AGENDA

(REGULAR AND CONSENT)

HOSPITAL AUTHORITY BOARD OF TRUSTEES
AND
UNIVERSITY BOARD OF TRUSTEES

December 13, 2013

MEDICAL UNIVERSITY HOSPITAL AUTHORITY

REGULAR AGENDA

Board of Trustees Meeting
Friday, December 13, 2013
9:00 a.m.
101 Colcock Hall

Members of the Board of Trustees

Thomas L. Stephenson, Esquire, Chairman
Dr. James E. Wiseman, Jr., V-Chairman
Dr. Stanley C. Baker, Jr.
The Honorable James A. Battle
Mr. William H. Bingham, Sr.
Mr. William B. Hewitt
Dr. Harold W. Jablon
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. Ragin C. Monteith
Dr. E. Conyers O'Bryan, Jr.
Mr. Charles W. Schulze
The Honorable Robin M. Tallon
Dr. Thomas C. Rowland, Jr.
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Dr. Charles B. Thomas, Jr.

Trustees Emeriti
Mrs. Margaret M. Addison
Dr. Cotesworth P. Fishburne, Jr.
Mrs. Claudia W. Peeples
Mr. Allan E. Stalvey

Item 1. Call to Order-Roll Call.

Item 2. Secretary to Report Date of Next Meeting.

Regular Meeting: Friday, December 14, 2014.

Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of October 11, 2013.

Board Action:

RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT

OLD BUSINESS:

NEW BUSINESS:

Item 4. General Informational Report of the Interim President.

Statement: Dr. Sothmann will present a general report.

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

Board Action:

Item 5. Other Business.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY OPERATIONS, QUALTY and FINANCE COMMITTEE. CHAIRMAN: DR. STANLEY C. BAKER, JR.

OLD BUSINESS:

NEW BUSINESS:

Item 6. Medical University Hospital Authority Status Report.

Statement: Dr. Pat Cawley will report on the status of the Medical Center.

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

Recommendation of Committee:

Board Action:

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

Statement: Mr. Steve Hargett will present the financial and statistical report for MUHA.

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

Recommendation of Committee:

Board Action:

Item 8. Report on Quality and Patient Safety.

Statement: Dr. Danielle Scheurer will present a report on Quality and Patient Safety.

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

Recommendation of Committee:

Board Action:

Item 9. General Report of the Dean, COM and Vice President for Medical Affairs.

Statement: Dean Pisano will present a general update.

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

Recommendation of Committee:

Board Action:

Item 10. Update on MUSC Physicians.

Statement: Dr. David Cole will present a general update.

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

Recommendation of Committee:

Board Action:

Item 11. Legislative Update.

Statement: Mr. Bo Faulkner and Mr. Mark Sweatman will present an update on legislative issues.

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

Recommendation of Committee:

Board Action:

Item 12. Other Committee Business.

CONSENT ITEM FOR APPROVAL:

Item 13. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges.

Item 14. Revisions to the Medical Staff Bylaws.

Item 15. Revisions to the Medical Staff Rules & Regulations.

Item 16. Revisions to the Medical Staff Credentials Manual.

Item 17. Plan for Provision of Care.

Item 18. Update on Performance Improvement Plan.

Item 19. Transplant Quality Plan.

CONSENT ITEMS FOR INFORMATION:

Item 20. Medical Executive Committee Minutes.

Item 21. Contracts and Agreements.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY PHYSICAL FACILITIES COMMITTEE. CHAIRMAN: MR. WILLIAM H. BINGHAM, SR.

OLD BUSINESS:

NEW BUSINESS:

Item 22. Facilities Procurements/Contracts Proposed.

Statement: Mr. Dennis Frazier will present procurements/contracts for approval.

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

Recommendation of Committee:

Board Action:

Item 23. Update on Projects.

Statement: Mr. Dennis Frazier will present an update on Medical University Hospital Authority projects.

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

Recommendation of Committee:

Board Action:

Item 24. Other Committee Business.

CONSENT ITEM FOR INFORMATION:

Item 25. Facilities Contracts Awarded.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY AUDIT COMMITTEE. CHAIRMAN: MR. WILLIAM B. HEWITT.

OLD BUSINESS:

NEW BUSINESS:

Item 26. External Financial Statement and Audit Report of MUHA for Fiscal Year End June 30, 2013.

Statement: Representatives from KPMG will present the results of the MUHA annual external audit for the period ending June 30, 2013.

Statement: The external audit firm of KPMG will present the Audit report.

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

Recommendation of Committee:

Board Action:

Item 27. Information Technology Security Update.

Statement: Dr. Frank Clark will present an update on IT Security.

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

Recommendation of Committee:

Board Action:

Item 28. Report of the Office of Internal Audit.

Statement: Ms. Susan Barnhart will report on the activities of the Office of Internal Audit.

Recommendation of Administration: That this be received as information.

Recommendation of Committee:

Board Action:

Item 29. Other Committee Business.

OTHER BUSINESS FOR THE BOARD OF TRUSTEES:

Item 30. Approval of Consent Agenda.

Statement: Approval of the Consent Agenda is requested.

Recommendation of Administration: That the consent agenda be approved.

Board Action:

Item 31. New Business for the Board of Trustees.

Item 32. Report from the Chairman.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Interim Financial Statements
October 31, 2013 and 2012

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Statement of Net Position
October 31, 2013 and June 30, 2013

Assets and Deferred Outflows	**At 10/31/2013**	**FYE 06/30/2013 (audited)**
Current Assets:		
Cash and Cash Equivalents	$ 50,424,816	$ 38,260,407
Cash Restricted for Capital Improvements	9,500,000	5,500,000
Patient Accounts Receivable, Net of Allowance for Uncollectible Accounts of $62,264,475 and $48,500,000	172,814,247	169,293,014
Due from Third-Party Payors	11,709,420	14,664,395
Other Current Assets	44,980,084	49,795,671
Total Current Assets	289,428,567	277,513,487
Investments Held by Trustees Under Indenture Agreements	44,986,268	46,256,860
Capital Assets, Net	522,295,091	526,690,282
Deferred Borrowing Costs	4,148,038	4,267,895
Total Assets	860,857,964	854,728,524
Deferred Outflows	1,961,392	2,262,745
Total Assets and Deferred Outflows	$ 862,819,356	$ 856,991,269
Liabilities and Net Position		
Current Liabilities:		
Current Installments of Long-Term Debt	$ 15,117,012	$ 14,906,814
Current Installments of Capital Lease Obligations	262,957	261,751
Current Installments of Notes Payable	1,561,273	1,788,574
Due to Related Parties	12,505,650	5,935,676
Accounts Payable	34,526,769	45,613,804
Accrued Payroll, Withholdings and Benefits	53,325,048	51,846,839
Other Accrued Expenses	7,492,739	13,068,801
Deferred Revenue	9,500,000	5,500,000
Total Current Liabilities	134,291,448	138,922,259
Long-Term Debt	338,442,988	343,853,705
Capital Lease Obligations	265,348	353,403
Derivative Instruments	1,961,392	2,262,745
Notes Payable	11,995,497	12,300,020
Other Liabilities	2,823,184	3,629,808
Total Liabilities	489,779,857	501,321,940
Net Position:		
Invested in Capital Assets, Net of Related Debt	153,674,855	151,444,230
Restricted Under Indenture Agreements	44,986,268	46,256,860
UnRestricted	174,378,376	157,968,239
Total Net Position	373,039,499	355,669,329
Total Liabilities and Net Position	$ 862,819,356	$ 856,991,269

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Statement of Revenues, Expenses and Changes in Net Position
For the 4 Month Periods Ending October 31, 2013 and 2012

	2013	2012
Operating Revenue:		
Net Patient Service Revenue	$ 376,527,772	$ 355,110,757
Other Revenue	5,824,865	6,712,452
Total Operating Revenue	382,352,637	361,823,209
Operating Expenses:		
Compensation and Employee Benefits	153,955,897	158,777,111
Services and Supplies	187,589,735	176,341,795
Depreciation and Amortization	17,178,345	19,014,051
Total Operating Expenses	358,723,977	354,132,957
Operating Income (Loss)	23,628,660	7,690,252
NonOperating Revenue (Expense):		
Investment Income	(1,331,967)	1,075,490
Interest Expense	(4,926,523)	(7,989,888)
Total NonOperating Revenue (Expense)	(6,258,490)	(6,914,398)
Change in Net Position	$ 17,370,170	$ 775,854

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
SRECNA - Comparative Variance Analysis
For the 4 Month Periods October 31, 2013 and 2012

	Current Month			Comparative Period		Fiscal Year To Date			Comparative Period	
	Actual	Budget	Variance	Oct 2012	Variance	Actual	Budget	Variance	July ~Oct FY2013	Variance
Operating Revenue:										
Net Patient Service Revenue	$ 99,656,409	$ 90,844,734	9.70%	$ 95,554,674	4.29%	$ 376,527,772	$ 363,378,935	3.62%	$ 355,110,757	6.03%
Other Revenue	1,758,968	1,576,944	11.54%	1,739,697	1.11%	5,824,865	6,307,776	-7.66%	6,712,452	-13.22%
Total Operating Revenue	101,415,377	92,421,678	9.73%	97,294,371	4.24%	382,352,637	369,686,711	3.43%	361,823,209	5.67%
Operating Expenses:										
Compensation and Employee Benefits	39,476,624	39,568,016	0.23%	40,721,977	3.06%	153,955,897	158,272,065	2.73%	158,777,111	3.04%
Services and Supplies	51,060,224	44,627,310	-14.41%	47,999,509	-6.38%	187,589,735	178,509,223	-5.09%	176,341,795	-6.38%
Depreciation and Amortization	2,761,201	4,805,765	42.54%	4,615,992	40.18%	17,178,345	19,223,061	10.64%	19,014,051	9.65%
Total Operating Expenses	93,298,049	89,001,091	-4.83%	93,337,478	0.04%	358,723,977	356,004,349	-0.76%	354,132,957	-1.30%
Operating Income (Loss)	8,117,328	3,420,587	137.31%	3,956,893	105.14%	23,628,660	13,682,362	72.69%	7,690,252	207.25%
Operating Margin	8.00%	3.70%		4.07%		6.18%	3.70%		2.13%	
NonOperating Revenue (Expense):										
Investment Income	331,987	164,613	101.68%	183,088	81.33%	(1,331,967)	658,451	-302.29%	1,075,490	-223.85%
Interest Expense	(1,205,966)	(1,390,761)	13.29%	(2,008,513)	39.96%	(4,926,523)	(5,563,041)	11.44%	(7,989,888)	38.34%
Total NonOperating Revenue (Expense)	(873,979)	(1,226,148)	28.72%	(1,825,425)	52.12%	(6,258,490)	(4,904,590)	-27.60%	(6,914,398)	9.49%
Change in Net Position	$ 7,243,349	$ 2,194,439	230.08%	$ 2,131,468	239.83%	$ 17,370,170	$ 8,777,772	97.89%	$ 775,854	2138.85%

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Schedule of Functional Expenses
For the 4 Month Periods Ending October 31, 2013 and 2012

