

All QMRs are assigned an administrator champion, a process owner, and a performance improvement facilitator. The administrator is expected to eliminate barriers in the implementation of the remedy. The process owner is expected to lead the team. The facilitator is expected to assist the process owner in adhering to the I.M.P.R.O.V.E format. Appendix A

#### **2. Performance Measures Reports (PMR)**

PMRs are the organization wide measures that are monitored on an ongoing basis (see Appendix B). These reports are designed to track and trend key quality metrics for the medical center and to let senior leadership know when and where to dedicate resources to improve performance.

### **3. Quality Monitoring Reports (QMR)**

Quality Measures Reports are focused performance improvement projects that follow our I.M.P.R.O.V.E methodology are identified by:

- Patients and families - Through complaints, comments or patient satisfaction surveys.
- Staff at all levels - Through volunteer occurrence reports (patient safety net), house staff representatives on quality committee, culture of safety survey and employee partnership survey.
- Senior Leadership - Goals related to strategic plan or assigned by the administrative review group.
- External Benchmarks - Quarterly review of quality and safety benchmark reports from external agencies (American College of Surgeons, American Heart Association, etc.) and The University Health System Consortium (UHC).
- Regulatory Agencies and Healthcare Payors - The Joint Commission, Center for Medicare and Medicaid Services, Department of Health and Environmental Control, and other Health Care Payors
- PMRs - When performance falls below target it is assessed by senior leadership on whether there needs to be a QMR

Before a project can become a QMR, it must be brought before the Hospital Operations Quality Committee and approved as a project. This is done to ensure interdisciplinary assessment of the QMR in order to properly assign resources and expectations of completions. All QMRs are assigned an administrator champion, a process owner, and a performance improvement facilitator. The administrator is expected to eliminate barriers in the implementation of the remedy. The process owner is expected to lead the team. The facilitator is expected to assist the process owner in adhering to the I.M.P.R.O.V.E format.

### **4. THE BOARD OF TRUSTEES**

#### **PURPOSE:**

The MUSC Board of Trustees is responsible of the quality of patient care provided. The Board of Trustees requires the medical staff to implement and report on the activities and mechanisms for monitoring, assessing and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility.

The Board of Trustees is supported by the medical center policies, Medical Staff Bylaws and this Performance Improvement Plan. The MUSC Board of Trustees delegates and directs the Hospital Administration and the Medical Staff to:

- Recommend the strategic direction.
- Require reports and mechanisms for monitoring and evaluating the quality of patient care services to include the frequency of monitoring.
- Provide resources and support systems for performance improvement functions related to patient care services and safety.
- Require mechanisms to assure that all patients with the same health problem are receiving comparable levels of care in the Medical Center.
- Review information needed to educate the Board members about their responsibility for the quality and safety of patient care.
- Evaluate the Performance Improvement Plan annually.

#### **5. THE MEDICAL EXECUTIVE COMMITTEE (MEC)**

##### **PURPOSE:**

The MUSC Medical Center MEC is comprised of senior physician and administrative leadership from all components of the clinical enterprise. The MEC has responsibility for overseeing, supporting, and evaluating the Quality and Safety Network structure and outcomes. This committee is the structure that ensures medical staff leadership and involvement in performance improvement and that ensures coordination and accountability among department chairpersons, faculty, and residents.

The MEC delegates the responsibility of physician performance improvement to the Department Chairpersons. More specifically, the purpose of the MEC is to ensure high quality, safe, patient-centered, cost-effective care throughout the MUSC clinical enterprise.

#### **6. THE HOSPITAL OPERATIONS QUALITY COMMITTEE**

##### **PURPOSE:**

The MUSC Hospital Operations Quality Committee is made up of senior leadership representing each of the service lines as well as other functional areas, oversees and coordinates the performance assessment and improvement activities within the organization. This group ensures that improvements are planned, designed, measured, analyzed, and sustained. More specifically, the Hospital Operations Quality Committee:

- Operationalizes improvement activities that are consistent with the MUSC Medical Center Strategic Plan.
- Receives reports and takes action on issues and initiatives that address each of the domains of quality. Such examples are, but not limited to: patient care process, infection control, utilization review, environment of care, continuum of care, and leadership.
- Uses performance data in the design and evaluation of new services or programs.
- Identifies improvement actions to be taken, assigns in writing responsibility for each action, and ensures accountability for follow through.
- Oversees analyses of sentinel events and ensures appropriate risk reduction strategies are implemented.
- Oversees organizational proactive risk assessment (example - Failure Mode Effects and Analysis) and ensures appropriate risk reduction activities.
- Supports education for key personnel on the approaches and methods of performance improvement.
- Selects, prioritizes, and monitors the progress of the organization-wide quality improvement projects.
- Allocates financial resources necessary to support organization-wide quality improvement projects.
- Manages the flow of information to ensure effective communication and follow-up.
- Communicates performance assessment information and improvement activities to the Medical Executive Committee and MUSC Board of Trustees.
- Ensures that the performance improvement infrastructure meets regulatory standards.

## **7. THE I.M.P.R.O.V.E COMMITTEE**

### **PURPOSE:**

The IMPROVE Committee is made up of hospital administrators, directors, appropriate physician leaders, and performance improvement leadership and staff. This committee oversees the Quality Monitoring Reports (QMRs) process and ensures that the process adheres to a standard quality improvement methodology such as I.M.P.R.O.V.E., LEAN, or Six Sigma. The Committee receives QMRs from the Hospital Operations Quality

Committee, schedules timely review of the QMR, and ensures that the QMR actions are appropriate to the identified problem and completed in a timely manner. The Committee makes recommendations to the Hospital Operations Quality Committee to modify the original charge if necessary, close out the QMR, or convert to a performance measure report.

## **8. ORGANIZATION-WIDE PERFORMANCE IMPROVEMENT TEAMS**

### **PURPOSE:**

Organization-wide Performance Improvement (PI) Teams at the MUSC Medical Center are multidisciplinary teams that are charged by senior leadership to use a standard quality improvement methodology such as I.M.P.R.O.V.E. model, LEAN, or Six Sigma to make improvements in a specific process. Projects that follow a standard quality improvement methodology at MUSC Medical Center are termed IMPROVE Projects. These teams use the principles, concepts, and tools of basic statistical and performance analysis to define, analyze, measure and improve the key processes that achieve the outcomes that meet our patients', families', and health care providers' needs.

Selection of organization-wide projects is based on alignment with strategic initiatives as well as those processes that are known to jeopardize the safety of the patient or are associated with sentinel events as published in the literature.

## **9. PATIENT POPULATION SPECIFIC APPROACH**

The MUSC Medical Center recognizes that performance improvement is often best approached from a patient centric viewpoint and therefore organizes performance improvement activities as appropriate in service lines, clinical units, or interdisciplinary teams with the purpose of overseeing efforts to continuously assess and improve patient outcomes. Such activities may constitute a big versus small performance improvement project as outlined in Section VI. Additional, such activities may stem from QMRs or PMRs as outlined in Section VI.

## **10. KEY FUNCTIONS**

There are many key functions that support positive patient outcomes. These functions are performed by many different clinical and support staff, with appropriate input, participation, and leadership by physicians. Some of these functions are managed through committees, while others rely on advisory panels or other mechanisms. Regardless of the method, those responsible for key functions report relevant performance information through Hospital

Operations Quality Committee, and Medical Executive Committee, to the Board of Trustees.

Those responsible for these functions will:

- Identify and review on-going performance measures.
- Prioritize and select performance improvement projects in alignment with the organization's strategic improvement priorities.
- Oversee these IMPROVE projects.
- Collect data and perform comparative analysis.
- Determine if action is necessary based on comparisons and patterns of variation.
- Evaluate the effectiveness of action plans for organization-wide implementation.
- Focus on processes and activities that affect quality of patient care and services.
- Monitor safety and effectiveness of care based on established standards.
- Assure appropriate resource utilization.
- Establish effective communication channels.
- Coordinate with and support the improvement efforts of the patient population committees.
- Report frequency as indicated in Appendix B.

## **VII. PERFORMANCE IMPROVEMENT METHODOLOGY**

### **THE IMPROVEMENT PROCESS**

In an effort to continually improve organizational performance and maintain the safety and quality of patient care, MUSC Medical Center evaluates the development of new processes as well as the redesign or improvement of existing processes.

A systematic approach is utilized to:

- Problem solve, identify the new process or potential improvement.
- Assess/test the strategy for change.
- Analyze data from the test (to determine if the change produced the desired result).
- Implement the improvement strategy system-wide when applicable.
- Monitor for sustained change.