	2013	2012
Nursing Services:		
Administration and Education	12,571,089	$ 9,795,278
Medical and Surgical	20,073,672	21,156,547
Pediatrics	5,478,575	5,422,328
Emergency and Trauma Units	7,071,436	7,191,828
Intensive Care Units	17,942,521	18,609,175
Coronary Care Units	1,245,668	1,345,105
Psychiatric	7,795,019	8,231,590
Operating Rooms	11,499,555	11,834,109
Recovery Rooms	1,511,783	1,561,360
Delivery and Labor Rooms	1,360,698	1,437,411
Obstetrics	2,059,875	2,034,476
Total Nursing Services	$ 88,609,891	$ 88,619,207
Other Professional Services:		
Laboratories and Laboratory Support	$ 16,284,948	$ 16,393,666
Electrocardiology	2,016,839	2,068,387
Radiology	8,451,797	8,605,239
Pharmacy	36,842,706	35,044,839
Heart Catheterization	3,324,716	3,619,871
Central Services and Supply	27,679,473	29,048,824
Anesthesiology	6,367,530	6,702,295
Nuclear Medicine	396,985	401,316
Respiratory Therapy	4,595,421	4,364,676
Physical Medicine	2,700,644	2,979,431
Dialysis	730,303	770,175
Pathology	1,137,568	1,379,437
Transplant	9,227,761	7,863,661
Other Miscellaneous Services	5,637,167	5,772,592
Medical Records and Quality Assurance	2,443,657	2,508,554
Resident Support	16,628,388	14,191,037
Total Other Professional Services	$ 144,465,903	$ 141,714,000
General Services:		
Dietary	$ 5,032,845	$ 5,223,139
Plant Ops, Maintenance, Security	20,197,677	21,330,647
Housekeeping	5,741,589	5,581,952
Total General Services	$ 30,972,111	$ 32,135,738
Fiscal and Administrative Services:		
Admitting	$ 2,194,012	$ 2,355,062
Administration	25,995,232	21,512,364
Shared Services	3,418,430	3,453,613
MUSC Support	5,833,725	4,973,884
Accounting	3,386,307	2,933,552
Hospital Patient Accounting	2,931,314	3,203,520
Marketing	2,388,164	2,558,200
Human Resources	870,196	868,741
Communications	591,086	731,197
Computer Services	14,096,625	13,988,396
Total Fiscal and Administrative Services	$ 61,705,091	$ 56,578,529
Ambulatory Care:		
Ambulatory Care	$ 15,792,636	$ 16,071,432
Total Ambulatory Care	$ 15,792,636	$ 16,071,432
Other:		
Depreciation	$ 17,178,345	$ 19,014,051
Interest	4,926,523	7,989,888
Total Other	$ 22,104,868	$ 27,003,939
Total Expenses	$ 363,650,500	$ 362,122,845

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Schedule of Revenues and Expenses - Actual versus Budget
For the 4 Month Period Ending October 31 , 2013

	Approved Budget	Year To Date Budget	Year To Date Actual	Variance Favorable/ Unfavorable	
Operating Revenue:					
Patient Service Revenue:					
Inpatient	$ 1,755,640,303	$ 585,213,434	$ 617,735,301	$ 32,521,867	F
Outpatient	1,221,324,345	407,108,115	426,204,003	19,095,888	F
Gross Patient Service Revenue	2,976,964,648	992,321,549	1,043,939,304	51,617,755	F
Patient Service Revenue net of Charity Care	2,976,964,648	992,321,549	1,016,399,762	24,078,213	F
Additions (Deductions) To/From Patient Service Revenue:					
Contractual and Other Adjustments	(1,925,654,520)	(641,884,840)	(652,814,215)	10,929,375	U
Payment from DHHS	18,628,621	6,209,540	6,209,540	-	F
Disproportionate Share	20,198,056	6,732,685	6,732,685	-	F
Net Additions (Deductions) To/From Patient Service Revenue	(1,886,827,843)	(628,942,614)	(639,871,990)	10,929,376	U
Net Patient Service Revenue	1,090,136,805	363,378,935	376,527,772	13,148,837	F
Other Operating Revenue:					
Other and IIT Transfers	18,923,328	6,307,776	5,824,865	482,911	U
Total Other Operating Revenue	18,923,328	6,307,776	5,824,865	482,911	U
Total Operating Revenue	$ 1,109,060,133	$ 369,686,711	$ 382,352,637	$ 12,665,926	F
Operating Expenses:					
Nursing Services	$ 265,664,105	$ 88,554,702	$ 88,609,891	$ 55,189	U
Other Professional Services	423,418,284	141,139,430	144,465,903	3,326,473	U
General Services	93,293,675	31,097,892	30,972,111	125,781	F
Fiscal and Administrative Services	178,797,215	59,599,069	61,705,091	2,106,022	U
Ambulatory Care	49,170,586	16,390,195	15,792,636	597,559	F
Other Expenses	57,669,182	19,223,061	17,178,345	2,044,716	F
Total Operating Expenses	1,068,013,047	356,004,349	358,723,977	2,719,628	U
Income (Loss) from Operations	41,047,086	13,682,362	23,628,660	9,946,298	F
NonOperating Revenue (Expense):					
Interest and Investments	(14,713,770)	(4,904,590)	(6,258,490)	1,353,900	U
Total NonOperating Revenue (Expense)	(14,713,770)	(4,904,590)	(6,258,490)	1,353,900	U
Change in Net Position	$ 26,333,316	$ 8,777,772	$ 17,370,170	$ 8,592,398	F

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
(A Component Unit of MUSC)
Schedule of Functional Expenses - Actual versus Budget
For the 4 Month Period Ending October 31, 2013

	Approved Budget	Year To Date Budget	Year To Date Actual	Variance Favorable/ Unfavorable
Nursing Services:				
Administration and Education	$ 29,855,509	$ 9,951,836	$ 12,571,089	$ 2,619,253 U
Medical and Surgical	61,867,632	20,622,544	20,073,672	548,872 F
Pediatrics	16,816,833	5,605,611	5,478,575	127,036 F
Emergency and Trauma Units	21,749,847	7,249,949	7,071,436	178,513 F
Intensive Care Units	56,914,316	18,971,439	17,942,521	1,028,918 F
Coronary Care Units	4,054,173	1,351,391	1,245,668	105,723 F
Psychiatric	24,859,395	8,286,465	7,795,019	491,446 F
Operating Rooms	34,609,960	11,536,653	11,499,555	37,098 F
Recovery Rooms	4,596,416	1,532,139	1,511,783	20,356 F
Delivery and Labor Rooms	4,231,070	1,410,357	1,360,698	49,659 F
Obstetrics	6,108,954	2,036,318	2,059,875	23,557 U
Total Nursing Services	$ 265,664,105	$ 88,554,702	$ 88,609,891	$ 55,189 U
Other Professional Services:				
Laboratories and Laboratory Support	$ 49,993,928	$ 16,664,643	$ 16,284,948	$ 379,695 F
Electrocardiology	6,238,495	2,079,498	2,016,839	62,659 F
Radiology	26,438,520	8,812,840	8,451,797	361,043 F
Pharmacy	105,153,326	35,051,109	36,842,706	1,791,597 U
Heart Catheterization	10,527,305	3,509,102	3,324,716	184,386 F
Central Services and Supply	86,076,017	28,692,006	27,679,473	1,012,533 F
Anesthesiology	20,085,917	6,695,306	6,367,530	327,776 F
Nuclear Medicine	1,174,430	391,477	396,985	5,508 U
Respiratory Therapy	14,359,619	4,786,540	4,595,421	191,119 F
Physical Medicine	8,689,927	2,896,642	2,700,644	195,998 F
Dialysis	2,202,368	734,123	730,303	3,820 F
Pathology	4,121,201	1,373,734	1,137,568	236,166 F
Transplant	22,438,314	7,479,438	9,227,761	1,748,323 U
Other Miscellaneous Services	17,696,178	5,898,726	5,637,167	261,559 F
Medical Records and Quality Assurance	7,535,953	2,511,984	2,443,657	68,327 F
Resident Support	40,686,786	13,562,262	16,628,388	3,066,126 U
Total Other Professional Services	$ 423,418,284	$ 141,139,430	$ 144,465,903	$ 3,326,473 U
General services:				
Dietary	$ 15,467,886	$ 5,155,962	$ 5,032,845	$ 123,117 F
Plant Ops, Maintenance, Security	60,817,389	20,272,463	20,197,677	74,786 F
Housekeeping	17,008,400	5,669,467	5,741,589	72,122 U
Total General Services	$ 93,293,675	$ 31,097,892	$ 30,972,111	$ 125,781 F
Fiscal and Administrative Services:				
Admitting	$ 6,974,073	$ 2,324,691	$ 2,194,012	$ 130,679 F
Administration	66,089,645	22,029,882	25,995,232	3,965,350 U
Shared Services	10,333,809	3,444,603	3,418,430	30,329 F
MUSC Support	21,457,734	7,152,578	5,833,725	1,318,853 F
Accounting	9,607,660	3,202,553	3,386,307	183,754 U
Hospital Patient Accounting	10,400,756	3,466,919	2,931,314	535,605 F
Marketing	7,421,610	2,473,870	2,388,164	85,706 F
Human Resources	2,608,039	869,346	870,196	850 U
Communications	2,035,753	678,584	591,086	87,498 F
Computer Services	41,868,136	13,956,045	14,096,625	140,580 U
Total Fiscal and Administrative Services	$ 178,797,215	$ 59,599,069	$ 61,705,091	$ 2,106,022 U
Ambulatory Care:				
Ambulatory Care	$ 49,170,586	$ 16,390,195	$ 15,792,636	$ 597,559 F
Total Ambulatory Care	$ 49,170,586	$ 16,390,195	$ 15,792,636	$ 597,559 F
Other:				
Depreciation	$ 57,669,182	$ 19,223,061	$ 17,178,345	$ 2,044,716 F
Interest	16,689,123	5,563,041	4,926,523	636,518 F
Total Other	$ 74,358,305	$ 24,786,102	$ 22,104,868	$ 2,681,234 F
Total Expenses	$ 1,084,702,170	$ 361,567,390	$ 363,650,500	$ 2,083,110 U

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
Notes to the Interim Financial Statements

Balance Sheet: **At 10/31/2013 and for the year ended 6/30/2013**

Assets:

Cash and cash equivalents, including cash restricted for construction projects, increased $16.2 million to $60 million from June 30th, 2013. The increase is a result of several factors from recent performance. Hospital Patient Accounting had record collections in the first four months of FY 14, $4 million net of the provider tax for Medicaid disproportionate share uninsured program payment, and the HUD debt service payments are now approximately $300k per month less than pre-refinancing amounts. The improvement in cash inflows was offset by a $3 million Medicaid prior year cost settlement and three payrolls in October.

Net patient accounts receivable has increased 2% on substantially higher volume due to HPA collections mentioned previously. The case mix index (an indication of patient acuity) at 1.865 is up from last year's 1.8331. October's case mix decreased to 1.844 from September's 1.856. CMI for the month of October, FY '13 was 1.859.

Other Current Assets decreased by $4.8 million from 6/30/13 due to increase in prepaid maintenance contracts offset by receipt of GME payments and prepayment of Medicaid DSH.

Liabilities:

As of October, 2013 Current Installments of Long-Term Debt include $13.3 million HUD related debt and $1.8 million for debt related to the Central Energy Plant. Current Installments of Notes Payable relate to G E loan for the McKesson clinical systems and the note payable for the Sabin St. energy plant.

Long term debt (net of deferred issuance costs) decreased $5,300,000. Prior to the December refinancing, principal was paid semi-annually, under the new debt structure, principal is paid monthly. In June MUHA accessed the State's loan program to borrow $12.9 million for the Sabin Street central energy plant project. This is shown in the long term debt section as Notes Payable.

Other Accrued Expenses decreased by $1.7 million related to reversal of prior year lease accruals and payment of the Medicaid prior year cost report.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
Notes to the Interim Financial Statements

Statement of Revenues, Expenses and Changes in Net Assets: For the four months ended October 31, 2013 and 2012

Operating Revenues:

Net patient revenue is up 6% from the same period last year. Inpatient census is up 5% over last fiscal year – driven by increases in all service areas**.** E R visits are up 5%. Operating room cases are up 6%. Transplant cases are down 17% compared to last year. MRI procedures are up 6.5% while CT procedures are up 2%. Outpatient visits are up 7.1%. The Medicare length of stay at 6.5 days is up three tenths of a day compared to same period last year while the Medicare CMI increased from 2.04 to 2.2.