Improvement projects use the I.M.P.R.O.V.E. model described below and are documented with the forms on the Quality Network web page:

<http://mcintranet.musc.edu/cceps/QualityNetwork/index>



- I Identify a problem or an opportunity
- M Establish a measurement
- P Problem analysis
- R Remedy Selection
- O Operationalize the interventions
- V Validate the effectiveness of your interventions
- E Evaluate whether your improvement is sustained

The MUSC Medical Center also recognizes other standard quality improvement methodologies including LEAN and Six Sigma and ensures that the Performance Improvement Department has appropriate competencies in these areas.

#### **VIII.     SELECTION OF IMPROVEMENT PRIORITIES**

Organizational improvement priorities are selected both proactively and in response to problems that are identified through ongoing assessment of data and analysis of adverse events. More specifically, the following sources of information are used to identify improvement opportunities:

- Strategic planning process
- Benchmark and other external comparative data
- Patient satisfaction data/complaints
- Occurrences, Near Misses and Safety Concerns
- Sentinel events
- Other performance data

#### **IX.     MONITORING AND EVALUATION PROCESSES**

The Board of Trustees, management, clinical, and support services believe that indicators are central to the performance improvement process. The MUSC Medical Center leadership has identified a number of organization-wide performance indicators that will be monitored on an ongoing basis. These indicators have been identified to assess and measure the performance of key services and functions within the organization. The MUSC Medical Center leadership appreciates that indicators are not direct measures of quality, but instead are flags that may suggest areas for potential analysis.

The MUSC Medical Center leadership through the Hospital Quality Operations Committee and the Medical Executive Committee monitor the organization-wide performance indicator data, which are coordinated through the Quality Department. In addition, these groups determine if the data reveal acceptable statistical means and variation and if the data display any statistically

unusual patterns. If any unusual patterns are detected, further investigation is conducted to determine the cause. Improvement efforts would subsequently bring the function under control. Improvement efforts might also be initiated to improve the mean and/or amount of variation. Once the areas that require improvement are confirmed, an action is planned and then implemented. A reassessment effort and episodic monitoring is completed to ensure that the changes have had their intended effect and have been sustained.

**X. INFORMATION FLOW**

Multiple departments and disciplines contribute to the evaluation and improvement of clinical care delivery through their participation in the monitoring process and interdisciplinary committees and teams.

**XI. ANNUAL EVALUATION**

The Performance Improvement Plan will be reviewed by the Hospital Operations Quality Committee and the Medical Executive Committee. In addition, participation of department committees will be monitored and evaluated.

The following criteria will be used in the evaluation of this plan:

- Utilization of IMPROVE methodology
- Dissemination of Important lessons learned across the organization
- Project initiation was driven by the data or literature
- Teams and individuals evaluated the effect and sustainability of the change
- Increased development of evidence based practice guidelines
- Statistically significant improvement
- Use of the literature in the prevention of adverse events

Approved Medical Executive Committee, November 16, 2011

Approved Quality Operations, November 17, 2011

Approved Board of Trustees <enter date>

## Appendix A

Appendix B

**Quality - Performance Measures Reports**

\*Frequency may be increased at direction of Quality Operations or Medical Executive Committee

<b>PMRs</b>	<b>Minimum Frequency*</b>	<b>Indicators</b>
Anesthesia Outcomes	Quarterly	
Autopsy	Quarterly	Autopsy rate - % Compliance for Requesting when Criteria Exists - Pre/Post mortem correlation
Blood Usage	Annual	Crossmatch to transfusion (C/T) ratio Specimen labeling errors Blood product ordering criteria compliance Tissue Utilization Statistics Improper handling by nursing house/staff Ordered product not transfused - OR Ordered product not transfused - Non-OR Adverse Reaction Recognition & evaluation Hemolytic transfusion reaction Blood/components must match order; match pt. to blood/component; 2 person verification process (NPSG 1)
Certification - Advanced Diagnostic Imaging Accreditation	Certification time	
Certification - Bariatric	Certification time	
Certification - Cancer Program	Certification time	
Certification - Diabetes	Certification time	
Certification – FACT	Certification time	
Certification – Joint Replacement	Certification time	
Certification - Radiation Safety	Certification time	
Certification – Sleep	Certification time	
Certification - Stroke Center	Certification time	
Certification - Transplant	Certification time	
Certification – Trauma	Annual	
Certification – Ventricular Assist Device	Certification time	
Chest Pain Center- ACS Data	Certification time	
Competency	Annual – refer to Ops	

Dietary	Annual	
Effectiveness of patient education	Bi-annual	
• Get Well Network	Annual	
Effectiveness of staff education	Bi-annual	
Employee Perception of Safety	Annual	
• Action Plan	Annual	
EOC Consultant Report	Quarterly	
EOC Indicators	Quarterly	
• Falls - Mobility Committee	Bi-annual	
Fire Committee (inspection & maintenance matrix)	Quarterly	
FMEA/18 mo	Annual & to BOT	
Hospital Acquired Conditions (HAC)	Quarterly	
Hand washing Audits	Monthly	
High Risk/Low Volume Procedures	Annual	
Housekeeping	Annual	
Infection Control: (Hand hygiene/isolation compliance; SSI; bundle compliance; MRSA/VRE/ARO; antimicrobial stewardship; publicly reported HIDA/CMS)	Bi-monthly	Hand washing (NPSG 7) Multi drug resistant order MDRO (NPSG 7) CLABSI (NPSG 7) SSI (NPSG 7) VAP/1000 Vent Days
• Infection Control: Flash Sterilization/SPD	Quarterly	
Length of Stay & Patient Flow	Quarterly	LOS ALOS
Medical Records (Health Information Management)	Quarterly	Delinquent Medical Records Overdue Discharge Summaries Delinquent OP note rate Overdue Operative Reports Compliance with Death Note Need Interdisciplinary Medical Record Review Audit and we determine what the indicators are.
Medical Staff Performance/Peer Review	Annual	
Medication Use	Annual reports on each item	Adverse Reaction Total ADRs Total Serious & preventable Total Serious & preventable & internal ADRs Medication Errors/Medication SafetyPSN reports received/1000 pt days Harm scores Errors in med use cycle
Mortality	Quarterly	
NPSGs/Patient Safety	Quarterly	items now standards, not NPSG: Prohibited abbreviations; Hand off communication; look-alike sound alike Improve accuracy of Pt identification - 2 identifiers (interview/observed) Universal protocol (time out): Pt identification pre-procedure process; site markings; timeout (3 required NPSG Universal Protocol) Evaluate safety practices & take action to improve. Med Use reporting schedule Label meds and solution containers on or off the sterile field (NPSG3) Reduce likelihood of patient harm with anticoagulants (NPSG3) Med Reconciliation (not scored at this time) (NPSG 8)

		Suicide Risk Screens (NPSG 17) Coming under other categories (i.e., HAC) Falls/1000 Days Restraint/1000 Days Pressure Ulcer/1000 Days
Nursing Outcome Indicators	Annual	
Operative/Procedure Reviews - H&V; IOP; OR	Annual	Must show all significant discrepancies between pre and post op diagnosis. Operative or procedures that place pt at risk of disability or death must be reviewed based on our own data.
Organ Conversion Rate	Quarterly	Conversion rate (actual donors/eligible donors) Organ Donation Referral Compliance Organ Donation Conversion Rate Eye/Tissue Donation Referral Compliance Eye/Tissue Conversion rate
Oryx/Core Measures	Quarterly	Diagnosis Mortality DVT DC on Antithrombotic Atrial Fib Receiving Anticoagulation Therapy TPA considered TPA administered Antithrom within 48 hours Lipids Dysphagia Stroke Education Smoking Cessation Plan for Rehab was considered Door to Needle IV
Pain Management	Annual	JC Auditing Pt's perception: How well did we manage the pain. Required, but are we doing it?
Palliative Care	Annual	
Patient Care Contracts	Quarterly	
Priorities of Organization	Annual	
Radiation Safety • Radiation Safety Regulatory Improvement Plan	Quarterly • Monthly or per QOPs	
Resource Utilization	Refer to 5/5 Meetings	
Research as appropriate	Annual if necessary	
Restraint/Seclusion/Behavior Mgmt	Quarterly	Questions for Steve - do we have any official behavior management programs? If so, must be reported to QC. Patient Understands reason Events leading to seclusion/restraint Factors contributing Modification made to Tx Plan Freq /length of restra/alternatives attempted. Med/Surg? Are we collecting data?