On a volume adjusted basis (adjusted discharges) net patient revenue is up 3% at $18,442 per case. This is a result of an increase in acuity driven by the increase in surgical cases.

Operating Expenses:

When compared to the same period last fiscal year salaries and benefits decreased $4.8million (3%). The number of paid full time equivalent employees has decreased by 96 compared to the same period last year. Staffing has increased by 77 fte's since the start of the EPIC project – but up only 12 from the same 4 month period last year, while decreases are seen in facilities, several ancillary departments such as surgery, lab and radiology, and in a number of nursing areas – all resulting from MUSC Performance Excellence initiatives.

Services and supplies are up 6% compared to last year. The increase in equipment operating leases, increased Huron fees as we near the end of their project, and Epic system conversion are responsible for the increase. Total Epic related expense (salaries and other) for FY 14 are $2,034,786.

Depreciation and Amortization is 10% below the prior year comparative period as the quarterly review of depreciable equipment was completed and the year to date adjustment booked in October.

Non Operating Expense

Interest expense is down $3 million (38%) based on lower long-term debt balances and interest rate reduction.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY
Notes to the Interim Financial Statements

Budget Comparison:

As of October, 2013 MUHA's net income is $8.6 million ahead of budget. The operating margin is 6.2% compared to 3.7% budget.

Net patient service revenues are up 3.6% compared to budget, due to the increased volume, while operating expenses are above budget by less than 1%.

Investment income is $2 million below budget due to mark to market adjustments driven by the current interest rate environment. In October, investment income was 101% of budget due to market conditions. The underlying investments are part of the HUD special reserve and mortgage reserve accounts. The investments will be held to maturity, and redeemed at par, eliminating the loss on investments.

Unusual and non-recurring items impacting current month earnings:

Implementation of GASB 53 – accounting and financial reporting for derivative instruments occurred in fiscal 2010. While this does not have an immediate impact on the income statement, the negative value of the interest rate hedge associated with the central energy plant financing is reflected on the balance sheet in the asset section as a deferred outflow and in the long-term debt section titled "Derivative Instruments". The negative balance of $1.96 million at 10/31/13 is a $300,000 improvement from 6/30/13.

On December 19, 2012 the 2004 HUD debt was refinanced resulting in substantial savings in interest expense. Long term debt was reduced when funds in the debt service reserve and other accounts of approximately $45 million were made available to reduce principle. Interest rate is fixed at 2.94% and amortization schedule was not extended.

FACILITIES
HOSPITAL AUTHORITY
NEW LEASE
FOR APPROVAL

DECEMBER 13, 2013

DESCRIPTION OF LEASE: This lease is for 16,785 square feet of office space located on the 2nd floor of Parkshore Centre, 1 Poston Road in West Ashley. This lease will provide space for Hospital Patient Accounting and Revenue Systems which is currently located at 135 Cannon Street. The purpose of this relocation is to prepare for the Single Business Office model under Epic and will support the integrated Revenue Cycle initiative. The per square foot rent rate for this lease is $27.30. The monthly rent shall be $38,185.88 (rounded) resulting in an annual rent of $458,230.50. Rent shall increase annually 3%.

NEW LEASE AGREEMENT __X__
RENEWAL LEASE AGREEMENT ____

LANDLORD: Parkshore Centre I, Limited Partnership

LANDLORD CONTACT: John Durlach, Owner, 723-2848

TENANT NAME AND CONTACT: Suzanne Rosenthall, Director, 792-7854

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

TERM: Ten (10) Years [7/1/2015-6/30/2025]
AMOUNT PER SQUARE FOOT: $27.30
ANNUALIZED LEASE AMOUNT:

Year 1	$458,230.50	Year 6	$531,214.74
Year 2	$471,977.42	Year 7	$547,151.18
Year 3	$486,136.74	Year 8	$563,565.72
Year 4	$500,720.84	Year 9	$580,472.69
Year 5	$515,742.47	Year 10	$597,886.87

TOTAL AMOUNT OF LEASE: $5,253,099.17

EXTENDED TERM(S): To be negotiated.

OPERATING COSTS:
FULL SERVICE __X__ [excludes operating cost increases]
NET ____

FACILITIES
HOSPITAL AUTHORITY
LEASE RENEWAL
FOR APPROVAL

DECEMBER 13, 2013

DESCRIPTION OF LEASE RENEWAL: This lease renewal is for 10,578 square feet of office space located on the 3rd floor of Cannon Park Place at 261 Calhoun Street. The purpose of this lease renewal is to continue to provide office space for Ambulatory Care Administration and the Ambulatory Care EMP Implementation Project (EPIC). The per square foot rent rate for this lease is $18.90 (rounded). The total monthly rent shall be $16,660.03 (rounded) resulting in an annual rent amount of $199,920.33.

University Medical Associates holds the master lease for this space, in which 10,578 square feet is being further subleased to the Medical University Hospital Authority. The terms for this lease renewal coincide with the terms of the master lease.

NEW LEASE AGREEMENT ____
RENEWAL LEASE AGREEMENT __X_

LANDLORD: University Medical Associates

LANDLORD CONTACT: Marty Phillips, 852-3109

TENANT NAME AND CONTACT: Hospital Facilities, Dennis Frazier, Administrator, 792-7727

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

TERM: One (1) year, nine (9) months [2/1/2014-10/31/2015]
AMOUNT PER SQUARE FOOT: $18.90
ANNUALIZED LEASE AMOUNT: $199,920.33
TOTAL AMOUNT OF LEASE: $349,860.58

EXTENDED TERM(S): To be negotiated.

OPERATING COSTS:
FULL SERVICE ___
NET __X__

MEDICAL UNIVERSITY HOSPITAL AUTHORITY

CONSENT AGENDA

Board of Trustees Meeting
Friday, December 14, 2013
101 Colcock Hall

Members of the Board of Trustees

Thomas L. Stephenson, Esquire, Chairman
Dr. James E. Wiseman, Jr., V-Chairman
Dr. Stanley C. Baker, Jr.
The Honorable James A. Battle
Mr. William H. Bingham, Sr.
Mr. William B. Hewitt
Dr. Harold W. Jablon
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. Ragin C. Monteith
Dr. E. Conyers O'Bryan, Jr.
Mr. Charles W. Schulze
The Honorable Robin M. Tallon
Dr. Thomas C. Rowland, Jr.
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Dr. Charles B. Thomas, Jr.

Trustees Emeriti
Mrs. Margaret M. Addison
Dr. Cotesworth P. Fishburne, Jr.
Mrs. Claudia W. Peeples
Mr. Allan E. Stalvey

MEDICAL UNIVERISTY HOSPITAL AUTHORITY OPERATIONS, QUALITY and FINANCE COMMITTEE
CHAIRMAN: DR. STANLEY C. BAKER, JR.

(APPROVAL ITEMS)

Item 13. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges.

Statement: Approval will be sought for the appointments, reappointments and delineation of privileges of the Medical and Allied Health Staff.

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

Recommendation of Committee:

Board Action:

Item 14. Revisions to Medical Staff Bylaws.

Statement: Dr. Barton Sachs will present revisions to the Medical Staff Bylaws for approval.

Recommendation of Administration: That the revisions be approved.

Recommendation of Committee:

Board Action:

Item 15. Revisions to the Medical Staff Rules and Regulations.

Statement: Dr. Barton Sachs will present revisions to the Medical Staff Rules and Regulations for approval.

Recommendation of Administration: That the revisions be approved.

Recommendation of Committee:

Board Action:

Item 16. Revisions to the Medical Staff Credentials Manual.

Statement: Dr. Barton Sachs will present revisions to the Medical Staff Credentials Manual.

Recommendation of Administration: That the revisions be approved.

Recommendation of Committee:

Board Action:

Item 17. Plan for Provision of Care.

Statement: Dr. Barton Sachs will present the Plan for Provision of Care.

Recommendation of Administration: That the Plan be approved.

Recommendation of Committee:

Board Action:

Item 18. Update on Performance Improvement Plan.

Statement: Dr. Barton Sachs will present the Update on the Performance Improvement Plan for approval.

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

Recommendation of Committee:

Board Action:

Item 19. Transplant Quality Plan.

Statement: Dr. Barton Sachs will present the Transplant Quality Plan for approval.

Recommendation of Administration: That the Transplant Quality Plan be approved.

Recommendation of Committee:

Board Action:

(INFORMATIONAL ITEMS)

Item 20. Medical Executive Committee Minutes.

Statement: The minutes of the Medical Executive Committee will be presented.

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

Recommendation of Committee:

Board Action:

Item 21. Medical Center Contracts and Agreements.

Statement: The contracts and agreements signed since the last board meeting will be presented for information.

Recommendation of Administration: That the contracts and agreements be received as information.

Recommendation of Committee:

Board Action:

AUTHORITY PHYSICAL FACILITIES COMMITTEE
CHAIRMAN: MR. WILLIAM H. BINGHAM, SR.

(INFORMATIONAL ITEM)

Item 25. Facilities Contracts Awarded.

Statement: The facilities contracts awarded since the last meeting will be presented for information.

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

Recommendation of Committee:

Board Action:

Board of Trustees Credentialing Subcommittee - September 2013

The Medical Executive Committee reviewed the following applicants on September 18, 2013 and recommends approval by the Board of Trustees Credentialing Subcommittee effective September 28, 2013

Medical Staff Initial Appointment and Privileges

Bradley S. Amerson, M.D.	Provisional Affiliate - Refer & Follow	Radiology
Jeffrey P. Blice, M.D.	Active Provisional	Ophthalmology
Thomas Edward Brouette, M.D.	Active Provisional	Psychiatry
Alexander DiBona, M.D.	Provisional Affiliate - Refer & Follow	Radiology
Angie Duong, M.D.	Active Provisional	Pathology & Lab. Med.
David Manning French, M.D.	Active Provisional	Medicine
Jussuf T. Kaifi, M.D., Ph.D.	Active Provisional	Surgery
Pramod Mambalam, M.D.	Active Provisional	Radiology
Dino Peter Massoglia, M.D., Ph.D.,	Provisional Affiliate - Refer & Follow	Radiology
Darryl Randolph Pauls, M.D., M.H.A.	Provisional Affiliate - Refer & Follow	Radiology
Richard Quan, M.D.	Active Provisional	Pediatrics
Christopher C. Ward, M.D.	Provisional Affiliate	Medicine

Medical Staff Reappointment and Privileges

Michelle Irene Amaya, M.D., M.P.H	Active	Pediatrics
Eric Bolin, M.D.	Active	Anesthesiology
Keith Borg, M.D., Ph.D.	Active	Pediatrics
Shana Catoe Bondo , M.D., M.S.P.H.	Active Provisional	Pediatrics
Jeanne Marie Campbell, M.D., Ph.D.	Affiliate CFC - Refer & Follow	Medicine
Ruth Campbell, M.D., M.S.P.H.	Active	Medicine
Thomas Bao Do, M.D.	Active Provisional	Pediatrics
Charles Morrison Farish, M.D.	Active Provisional	Pediatrics
Rabiya Khalid Hasan (Hasan), M.D.	Active	Psychiatry
John Terrill Huggins, M.D.	Active	Medicine
Samir Rameshchandra Karia, M.D.	Active	Neurosciences
William Keith McKibbin, M.D.	Active	Orthopaedic Surgery
Leonard William Mulbry, Jr., M.D.	Active	Psychiatry
Rick Olson, M.D.	Affiliate	Pediatrics
Dorothea Rosenberger , M.D., Ph.D.	Active	Anesthesiology
J. Wade Strong, M.D.	Active	Pathology & Lab. Med.
Rupal H Trivedi, M.D., M.S.C.R	Active	Ophthalmology
George O. Waring, IV, M.D.	Active	Ophthalmology

Medical Staff Reappointment and Change in Privileges

Natasha Ruth, M.D., M.S.	Active	Pediatrics	Add. RX of chemo agents

Medical Staff Change in Privileges			
Ryan Butts, M.D.	Active	Pediatrics	Add. RX of chemo agents
Christine Anne Carter-Kent, M.D.	Active	Pediatrics	Add. RX of chemo agents
Lucinda A. Halstead, M.D.	Active	Otolaryngology	Add. RX of chemo agents
Michelle P. Hudspeth, M.D.	Active	Pediatrics	Add. RX of chemo agents
Sherron M. Jackson, M.D.	Active	Pediatrics	Add. RX of chemo agents
Jennifer Joi Jaroscak, M.D.	Active	Pediatrics	Add. RX of chemo agents
Suzanne E. Kerns, M.B.B.S.	Active Provisional	Psychiatry	Addition of TMS
John Barnwell Kerrison, M.D.	Affiliate - Refer & Follow	Ophthalmology	Swith from R&F to OPH clinical privileges
Henry M. Lemon, M.D.	Active	Pediatrics	Add. RX of chemo agents
J. Antonio Quiros, M.D.	Active	Pediatrics	Add. RX of chemo agents
Andrew J. Savage, IV, M.D.	Active	Pediatrics	Add. RX of chemo agents
Ibrahim F. Shatat, M.D., M.S.	Active	Pediatrics	Add. RX of chemo agents
Katherine Elizabeth Twombley, M.D.	Active	Pediatrics	Add. RX of chemo agents
Julie Kanter Washko, M.D.	Active Provisional	Pediatrics	Add. RX of chemo agents
David R. White, M.D.	Active	Otolaryngology	Add. RX of chemo agents
Professional Staff Initial Appointment and Privileges			
Amy Elizabeth Clanton , F.N.P.	Prov. Allied Health CFC - R&F	Family Medicine	
Tiffany K. Garris, D.N.P., BSN	Provisional Allied Health	Otolaryngology	
Karen R. Karpick, P.A.C.	Provisional Allied Health	Surgery	
Heather L. Lane, P.N.P., D.N.P.	Provisional Allied Health	Pediatrics	
Jordan Lane, PAC	Provisional Allied Health	Neurosciences	
Misty Leigh Seawright, D.N.P., N.P.	Prov. Allied Health CFC - R&F	Medicine	
Carrie Thompson, PAC	Provisional Allied Health	Neurosciences	
Professional Staff Reappointment and Privileges			
Jennifer Beall, P.N.P., M.S.N., R.N.	Provisional Allied Health	Pediatrics	
Susan Diane Groome, C.R.N.A.	Allied Health	Anesthesiology	
Susan Simons Heath, C.R.N.A., BSN	Allied Health	Anesthesiology	
Leah Rebecca Lifland, P.A.C.	Provisional Allied Health	Surgery	
Eugene Mah, B.Sc., M.Sc.	Provisional Allied Health	Radiology	
Sarah Manco, A.P.R.N., M.S.N.	Provisional Allied Health	Psychiatry	
Natalie Claire O'Bryan , MSN, A.N.P.	Allied Health	Otolaryngology	
Jack Owens, C.R.N.A., D.C.	Allied Health	Anesthesiology	
Kerri Marie Presley, P.A.C.	Allied Health	Medicine	
Jennifer Lynn Runion, M.S.W.	Provisional Allied Health	Psychiatry	
Amy Allen Williams, P.N.P.	Allied Health	Pediatrics	
Kristyn Zajac, Ph.D.	Provisional Allied Health	Psychiatry	

Board of Trustees Credentialing Subcommittee - October 2013

The Medical Executive Committee reviewed the following applicants on October 16, 2013
and recommends approval by the Board of Trustees Credentialing Subcommittee effective October 28, 2013

Medical Staff Initial Appointment and Privileges			
R Bryan Butler, M.D.	Active Provisional	Orthopaedic Surgery	
Rambod Charepoo, M.D.	Active Provisional	Surgery	
Crystal Joy Houlton, M.D.	Active Provisional	OB&GYN	
Christine Toldrian Otruba, D.O.	Active Provisional	Pediatrics	
Lynn M. Schnapp, M.D.	Active Provisional	Medicine	
Craig Scott Woodard, M.D.,Ph.D.	Active Provisional	Neurosciences	
Medical Staff Reappointment and Privileges			
Tod Allen Brown, M.D.	Active	Anesthesiology	
Melissa Anne Cunningham, M.D., Ph.D.	Active Provisional	Medicine	
McLeod Gwynette, Jr., M.D.	Active	Psychiatry	
Latha Hebbar, M.B.B.S, M.D.	Active	Anesthesiology	
Fernando A. Herrera, Jr., M.D.	Active Provisional	Surgery	
Jennifer Joi Jaroscak, M.D.	Active	Pediatrics	
Andrew S. Kraft, M.D.	Active	Medicine	
Cheryl P. Lynch, M.D., M.P.H	Active	Medicine	
David Blair Mahoney, M.D.	Active Provisional	Family Medicine	
Roberto Pisoni, M.D.	Active	Medicine	
Joseph Victor Sakran, M.D., M.P.H.	Active Provisional	Surgery	
Jeffrey G. Wong, M.D.	Active	Medicine	
Medical Staff Reappointment and Change in Privileges			
Richard J. Friedman, M.D.	Active	Orthopaedic Surgery	Swith from R&F to Core Privs/Procedures
Medical Staff Change in Privileges			
Charles Michael Bowman, Ph.D., M.D.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
Robert Anthony Cina, M.D.	Active	Surgery	Addition of Telemedicine for Outpatient Consults
Samir M Fakhry, M.D.	Active	Surgery	Addition of Telemedicine for Outpatient Consults
Andre Hebra, M.D.	Active	Surgery	Addition of Telemedicine for Outpatient Consults
Jarom E. Hanson, M.D., B.S.	Active Provisional	Neurosciences	Addition of Spinal medication delivery privileges
Rebecca Kummer Lehman, M.D.	Active	Neurosciences	Addition of Telemedicine for Outpatient Consults
James Thomas McElligott, M.D., M.S.C.R.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
G. Shashidhar Pai, M.D.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
Remberto Paulo, Jr., M.D.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults

Medical Staff Change in Privileges (cont.)			
Jennifer Kinwa Poon, M.D.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
Todd Purves, M.D., Ph.D.	Active	Urology	Addition of Telemedicine for Outpatient Consults
Megan Elizabeth Redfern, M.D.	Active Provisional	Pediatrics	Addition of Peds ER privileges
Natasha Ruth, M.D., M.S.	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
David J Sas, D.O., M.P.H	Active	Pediatrics	Addition of Telemedicine for Outpatient Consults
Charles D. Smith, III, M.D., M.S.	Active	Surgery	Addition of Telemedicine for Outpatient Consults
Christian John Streck, Jr., M.D.	Active	Surgery	Addition of Telemedicine for Outpatient Consults
Christina Vaughan, M.D., M.H.S.	Active	Neurosciences	Addition of Telemedicine for Outpatient Consults
Professional Staff Initial Appointment and Privileges			
Mary Ryan Crittenden, A.P.R.N.	Provisional Allied Health	Anesthesiology	
Elizabeth T. Dowden, C.R.N.A.	Provisional Allied Health	Anesthesiology	
Lynn Catherine Mathewes, A.P.R.N., B.S.N.,	Provisional Allied Health	Anesthesiology	
Jennifer B. Mitchell, C.R.N.A.	Provisional Allied Health	Anesthesiology	
Alanna B. Shiflett, N.N.P.	Provisional Allied Health	Pediatrics	
Shannan Karlayne Toole Dufault, P.N.P.	Provisional Allied Health	Pediatrics	
Professional Staff Reappointment and Privileges			
Mary Adler, A.N.P., MSN	Allied Health	Medicine	
Brittany L. Crosby, P.A.	Allied Health	Otolaryngology	
Julie Anne DesMarteau, P.A.C.	Allied Health	Neurosciences	
Gretchen Lee Hahn, M.S.N., C.N.M., B.S.	Provisional Allied Health	OB&GYN	
Mary Ann Howerton, M.S., P.A.	Provisional Allied Health	Otolaryngology	
Elizabeth Hamilton Koontz , A.P.R.N., BSN	Allied Health	Neurosciences	
Cristina Maria Lopez, Ph.D.	Provisional Allied Health	Psychiatry	
Allison Sizemore Nissen, MSN, C.N.M.	Allied Health	OB&GYN	
Stefanie Marie Owczarski, P.A.C.	Allied Health	Surgery	
Gabrielle L. Poole, P.A.C.	Provisional Allied Health	Orthopaedic Surgery	
Joseph James Sistino, C.C.P., Ph.D.	Allied Health	Surgery	
Professional Staff Change in Privileges			
Jennifer Peltier, M.S.	Allied Health - R&F	Orthopaedic Surgery	Switching from R&F to clinical privileges

MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA

Medical Staff By-Laws Proposed Revisions

- Revised Membership: Added Chief Operating Officer, Chief Medical Information Officer; Corrected titles of other members

- Added provision required by Joint Commission standards: The organized medical staff has the ability to adopt medical staff by-laws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body after communicating the proposed changes to the Medical Executive Committee.

- Joint Commission and CMS requirements: Updated “History and Physical” to include “re-examination of the patient must take place as a part of the history and physical update within 24 hours of admission” (must include the word “RE-EXAMINED” in the update).

Medical University of South Carolina Medical Center

Medical Staff Bylaws

~~December~~ ~~August~~ September ~~2011~~2013

Table of Contents

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:

(a) Provide oversight of quality of care, treatment and services to patients of the MUSC Medical Center.

(b) Determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership.

(c) Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities for non-member practitioners with independent privileges.

(d) Review new and on-going privileges of members and non-member practitioners with independent privileges.

(e) Approve and amend medical staff bylaws, and rules and regulations.

(f) Provide a mechanism to create a uniform standard of care, treatment, and service.

(g) 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:

(a) Ongoing evaluation of the competency of practitioners who are privileged.

(b) Delineating the scope of privileges that will be granted to practitioners.

(c) Providing leadership in performance improvement activities within the organization.

(d) Assuring that practitioners practice only within the scope of their privileges.

(e) 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

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 affected member before formal activity commences.

(b) Access to Committees - Members of the Medical Staff are entitled to be present at a 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) 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 Plan.

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

(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.

(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.

(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. MEDICAL STAFF MEMBERSHIP & STRUCTURE

Section 3.01 MEDICAL STAFF APPOINTMENT - Appointment to the Medical Staff of the MUSC 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.

Section 3.02 QUALIFICATIONS FOR MEMBERSHIP

(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 of Trustees that any patient treated by them in the hospitals will be given a high quality of patient care,

(ii) Demonstrated adherence to the ethics of 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.

(c) Must be free from government sanctions and bans as outlined by Medicare and the 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.

(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 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. 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 MEC for approval.

(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, MUSC Medical Center and Board of Trustees.

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

Section 3.03 NON-DISCRIMINATION - The MUSC Medical Center will not discriminate in granting staff appointment and/or clinical privileges on the basis of age, sex, race, creed, color, nationality, gender, sexual orientation, or type of procedure or patient population in which the practitioner specializes.

Section 3.04 CONDITIONS AND DURATION OF APPOINTMENT

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

(b) The Board of Trustees shall act on appointments and reappointments only after there has been a recommendation from the Credentials Committee and MEC as outlined with associated details in the Credentials Manual.

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

(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.