Resuscitation: Effectiveness for Rapid Response	Annual	
Patient Complaints - Patient/Family Liaison	Bi-Annual	
Risk Management	Annual	
Satisfaction (Patient/Employee/Physician)	Each Annual	Need Pt perception of quality & how safe they feel.
Sedation	Bi-annual	need to focus on cases, complications, & adverse events specific requirement is for any adverse events
Sentinel Events and Near Misses - reported as necessary via SE & QMR process	Annual	
Shared Services	Annual	
Strategic Plan	Annual	
Utilization Management	Annual	
Value Based Purchasing	Annual	

**Memorandum of Understanding  
For  
Management and Administrative Support  
Outpatient Clinics**

This agreement, made this \_\_\_\_ day of \_\_\_\_\_ between the Medical University Hospital Authority (hereinafter "MUHA") and the Medical University of South Carolina University Medical Associates (hereinafter "UMA"), is for and in consideration of the mutual promises made herein. This agreement is for management and administrative support for outpatient areas that are not part of MUHA service lines.

WHEREAS, on or about July 1, 2007, the Parties entered into an Ambulatory Patient Care and Clinical Education Agreement governing the operation and management of MUHA provider based clinics including but not limited to assignment of certain employees of UMA to manage MUHA outpatient areas, transfer of certain equipment from UMA to MUHA, transfer of certain UMA facility leases to MUHA, and incorporation of financial management into the financial structure of MUHA; and

WHEREAS, during the course of the Ambulatory Patient Care and Clinical Education Agreement, equipment, facility leases and financial management of provider based clinics have been transitioned to appropriate MUHA departments; and

WHEREAS, management of certain off campus ambulatory care or outpatient clinics are operated by UMA and/or their wholly owned subsidiary, Carolina Family Care ("CFC"); and

WHEREAS, management of certain ambulatory care or outpatient clinics associated with MUHA services lines has transitioned to the MUHA Service Line Administrators; and

WHEREAS, MUHA wishes to retain certain UMA personnel to manage and administer the remaining provider based clinics which are not affiliated with a MUHA Service Line and to provide other management and administrative support as may be deemed necessary by MUHA from time to time;

NOW THEREFORE, for due consideration and the mutual covenants contained herein, the Parties hereby agree as follows:

**I. Responsibilities/Services**

Duties to be performed by the management and administrative personnel are set forth in the job descriptions attached hereto as Exhibit A and incorporated herein by reference. More particularly, the following individuals shall be covered by this Agreement:

**Management and Support Staff**



Administrator  
Manager, Planning & Facility Management  
Manager, Performance Improvement/Staff Development  
Project Manager

**Revenue Cycle - Management Team members**

Director, Revenue Cycle Performance Improvement  
Manager, Scheduling Operations

**OCIO - Information Systems Management Team & Staff**

Manager, Information Systems  
Manager, Ambulatory Appl. Support  
Information Resource Coordinator  
Sr. Systems Analyst  
Systems Analyst

The above individuals shall provide services to MUHA on a full time basis. Should the individuals in the above positions transfer from or leave UMA for any reason, they will not be replaced except upon mutual agreement of the parties. Compensation for those individuals shall be deducted from the total amount payable under this agreement as of the last date of service.

**II. Compensation**

1. MUHA agrees to pay, and UMA agrees to accept, an amount equaling 100% of the compensation, including benefits for the FTE's assigned to provide services under this Agreement. That amount is currently \$ \_\_\_\_\_ per year, but may be adjusted periodically in accordance with MUHA compensation policies and procedures or as indicated above. The parties acknowledge and agree that the compensation set forth herein represents the fair market value of the Services provided by the above positions negotiated in an arm's-length transaction and has not been determined in a manner which takes into account the volume or value of referrals or business, if any, that may otherwise be generated between the parties. Nothing contained in this Agreement shall be construed in any manner as an obligation or inducement on the making of any referrals by any contracted individual, or physician to MUHA, or by MUHA. The parties further agree that this Agreement does not involve the counseling or promotion of a business arrangement that violates federal or state law.

2. Payment for these services shall be made on a quarterly basis, via an IIT, transferring the appropriate dollars from a specified MUHA account to a specified UMA account.

**III. Management Obligations**

1. MUHA shall be responsible for the annual operating and capital budget for non-service line associated ambulatory care or outpatient clinics managed by UMA employees

assigned pursuant to this Agreement. Employees assigned hereunder shall comply with MUHA policies and procedures, including but not limited to those associated with fiscal management of MUHA.