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

(g) 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 – Office of the Inspector General.

Section 3.05 PRIVILEGES AND PRACTICE EVALUATION - *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.*

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

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

(d) At the time of appointment and reappointment each candidate applying for privileges will be evaluated using the following six areas of general competence as a reference:

(i) Patient Care

(ii) Medical/Clinical Knowledge

(iii) Practice-based learning and improvement

(iv) Interpersonal and communication skills

(v) Professionalism

(vi) System-based practices

(e) A Focused Professional Practice Evaluation (FPPE) allows the medical staff to focus on specific aspects of a practitioner's performance. This evaluation is used when:

(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.

(ii) Questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation

(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 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.

(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.

Section 3.07 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 3.08 RESPONSIBILITIES OF MEMBERSHIP - Each staff member will:

(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.

(b) Assist the 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) Assist other practitioners in the care of his/her patients when asked.

(d) Act in an ethical and professional manner.

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

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

(g) Participate in peer review as appropriate.

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

(i) Abide by all standards from regulatory bodies. Example – Joint Commission National patient Safety Goals

(j) Participate in continuing education as directed by state licensure and the MEC.

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

(l) When required as a part of the practitioner well being program, comply with recommended actions.

(m) Manage and coordinate his/her patients care, treatment, and services.

Article IV. CATEGORIES OF THE MEDICAL STAFF

Section 4.01 THE ACTIVE CATEGORY

(a) Qualifications - Appointee to this category must:

(i) Be involved on a regular basis in patient care delivery at the MUSC Medical Center hospitals and clinics and annually providing the majority of his/her services/activities within the MUSC Medical Center.

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

(b) Prerogatives - Appointee to this category may:

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

(ii) Vote on all matters presented at general and special meetings of the Medical Staff, and of the Department and Committees on which he is appointed.

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

(iv) Admit patients to the MUSC Medical Center.

(c) Responsibilities - Appointee to this category must:

(i) Contribute to the organizational and administrative affairs of the Medical Staff.

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

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

(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.

Section 4.02 AFFILIATE CATEGORY

(a) Qualifications - Appointee to this category must:

(i) Participate in the clinical affairs of the MUSC Medical Center.

(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

(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) Prerogatives - Appointee to this category may

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

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

(iii) Request admitting privileges.

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

Section 4.03 HONORARY / ADMINISTRATIVE CATEGORY - 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.

(a) Such staff appointees are not eligible to admit patients to the MUSC Medical Center, vote, or exercise clinical privileges. 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 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 REFER and FOLLOW CATEGORY – This category consists of individuals who do not plan to admit or treat patients at MUSC Medical Center but wish to monitor their patients while they are in the hospital and access the patient's medical record.

(a) Refer and Follow Medical Staff of this category may subsequently apply for membership and clinical privileges in another Medical Staff category at any time.

(b) Refer and Follow Medical Staff do not have clinical privileges to admit, consult, or treat patients at MUSC Medical Center. In addition, members of this category shall not provide emergency call or back-up call coverage. Refer and Follow members shall not vote or hold office. Member of this category shall not electronically either enter orders or give verbal orders or otherwise document in the medical record and shall not perform any procedures or provide any treatment.

(c) Refer and Follow Medical Staff may attend Medical Staff, Department and Committee meetings. In addition, members of this medical staff category may visit and follow his/her referred hospitalized patients and may access

the electronic medical record both remotely and at the hospital. No meeting attendance or minimum number of patient contacts is required to maintain Refer and Follow status.

Section 4.05 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.

(ii) 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 his/her training are qualified for assignment to the House Staff.

(iii) 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 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.

Section 4.06 CONTRACT SERVICES - 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.

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Article V. OFFICERS

Section 5.01 OFFICERS OF THE MEDICAL STAFF - The officers of the Medical Staff shall be:

(a) President

(b) Vice President

(c) Secretary

Section 5.02 QUALIFICATIONS OF OFFICERS - *Officers must be members of the Active Medical Staff at the time of nomination and election and must remain members in good standing during 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.*

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

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

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

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

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

Section 5.05 VACANCIES IN OFFICE - 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 DUTIES OF OFFICERS

(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) Vice President - In the absence of the President, Vice President shall assume all the duties and have the authority of the President. He/she 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) Secretary -The secretary shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all Medical Staff meetings. The secretary serves as the MEC liaison to the housestaff peer review committee.

Section 5.07 REMOVAL FROM OFFICE

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

(b) Medical Center and/or the Medical Staff, physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the office.

(c) Elected officers may be removed by 2/3 majority vote of the Medical Staff for the reasons stated in ~~VII A~~5.07 (a) & (b) above.

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

(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.

Article VI. DEPARTMENTS

Section 6.01 ORGANIZATION OF DEPARTMENTS - The Medical Staff shall be organized into departments, divisions, and or sections, in a manner as to best assure:

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

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

(c) the discovery of new knowledge;

(d) the dissemination of new knowledge;

(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.

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

Section 6.02 QUALIFICATIONS AND SELECTION OF DEPARTMENT CHAIRPERSON

(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.

(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.

Section 6.03 FUNCTIONS OF DEPARTMENT - Through the department Chairperson each department shall:

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

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

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

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

(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) 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.

(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) Represent a balance between intra-institutional and outside activities.
(ii) Be based, when applicable, on the findings of the quality improvement effort.
(iii) Be appropriate to the practitioner's privileges and will be considered as part of the reappointment process.

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

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

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

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

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

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

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

(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) Recommend space and resource needs of the department.

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

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

(t) Assess and improve on a continuing basis the quality of care, treatment, and services provided in the department.

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

Article VII. COMMITTEES AND FUNCTIONS

Section 7.01 MEDICAL EXECUTIVE COMMITTEE (MEC)

(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:

1) the elected officers of the Medical Staff,

2) Past President of the Medical Staff,

3) Vice President for Clinical Operations/Executive Director of MUSC Medical Center,

~~3)~~ 4) ~~Executive Senior Associate Dean for Clinical Affairs,~~

~~4)~~ 5) Executive Senior Associate Dean for Clinical Affairs,

6) Executive Medical Director (Chief Medical Officer),

~~5)~~ 7) Chief Operating Officer,

~~6)~~ 8) Associate Executive Medical Directors,

~~7)~~9) Administrator of Clinical Services/Chief Nursing Executive,

~~8)~~10) Department of Medicine Chairperson,

~~9)~~11) Department of Surgery Chairperson,

~~10)~~12) Director of Quality and Chief Quality Officer~~,~~

13) Chief Strategy Officer,

Director of Analytics

~~11)~~14) Chief Medical Information Officer,~~Director of Strategic Planning,~~

~~12)~~15) Director of Pharmacy,

~~13)~~16) Administrator of Ambulatory Care,

~~14)~~17) Vice President for Medical Affairs,

~~15)~~18) CEO and CMO of UMA,

~~16)~~19) Member as elected by the House Staff (voting),

~~17)~~20) Chairperson of Credentials Committee,

~~18)~~21) Physician Director of Children's Health Services,

~~19)~~22) Senior Associate Dean for Medical Education,

~~20)~~23) Director for Graduate Medical Education,

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~~21)~~24) President of UMA,

~~22)~~25) Division Chief of Emergency Medicine,

~~23)~~26) Chairpersons (or designee) of the Departments of Laboratory Medicine & Pathology, Anesthesiology and Perioperative Medicine, and Radiology,

~~24)~~27) 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)~~28) Three elected Medical Directors from service lines,

~~26)~~29) Two (2) Department Chairpersons not already assigned

30) Accreditation representative

~~27)~~

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

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

(d) All members will have voting rights.

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

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

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

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

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

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

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

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

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

(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;

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

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

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

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

(xiv) Report at each general staff meeting; and

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

(f) Delegated Authority-

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

(ii) 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.

The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto , and to propose them directly to the governing body after communicating the proposed changes to the Medical Executive Committee.

~~(ii)~~

Comment [LK1]: Please note that we could notify the medical staff in their Oct meeting of changes to the rules and regs. We do not need approval only MEC. Bylaws must have approval however.

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(iii) The authority to amend these bylaws cannot be delegated.

(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.

(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 MEC 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.

Section 7.02 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 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.

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

(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;

(ii) Conduct or coordinate utilization activities;

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

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

(v) Develop and maintain surveillance over drug utilization policies and practices;

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

(vii) Plan for response to fire and other disasters;

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

Article VIII. HISTORY AND PHYSICAL REQUIREMENTS

Section 8.01 Comprehensive History and Physical - 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 diagnostic or therapeutic procedure, or procedures requiring deep sedation or anesthesia regardless of setting.

(a) A complete H&P (except in circumstances 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,

(x) conclusion or a planned course of action.

Section 8.02 Focused History and Physical - For other non-inpatients procedures, a focused history and physical may be completed 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 mental status.

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

Section 8.03 Primary Care Clinics - 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). The focused H&P must meet the requirements for a focused H&P.

Section 8.04 ***H&P Not Present -*** *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 completed unless it is an emergency.*

Section 8.05 Updating an H&P - 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, a re-examination of the patient must take place as a part of the history and physical update~~n update to the H&P must be completed~~ within 24 hours of admission for inpatients or prior to the procedure whichever comes 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 combination with the preanesthesia assessment.

Section 8.06 H&P Responsibility:

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

(b) Oral and maxillofacial surgeons may perform a medical H&P examination in order to assess the status and risk of the proposed surgery or procedures.

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

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

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

(a) Residents, advanced nurse practitioners and in some cases physicians assistants, 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.

(c) The co-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.

Comment [LK2]: Is 48 hours too long given the changes we are making in rules and regs?

Article IX. MEDICAL STAFF MEETINGS

Section 9.01 REGULAR MEETINGS

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

(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.

(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.

Section 9.02 SPECIAL MEETINGS - *The President of the Medical Staff, the Executive Medical Director, the Dean of the College of Medicine, or the 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.*

Section 9.03 QUORUM - *The quorum requirements for all meetings shall be those present and voting, unless otherwise indicated in these Bylaws.*

Section 9.04 ATTENDANCE REQUIREMENTS

(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) 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.

Section 9.05 PARTICIPATION BY EXECUTIVE DIRECTOR OF THE MUSC MEDICAL CENTER - *The Executive Director of the MUSC Medical Center or his/her designee may attend any Committee, Department, or Section meeting of the Medical Staff.*

Section 9.06 ROBERT'S RULES OF ORDER - *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.*

Section 9.07 NOTICE OF MEETINGS - *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.*

Section 9.08 ACTION OF COMMITTEE/DEPARTMENT - *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.*

Section 9.09 MINUTES - 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. TERMINATION, REDUCTION, AND SUSPENSION OF PRIVILEGES

Section 10.01 SUSPENSION - *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, 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 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 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 the record being defined as delinquent and 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

(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 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.

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

(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.

Section 10.03 FAIR HEARING PLAN - *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) Denial of initial staff appointment,

(ii) Denial of reappointment,

(iii) Revocation of staff appointment,

(iv) Denial or restriction of requested clinical privileges,

(v) Reduction in clinical privileges,

(vi) Revocation of clinical privileges,

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

(viii) Suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.

(b) PROFESSIONAL REVIEW ACTION

(i) DEFINITIONS

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

1) Notice of Proposed Action – the practitioner shall be given a notice stating: that a professional review action has been proposed to be taken against the practitioner; the reasons for the proposed action; that the practitioner has a right to request a hearing on the proposed action; and that the practitioner has thirty (30) days within which to request such hearing;

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.

(e) NOTICE AND REQUEST FOR HEARING - 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.

(g) RIGHTS OF THE PARTIES - 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.

(h) COMPLETION OF HEARING - 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

(i) 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.

(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 convenience 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.

(j) 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 taken 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.

(k) 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, 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.

(l) REPORT AND FURTHER ACTION - 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 a 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 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.

(p) FINAL DECISION BY THE BOARD OF TRUSTEES - 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.

(q) ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES - 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.

Article XI. CONFLICT MANAGEMENT AND RESOLUTION

Section 11.01 MEC and Medical Staff - *If a conflict arises between the 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) active 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.

Section 11.02 MEC and BOARD of TRUSTEES - 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. OFFICIAL MEDICAL STAFF DOCUMENTS

The official governing documents of the Medical Staff shall be these 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 amendment of these documents shall be as provided below.

Section 12.01 BYLAWS - *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 supersede.*

(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.

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

(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 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 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

(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.

(c) When there is a documented need for an urgent amendment to the Rules and Regulations to comply with the a law or regulation, the voting members of the organized medical staff delegate the authority to the MEC who 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, at a called meeting, or through electronic communication will retrospectively review the provisional amendment. If there is no conflict between the 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 these bylaws will be implemented.

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

(e) 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,

Section 12.03 *RULE CHALLENGE*

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) Provide the petitions with information clarifying the intent of such rule, regulation, or policy and/or

(b) Schedule a meeting with the petitioners to discuss the issue.

Approved by the Medical Executive Committee on November 16, 2011. Approved by Medical Staff on October 23, 2012.

Revisions approved by the Board of Trustees in December 2011.

Summary of Proposed Changes to Medical Staff
Rules and Regulations
November 2013

1. Definitions: Added definition of CMIO and CMO. Modified definition of Authentication: refers to the **full name signature, date, time and credentials**. Other grammatical edits.
2. Admissions: Changed admitting physician to attending physician responsible for admission. (Typo from last revision)
3. Medical Records:
    - Modified the definition of a Medical Record:
      The "legal medical record" consists of all authenticated (signed) documentation, handwritten or electronically generated related to the care of an individual patient and **any related communication between a physician and a patient specific to the patient's care or treatment**.
    - Added: The attending physician is specifically responsible for the completion of the medical record for each **patient encounter** (e.g. admission).
    - Added Informed consent to documents that must be completed without abbreviations.
    - Deleted reference to medical student notes and stat dictation.
    - Added section on medical record requirements for out-patients.
    - Added medication reconciliation as a requirement for a complete record.
    - Changed timeframes for completion to :
      History and physical- 24 hours after admission or prior to invasive or operative procedure whichever comes first
      Consultation report- within 24 hours of request
      Labor and Delivery summary- within 24 hours of delivery
      Operative and procedure reports – within 24 hours of procedure
      Discharge summary- within 24 hours of discharge for preliminary and within 3 days of discharge for official
      Diagnostic study- within 24 hours after completion of the study
      Transfer Summary- within 24 hours of discharge
      ED procedure notes- within 24 hours
      Verbal Orders- within 14 days after discharge
    - Redefined what elements make records delinquent and revised timeframes:

Medical Record Required Element	**Required Completion time within:**	**Attending's Signature required within:**	**Deemed Delinquent at:**
Admission H&Ps	24 hours	3 days	4 days
Inpatient and ED consultations	24 hours	3 days	4 days
Discharge Summaries	Preliminary version in 24 hours). Official within 3 days	3 days	4 days
ED Attending Notes	24 hours	3 days	4 days
Operative/Procedure reports	24 hours	3 days	4 days
Outpatient visit notes	7 days	14 days	14 days

- Notifications Clarified: **Physicians will receive two (2) notifications from the Health Information Department during the 14 day period post patient discharge regarding missing medical record elements including signatures. Suspension notification will be sent on day 14.**

- Clarified Failure to Complete Medical Records: **All significant portions of the medical record of each patient's medical record shall be completed within the time period after the patient's discharge as stated in the Delinquency Table within the Medical Staff Rules and Regulations. Failure to do so automatically results in the record being defined as delinquent and notification of the practitioner of the delinquency**.
- Clarified Medical Record temporary suspension: **Temporary suspension is automatically instituted 3 days following the determination that the provider has three or more simultaneous total medical record delinquencies (from one or more of the above six record types)**
- Clarified the appeal process: Added CMIO to appeal process and clarified language.

4. Orders:
    - Clarified who can give orders (Within scope of practice).
    - Added language regarding POST orders: **A validly completed and executed South Carolina Physician Orders for Scope of Treatment ("POST") form may be accepted in any emergency situation as a valid expression of patient wishes until the contents are reviewed with the patient or the legally authorized representative at the earliest possible opportunity. The attending physician should document review of the POST and conversations about the POST in the medical record.**
    - Clarified Allow Natural Death orders: **Allow Natural Death (AND) order should be followed according to Medical Center Policy #C-023. When a patient or family presents a signed AND Advanced Directive, discussion must occur between treating physician and patient (or surrogate.)**
    - Added who can take verbal orders: **Other disciplines as specifically approved by the Chief Medical Officer, and subsequently endorsed by the Medical Executive Committee**
    - Added: that verbal orders must have **immediate contact information**
    - Added: the phrase **certain high risk medications** to language regarding when verbal orders are not allowed
    - Added to Admission Orders: **Admission orders should be written and signed by the physician on service that is accepting admitted patient.**
5. Substance Abuse/Psychiatric Patients: Deleted the phrase: "**only after consultation with the Executive Medical Director or his designee and the assigned Medical Director of the relevant service."** regarding admission of IOP patients to other units in the hospital. Deleted that all substance abuse patients require a psych consult.
6. Patient Discharge: Changed from patients may only be discharged by order of the attending to **only under direction of the attending**.
7. Hospital Admission Census: Added **In situations where the hospital bed occupancy is full, the Medical Center may reference and implement the Emergency Patient Placement Policy (EP3 Policy).**
8. House Staff Requirements**:** Added**: Appropriately credentialed fellows serving as attending physicians are excluded from these requirements.**

Field Code Changed

Medical University of South Carolina Medical Center

Medical Staff Rules and Regulations

~~September~~ August ~~2012~~2013
November 2013

DEFINITIONS:

1. **Medical Staff** - all persons who are privileged to engage in the evaluation, diagnosis and treatment of patients admitted to the MUSC Medical Center, and includes medical physicians, osteopathic physicians, oral ~~surgeons and~~surgeons ~~,~~and dentists.
2. **Board of Trustees** - the Board of Trustees of the Medical University of South Carolina, which also functions as the Board of Trustees for the MUSC Medical Center.

3. **University Executive Administration** - refers to the President of the Medical University of South Carolina and such Vice Presidents and Administrators as the Board directs to act responsibly for the Hospital.

4. **Dean** - the Dean of the appropriate College of the Medical University of South Carolina.

5. **VP for Clinical Operations/ Executive Director, Medical Center** - the individual who is responsible for the overall management of the Hospital.

6. **Executive Medical Director/Chief Medical Officer** - the individual who is responsible for the overall management of medical staff functions.

7. **Practitioner** - an appropriately licensed medical physician, osteopathic physician, oral surgeon, dentist, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice.

8. **Chief Medical Information Officer**- the individual with the strategic and operational responsibilities of optimizing the collection, appropriate use and protection of patient health information for best care and research.

8.

~~9.~~ **Executive Committee** ~~- the Executive Committee of the Hospital.~~ The Medical Executive Committee of the Medical Staff.

~~10.~~9. **House Staff** - any post graduate physician practitioner in specialty or sub-specialty training.

~~11.~~10. **Allied Health Professional** - any health professional who is not a licensed medical physician, osteopathic physician, oral surgeon, or dentist; subject to licensure requirements or other legal limitations; with delineated clinical privileges; exercises independent judgment within areas of his professional competence and, is qualified to render direct or indirect care.

~~12.~~11. ~~**Medical Record** - any/all information, paper and/or computer (consents, OR notes, path, lab & imaging reports, consultations, D/C summary), concerning a single patient that describes the course of the evaluation, treatment and change in condition during a hospital stay, an ambulatory or emergency visit. It is the legal record of care.~~

~~13.~~12. **Authenticat~~ione~~** - refers to the full name signature,date,time and ~~signature~~ credentials by the author of the entry in the medical record; signature is to include full name and the individual's credentials. The signature may be handwritten, by rubber stamp, or by

computer key.

~~14.~~13. Whereas herein the word "**Hospital"** is used it refers to the MUSC Medical Center and its component hospitals and outpatient activities.

~~15.~~14. Since the English language contains no singular pronoun which includes both sexes, wherever the word "**he**" appears in this document, it signifies he/she.

MEDICAL STAFF RULES AND REGULATIONS

I INTRODUCTION

It is the duty and responsibility of each member of the medical staff to abide by the Rules and Regulations set forth here within this document. These rules and regulations shall be made a part of the MUSC Medical Staff Bylaws. Such amendments shall become effective when approved by the Board.

II ADMISSIONS

Who May Admit Patients

A patient may be admitted to the Medical Center only by a medical staff member who has been appointed to the staff and who has privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel~~. When the Medical Center does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Medical Center, the Medical Center or attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.~~ Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

~~Admitting~~ Attending Physician Responsibilities

Each patient shall be the responsibility of a designated attending physician of the medical staff. Such attendings shall be responsible for the

- initial evaluation and assessment of the admitted patient. Such an evaluation must be completed within 24 hours of admission.
- management and coordination of the care, treatment, and services for the patient including direct daily assessment, evaluation and documentation in the medical record by the attending or the designated credentialed provider
- for the prompt completeness and accuracy of the medical record,
- for necessary special instructions, and
- for transmitting reports of the condition of the patient to the referring physician or agency. Whenever these responsibilities are transferred to another medical staff member and service, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

The admitting practitioner shall be responsible for providing the Medical Center with such information concerning the patient as may be necessary to protect the patient,

other
patients, or Medical Center personnel from infection, disease, or other harm, and to protect the patient from self-harm.

Alternate Coverage
Each medical staff appointee shall provide assurance of immediate availability of adequate professional care for his patients in the Medical Center by being available or having available, an alternate medical staff appointee with whom prior arrangements have been made and who has clinical privileges at the Medical Center sufficient to care for the patient. Residents may provide coverage only under the direct supervision of an attending physician.

Emergency Admissions
The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart no later than 24 hours after admission. In the case of emergency admission, patients who do not already have a personal admitting physician will be assigned to a medical staff appointee with privileges in the clinical department appropriate to the admitting diagnosis.

III MEDICAL RECORDS

General Guidelines

a) The "legal medical record" consists of all authenticated (signed) documentation, handwritten or electronically generated related to the care of an individual patient and any related communication between a physician and a patient specific to the patient's care or treatment -regardless of storage site or media. Included are all inpatient records from the Medical Center, ~~IOP~~ Institute of Psychiatry, Children's Hospital, and their outpatient, provider-based clinics and associated aspects of care documentation of patients participating in research projects~~.~~. Each element of the medical record, including all notes and orders, must unambiguously identify the patient with information to include name and medical record number and be authenticated, inclusive of date/time, and (electronic) signature with credentials of the authorized author of the entry.

b) All records are the property of MUSC and shall not be removed except as pursuant to provision of law. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

~~c) Medical Staff members shall not remove any part of the medical record for any reason. Any physician practitioner governed by these Rules and Regulations who purposely removes any document from a medical record will be suspended and/or lose Medical Staff Membership~~**.** Medical Staff and other practitioners shall not remove or destroy any part or authenticated entry of information in the medical record for any reason. Identification and correction of errors in the record is governed by separate policy. Any member of the medical staff or privileged practitioner who purposely removes any document from a medical record will be suspended and/or lose Medical Staff Membership and or privileges.