2. MUHA shall be responsible for compliance with all standards, regulations, and guidelines applicable to ambulatory care operations as determined by MUHA, the Joint Commission, the Department of Health and Environmental Control, the Occupational Safety and Health Administration, the Health and Fire Code Requirements, and any other applicable regulatory agencies. UMA employees assigned hereunder shall comply with MUHA policies and procedures, including but not limited to those associated with licensing and accreditation.

3. UMA employees assigned hereunder shall comply with all of MUHA policies and procedures including but not limited to policies and procedure concerning the maintenance, retention and disclosure of medical records.

4. UMA employees assigned hereunder shall be subject to all of MUHA's policies and procedures related to management of personnel or human resources including disciplinary actions, PTO policies and procedures, and performance assessment.

5. UMA employees assigned hereunder shall remain UMA employees at all times.

6. The remaining initiatives covered by the Ambulatory Patient Care and Clinical Education Agreement have been transitioned to MUHA over time or are covered through other agreements including but not limited to real property leases, equipment leases, medical director agreements, and affiliation agreements. MUHA, MUSC and UMA obligations or duties related to those services shall be set forth in those separate agreements.

### **III. Terms and Conditions**

1. Term: The initial term of this Agreement shall be for a period of one (1) year commencing on July 1, 2011 and terminating on June 30, 2012. This Agreement shall be renewed automatically for additional successive one (1) year terms (each, a "Renewal Term") unless terminated as provided for below and may be subject to appropriate adjustments in compensation at the time of renewal. Upon renewal of this Agreement, all other terms and conditions of this Agreement in existence at the end of the Initial Term shall continue in place. The word "Term" when used in this Agreement shall mean the Initial Term and any Renewal Term.

2. Termination: This Agreement may be terminated in whole or in part as described below; provided, however, that if such termination occurs prior to expiration of the Initial Term, the parties may not enter into another agreement for Services for the remainder of the Initial Term:

- Upon mutual agreement of the parties to terminate all or part of this Agreement,

including but not limited to mutual agreement to remove certain personnel from this Agreement;

- Upon ninety (90) days prior written notice of intent to terminate by either party.
- By MUHA upon the employee's physical or mental incapacitation such that nurse(s) is unable to perform Services under this Agreement for a period of thirty (30) consecutive days unless Department provides an appropriate personnel acceptable to UMA to render all professional services incident to this Agreement;
- By MUHA if disciplinary action is concluded by UMA or any governmental authority;
- By MUHA if an individuals assigned hereunder is convicted in a court of law of any felony, any crime or offense involving money or property of MUHA, or any program-related crime under the Medicare;
- By MUHA, upon UMA's dissolution or the filing of a voluntary petition in bankruptcy, or an assignment for the benefit of creditors or other action taken voluntarily by UMA, under any state or federal statute for the protection of debtors, or the filing of an involuntary petition in bankruptcy or other similar involuntary proceeding against UMA under any state or federal statute for the protection of debtors if such involuntary petition or other involuntary proceeding is not dismissed within thirty (30) days of its filing; or
- By UMA, upon revocation of MUHA's Medicare certification.

Should either party choose not to renew this Agreement, notice shall be given at least ninety (90) days prior to the anniversary date unless otherwise agreed upon by the parties.

3. Insurance: Employees assigned pursuant to this Agreement shall provide services under the supervision and control of MUHA and shall be considered contract employees of MUHA at all times. MUHA shall be responsible for providing liability insurance for individuals under assignment pursuant to this Agreement in accordance with standard MUHA policies and procedures.

#### **IV. Authorization**

The undersigned have reviewed the terms of this agreement and find them to be fair in consideration of described duties and compensation for the above noted positions.

---

W. Stuart Smith  
Executive Director, MUHA

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Date

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Stephen A. Valerio  
CEO, UMA

---

Date

DRAFT



**THE MEDICAL UNIVERSITY OF SOUTH  
CAROLINA**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**BY:** \_\_\_\_\_

LISA P. MONTGOMERY  
ITS: VICE PRESIDENT FOR FINANCE  
AND ADMINISTRATION  
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171 ASHLEY AVENUE  
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**THE MEDICAL UNIVERSITY HOSPITAL  
AUTHORITY**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**BY:** \_\_\_\_\_

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