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d.The attending Physician is specifically responsible for the completion of the medical record for each patient encounter (e.g. admission).

e) Diagnostic and therapeutic orders given by medical staff members shall be authenticated by the responsible practitioner.

f) Symbols and abbreviations may be used only when approved by the Medical Staff. The use of unapproved abbreviations as specified in Medical Center Policy #C-21 "Use of Abbreviations" is prohibited. All final diagnosis, complications, or procedures and informed consent must be recorded without abbreviations.

g) Electronic signatures may only be utilized in accord with governing regulation/law and institutional policy and procedures; sharing electronic keys/passwords is fraudulent and grounds for Medical Staff suspension.

h) Progress notes are to be documented daily by the designated attending or his designated credentialed provider for all inpatient and observation patients.

i) The patient's medical record requires the progress notes, final diagnosis, and discharge summary or final visit note to be completed with authenticated dates and signatures. All final diagnosis, complications, or procedures must be recorded without abbreviations.

1.

~~Patient progress note entered into the Medical Record by Medical students must be co-signed by either a resident or an attending physician.~~

~~Stat dictation shall be limited to urgent situations such as when a patient transfer is pending.~~

Informed Consent Requirements

It is the responsibility of the attending physician to assure appropriate informed consent. Is obtained and documented in the medical record and when appropriate, also document the discussion in a progress note .Nursing staff and other personnel may witness patient signature but may not consent the patient.

Informed consent is required for all invasive procedures, for the use of anesthesia including moderate and deep sedation and for the use of blood and blood products.

Appropriate informed consent shall include at a minimum:

- patient identity,
- date,
- procedure or treatment to be performed,
- name of person performing the procedure or treatment,
- authorization for the proposed procedure
- authorization for anesthesia or moderate sedation if indicated.
- indication that alternate means, risk and complications of the planned procedure and recuperation, and anesthesia have been have been explained,
- authorization for disposition of any tissue or body parts as indicated,
- risks and complications of blood or blood product usage (if appropriate),
- witnessed signature of the patient or other empowered individual authorizing informed consent, and
- signature, name/identity and pager # of the physician who obtained the consent, (verbal consent may be witnessed by the nurse and indicated on the consent form).
- physician documentation of the consent process in a progress note or on the consent form.

Physician documentation of the consent process and discussion may be accomplished with either an out-patient or in-patient note in the record.

Operative and Other Procedure Documentation Requirements

Operative Procedure Note:

Immediately after the operation/procedure a progress note will be written and promptly signed by the primary physician/surgeon (this applies to both inpatients and outpatients). This progress note is considered an abbreviated report and will include the pre-operative procedure/diagnosis, the name of the primary physician/surgeon and assistants, findings, procedure performed and a description of the procedure, estimated blood loss, as indicated any specimens/tissues removed, and the postoperative/procedure diagnosis.

Operative/Procedure Report:

For all patients (both inpatient and outpatient) the full operative/procedure report shall be written or dictated ~~and signed by the primary physician/surgeon~~ and entered into the medical record no later than ~~seventy two (72)~~ twenty four (24) hours from the completion of operation/procedure The signature of the primary physician/surgeon is required within 3 ~~7~~ days of the procedure unless the operative report was completed by the primary surgeon in which case the signature is required with the completion of the report. (within 24 hours.) ~~.~~

Operative/ procedure reports may be completed by residents with supervision by the attending as evidenced by the attending's counter signature authenticating the report
These documentation requirements apply to all procedures billed as such according to a CPT code.

Discharge Summary Requirements

For all inpatient and observation stays, a preliminary discharge summary must be completed within ~~72~~ 24 hours of discharge with an official discharge summary and signature within ~~7~~ 3 days of discharge. The discharge summary must include reasons for hospitalization, significant findings, procedures performed, treatment given, condition of the patient upon discharge, specific instructions given to patient and/or patient's family in regard to activity, discharge, medications, diet, and follow-up instructions. Residents may

complete the discharge summary with attending supervision as evidenced by the attending's counter signature on the report.

For inpatient and observation stays less than 24 hours, in order to facilitate continuity and patient safety, an abbreviated discharge summary may be completed, but it must include the same elements as the previous paragraph.

Complete Medical Records

The attending physician is responsible for supervising the preparation of a complete medical record for each patient.

a. Specific record requirements for physicians shall include:

- identification date, name, address, birth date, next of kin, patient history number, legal status (for behavioral health patients)
- initial diagnosis
- history and physical
- medication reconciliation
- orders
- clinical observation, progress note, consultations
- reports of procedures, tests, and results
- operative/procedure reports including labor and delivery summaries
- reports of consultations
- discharge summary
- all final diagnoses, complications, or procedures
- AJCC staging for diagnosed cancer patients

~~F.~~ *Outpatient Care Documentation Requirements*

a) ED Attending Notes. ED Attending and ED consultation notes must be completed and authenticated in the medical record within 24 hours.

b) MUSC Medical Center Outpatient visits. This is inclusive of MUSC Medical Center outpatient visits at any location and MUSC Medical Center "e-visits" where the patient is "arrived" within the MUSC Medical Center system; documentation must be complete within 7 days.

c) Patient/family communications. All direct communications in any media (e.g. phone, email) with patients or family or other representative by a medical staff member should be documented and authenticated in the medical record within 24 hours.

d) Telehealth Consultation Requirements. Telehealth consultations are consultations requested by non-MUSC Medical Center providers to assist them in the care of their patients in other (non-MUSC Medical Center) healthcare facilities. In this circumstance, primary documentation of the consult will be in the other facility's medical record, and that record provided in a timely way. HOWEVER, by agreement, such patients should have an MUSC medical record number, and an official copy of the consult maintained as part of the MUSC medical record.

e) Other documentation. Other events pertinent to the patient's care, such as care coordination and medical decision making between patient contacts, should be documented and authenticated in the medical record as soon as possible after their occurrence.

~~G.~~ Medical Records Preparation and Completion

Completion Requirements:

Important elements in the medical record must be completed within the following timeframes:

- History and physical- 24 hours after admission or prior to invasive or operative procedure whichever comes first
- Consultation report- within 24 hours of request
- Labor and Delivery summary- within 24 hours of delivery
- Operative and procedure reports – within 24 hours of procedure
- Discharge summary- within 24hours of discharge for preliminary and within 3 days of discharge for official
- Diagnostic study- within 24 hours after completion of the study
- Transfer Summary- within 24 hours of discharge
- ED procedure notes- within 24 hours
- Verbal Orders- within 14 days after discharge

Delinquent Records:

A medical record of a patient is delinquent if specific significant elements of the record are not completed by the due date specified in these Rules and Regulations and not authenticated by the responsible attending physician 3 days following the completion due date, (The exception is outpatient visit notes when the attending physician's signature is not required until 14 days after completion of the note.) For the purposes of this rule, medical record delinquencies are individually identified by patient and encounter and are only for: (1) admission H&Ps; (2) inpatient and ED consultations; (3) discharge summaries; (4) ED attending notes; (5) inpatient and outpatient operative/procedure reports; and (6) outpatient visit notes. The Delinquency Summary table details this rule.

Delinquency Summary:

Medical Record Required Element	**Required Completion time within:**	**Attending's Signature required within:**	**Deemed Delinquent at:**
Admission H&Ps	24 hours	3 days	4 days
Inpatient and ED consultations	24 hours	3 days	4 days
Discharge Summaries	Preliminary version in 24 hours). Official within 3 days	3 days	4 days
ED Attending Notes	24 hours	3 days	4 days
Operative/Procedure reports	24 hours	3 days	4 days
Outpatient visit notes	7 days	14 days	14 days

Physicians will receive two (2) notifications from the Health Information Department during the 14 day period post patient discharge regarding missing medical record elements including signatures. Suspension notification will be sent on day 14.

Failure to Complete Medical Records - All significant portions of the medical record of each patient's medical record shall be completed within the time period after the patient's discharge as stated in the Delinquency Table within the Medical Staff Rules and Regulations. Failure to do so automatically results in the record being defined as delinquent and notification of the practitioner of the delinquency. Physicians will receive two (2) notifications from the Health

Information Department during the 14 day period post patient discharge regarding missing medical record elements including signatures. Suspension notifications will be sent on day 14.

A medical record temporary suspension is noted in a provider's internal credentials file, but is not otherwise reportable. Unless specifically exempted by the Chief Medical Officer to meet urgent patient care needs a temporary suspension means withdrawal of admitting privileges, scheduling of clinic appointments, or scheduling of elective surgical cases, effective until the medical records are complete. This temporary suspension shall be imposed automatically after warning a member of his/her delinquency and his/her failure to complete such medical records. The temporarily suspended physician can continue to provide care for those patients directly under his/her care prior to the suspension. Once records are complete the temporary suspension will end. Temporary suspensions can be set aside by the Chief Medical Officer. A temporary medical record suspension is NOT a suspension from the medical staff.

A medical record temporary suspension of a member of the medical staff is automatically instituted 3 days following the determination that the provider has three or more simultaneous total medical record delinquencies (from one or more of the above six record types), provided:

(a) The HIM Department has notified the provider as above that each record was delinquent; and
(b) The HIM Department has notified the provider in writing of the impending medical record suspension one day before its occurrence.
(c) The provider still has three or more delinquent records at the date and time the medical record suspension would otherwise become effective.
(d) The (pending) suspension has not been appealed. Appeals may originate with the provider, but in any event must be endorsed by a supervising physician (e.g. Division Chief, Department Chair, Chief Medical Officer). Appeals must be written, and include (1) an acknowledgement of the delinquent records; (2) an explanation of the delay in completion; and (3) a specific date by when ALL delinquent records will be completed. Appeals are considered by the Chief Medical Information Officer but if rejected, may be escalated to the CMO, whose decision is final. If the appeal is rejected, the provider is immediately placed on medical record suspension. When the explicit timeframe of an approved appeal expires, the provider is again immediately liable for medical record suspension, if 3 or more records remain delinquent.

The history and physical, consults, and orders as well as authentications of such will be completed in the time frame specified in these Rules and Regulations. All diagnostic study reports must be dictated and on the medical record within 72 hours of the completion of the study.

The records of all discharged patients (inpatients and ambulatory) not fully completed within fourteen (14) days of discharge will be considered delinquent

a. Five days after discharge, if a patient's medical record is not completed the attending physician will receive notification that the chart is incomplete.

~~a.~~b. The physician will receive a suspension warning if the chart remains incomplete after ten (10) days post discharge in writing by fax, email, or letter or orally by direct

phone call or pager.

i. If the record remains incomplete at thirteen (13) days the physician. Notice will receive
notice one day prior to suspension of privileges orally by direct phone call or pager.

~~b.~~c. The suspended physician cannot admit new patients to his or her care.

~~c.~~d. The suspended physician can continue to provide care for those patients directly under his/her care prior to the suspension.

e. Three (3) such suspensions in a twelve (12) month period will result in a loss of Medical Staff Membership, according to the MUSC Medical Staff Bylaws. Re-application for reinstatement to the staff is allowed immediately upon completion of the delinquent record(s).

IV. ORDERS

General Requirements

a. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Orders which are illegible or improperly written will not be carried out until they are clarified, rewritten, and are understood. Orders can not be written with abbreviations listed on the prohibited abbreviation list. Scientifically approved chemical symbols for certain drugs are acceptable (i.e., KCL for potassium chloride).

b. When a practitioner uses a rubber stamp signature, he/she is the only one who uses it and must sign a statement to that effect. It is the responsibility of each practitioner to forward a copy of this statement to the Medical Staff Office. When a practitioner uses an electronic signature, he/she must ensure it is only used in accordance with departmental policies and related regulatory guidelines.

c. When a patient returns to a patient care unit from the OR all orders must be totally rewritten with the exception of minor procedures as defined by a procedure that could also be performed in a non-OR setting. In that case, the pre-procedure orders are adjusted by the physician postoperatively according to patient condition. When the physician review is completed, a note is entered on the order form which states that the orders have been reviewed and all orders are current.

Patients transferred into or out of an intensive care unit from or to a non intensive care area must have all orders rewritten.

d. Orders will be rewritten when a patient is transferred between levels of care (i.e. from an intensive care unit to the floor or vice versa.) A reorder for medication or treatment is to be written after an automatic stop order has been employed.

e. Explicit orders must be written for each action to be taken.

f. Medications should be ordered within the MUSC formulary.

g. Blanket orders such as resume pre-op medications as outlined above in c or resume home medications are prohibited.

h. Illegible Orders. Admitting privileges and surgical or procedures privileges can also be suspended for illegible orders. Illegible is defined as orders that three (3) other individuals cannot read. Suspension will occur after the physician has been notified, either orally or in writing, on three (3) separate occasions regarding legibility.

i. All medication orders must be written according to Medical Center Policy #C-78 "Medication Orders".

Who May Write Orders

Orders may be written by members of the medical staff and allied health professionals (advanced nurse practitioners, PA's, residents, social workers, psychologists) within the scope of their practice, delineated clinical privileges, and approved protocols. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Authenticated electronic signatures for orders are acceptable when available.

Orders for Specific Procedures/Circumstances

a. All requests for tests such as imaging and labs, etc shall contain a statement of the reason for the examination.

b. All orders for therapy shall be entered in the patient's record and signed by the ordering practitioner.

c. Therapeutic diets shall be prescribed by the attending physician in written orders on the patient's chart. Orders for diet must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

d. All orders for *restraints* shall include the type of restraint, the reason for the restraint, the length of time (not to exceed 24 hours), and alternatives attempted. Restraints can be ordered by a physician, or an advanced nurse practitioner or psychologist within the scope of their duties. Such orders must be signed and dated by the ordering practitioner at the time restraints are ordered. Emergency verbal orders must be secured within one hour of the nurse initiating restraints. Verbal orders for restraints must be signed by the ordering practitioner within twenty-four (24) hours. PRN orders are not acceptable.

e. When restraints are used for behavioral reasons, the patient must be seen by an MD within one hour of initiation.

f. Do Not Resuscitate (DNR) orders may be accepted as a verbal order only when the

patient has executed an advance directive and that directive is included in the patient's record. A no-code (DNR) must be written by the attending physician with the progress notes reflecting the patient's mental status, the reasons for the DNR, diagnosis and prognosis, and a statement of the patient's wishes. Medical staff are to follow Medical Center Policy #C-13 "Resuscitation Orders". In all cases the patient has the right to refuse resuscitation verbally or as by written advanced directive.

g. Allow Natural Death (AND) order should be followed according to Medical Center Policy #C-023. When a patient or family presents a signed AND Advanced Directive, discussion must occur between treating physician and patient (or surrogate .)

h. A validly completed and executed South Carolina Physician Orders for Scope of Treatment ("POST") form may be accepted in any emergency situation as a valid expression of patient wishes until the contents are reviewed with the patient or the legally authorized representative at the earliest possible opportunity. The attending physician should document review of the POST and conversations about the POST in the medical record.

Verbal Orders

A verbal order is defined as an urgent or emergent order that has not been written and is relayed verbally from the physician or dentist. The request for and use of verbal orders should be limited to urgent or emergent situations. In all cases a telephone or verbal order will not be considered complete until the individual receiving the order, reads back and verifies the content of the order

a. The following disciplines may request and accept a verbal order within the scope of their practice when the need for such an order is urgent:
   - Registered Nurse
   - Licensed Practical Nurse (in ambulatory clinics only)
   - Certified Medical Assistant or Certified ophthalmic personnel (in ambulatory clinics only)
   - Licensed Physicians Assistant
   - Registered Pharmacist
   - Certified Respiratory Care Practitioner
   - Emergency Medical Technician
   - Licensed Physical Therapist
   - Licensed Occupational Therapist
   - Registered Dietician
   - Board Registered or Licensed Nuclear Medicine Technologist
   - Board Registered or Licensed Radiologic Technologist
   - Dental Hygienist
   - Licensed speech language pathologist
   - Organ Procurement Coordinators (transplant program only)
   - Other disciplines as specifically approved by the Chief Medical Officer, and subsequently endorsed by the Medical Executive Committee

b. Verbal orders must be signed with credentials, dated and timed, read back and verified, and flagged for signature by the person accepting the order.

c. The name and pager ID/immediate contact information of the practitioner who

dictated the order must be documented.

d. All verbal orders (with the exception of verbal orders for restraint or seclusion or verbal orders for controlled substances) must be signed, timed, and dated by the practitioner, or designee (a physician member of the service team) who issued the order within fourteen (14) days after patient is discharged.

e. Verbal orders for Schedule II Controlled Substances must be signed, timed and dated **only by the practitioner** who issued the order within 48 hours. (SC Code Ann.Reg 61-4.908 and 909)

f. Unsigned verbal orders for controlled substances must be discontinued after forty-eight (48) hours.
- The responsible physician or dentist must be notified by a nurse of the discontinuation.
- Documentation of notification of the physician or dentist must occur in the medical record.

g. Verbal orders must not be accepted for certain high risk medications including chemotherapy agents and ~~,~~ investigational drugs. ~~or Do Not Resuscitate Orders~~. Immunosuppressants may not be initiated with verbal orders, however a verbal order for subsequent dose modifications may be accepted.

h. Non-licensed/certified personnel (i.e., unit secretaries, pharmacy technicians) may not give or accept verbal orders from either physicians or dentists under any circumstances.

i. The above applies to both paper and electronic medical record verbal order entry.

j. When using the electronic system, the appropriate physician must select the verbal order within the sign tab and then submit the order.

a. Another practitioner responsible for the patient's care and authorized by hospital policy to write orders may authenticate the verbal order in the absence of the practitioner originating the order.

V CONSULTATIONS

Who May Give Consultations

Any qualified practitioner with clinical privileges in the Medical Center can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the medical staff as stated below, the President of the Medical Staff, or the appropriate department chair, or the designee of either of the above, shall at all times have the right to call in a consultant or consultants.

i. Admission orders should be written and signed by the physician on service that is accepting the admitted patient.

Required Consultations

a. Consultation shall be required in all non-emergency cases whenever requested by

the patient or the patient's personal representative if the patient is incompetent. Consultations are also required in all cases in which, in the judgment of the attending physician:

1. the diagnosis is obscure after ordinary diagnostic procedures have been completed,
2. there is doubt as to the choice of therapeutic measures to be utilized,
3. unusually complicated situations are present that may require specific skills of other practitioners,
4. the patient exhibits severe symptoms of mental illness or psychosis.

~~b.~~ The attending practitioner is responsible for requesting consultation when indicated. ~~and for calling in a qualified consultant.~~

~~c.~~b. It shall be the responsibility of all individuals exercising clinical privileges, to obtain any required consultations, and requests for a consultation shall be entered on an appropriate form in the medical record. If the history and physical are not on the chart and the consultation form has not been completed, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.

~~d.~~c. It is the duty of the Credentials Committee, the Department Chair, and the Medical Executive Committee, to make certain that appointees to the staff request consultations when needed.

Contents of Consultation Report

Consultations will be completed within 24 hours for inpatients. Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record within 24 hours of completion of the consultation. While the consultant may acknowledge data gathered by a member of the house staff, a limited statement, such as "I concur" alone does not constitute an acceptable consultation report. When operative or invasive procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date and time of the consultation and the signature of the consultant.

Emergency Department Consultations

Specialists who are requested as consultants to the Emergency Department (ED) must respond in a timely fashion as per reference to Medical Center Policy #C – 190 ~~(replacing #C – 040)~~. In addition, any specialist who provides a consultation in the ED for a patient with an urgent condition is responsible for providing or arranging follow-up care. It is the policy of the ED that all patients are seen by an attending physician physically present in the ED. House staff evaluating patients in the ED for the purpose of consultation will confer with the responsible attending within their given specialty who is physically present in the ED. When such an attending is not physically present, the attending physician responsible for overseeing the patient's care will default to the ED attending physician while in the ED.

VI SUBSTANCE ABUSE/PSYCHIATRIC PATIENTS

Any patient known to be suicidal in intent or with a primary diagnosis of substance abuse or psychiatric disorder shall be admitted to the appropriate psychiatric unit. If there are no accommodations available in this area, the patient shall be referred to another institution where suitable facilities are available. In the event that the patient has a non-psychiatric condition which requires treatment at the Medical Center and no accommodations are available in the Institute of Psychiatry, the patient may be admitted to another unit of the Medical Center~~. only after consultation with the Executive Medical Director or his designee and the assigned Medical Director of the relevant service.~~ Explicit orders regarding precautionary measures are required.

Any patient known or suspected to be suicidal or with a primary diagnosis ~~or substance abuse or~~ of a psychiatric disorder who is admitted to a non-psychiatric unit must have consultation by a Medical Staff member of the psychiatric staff.

All patients admitted to a non-psychiatric unit while awaiting transfer will be medically assessed and stabilized before transfer. The care of such patients will remain with the attending MD until transfer or discharge.

Patients exhibiting symptoms of a psychiatric disorder or substance abuse while hospitalized with a medical/surgical diagnosis will have a consultation by a physician or a member of the Department of Psychiatry.

VII MODERATE AND DEEP SEDATION

Moderate sedation will be administered under the immediate direct supervision of a physician, dentist, or other practitioner who is clinically privileged to perform moderate sedation. Moderate sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/Analgesia"

Deep sedation/analgesia will be administered only by an anesthesiologist, CRNA or a physician holding appropriate clinical privileges. Deep sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/ Analgesia".

VIII PATIENT DISCHARGE

Who May Discharge

Patients shall be discharged only ~~on the order~~ under the direction of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient will be asked to sign the Medical Center's hospital release form.

Discharge of Minors and Other Incompetent Patients

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or

guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

Transfer of Patient
Patients may be transferred to another medical care facility after arrangements for transfer and admission to the facility have been made. Clinical records of sufficient content to ensure continuity of care shall accompany the patient.

Death of Patient
Should a patient die while being treated at the Medical Center, the attending physician ~~should~~ shall be notified immediately. A practitioner will pronounce the patient dead, notify the family ASAP, and request and document permission to perform an autopsy, when applicable.

Methods for Obtaining an Autopsy
Methods for obtaining an autopsy shall include:

a. The family requests an autopsy

b. The death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County
   - The attending physician requests an autopsy based on the College of American Pathologists criteria and Medical Center #C-16 "Decedent Care Program".

c. No autopsy shall be performed without written consent of a responsible relative or authorized person unless ordered by the Coroner/Medical Examiner of Charleston County.

Duties of the Physician for Obtaining an Autopsy
a. Determine whether the death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County. (Refer to “A Guide to the Autopsy for Physicians and Nurses.”)

b. Obtain permits for organ donation when applicable according to the Organ Procurement, Medical Center Policy #C-17 "Organ/Tissue Donation".

c. Documentation of request for autopsy must be completed, authenticated, and placed in the medical record.

Scope of Autopsy
a. The scope of the autopsy should be sufficiently completed in order to answer all questions posed by the attending physician and by the pathologist, upon review of the clinical database.

b. The autopsy report should include: a summary of the clinical history, diagnoses, gross descriptions, microscopic descriptions, and a final summary that includes a clinicopathologic correlation.

c. The autopsy findings should be promptly communicated to the attending physician along with all additional information the pathologist considers relevant to the case

d. The results of autopsies will be monitored as a part of performance improvement.

IX HOSPITAL ADMISSION CENSUS

In situations where the hospital bed occupancy is full, the Medical Center may reference and implement the Emergency Patient Placement Policy (EP3 Policy).

X MAYDAY PROCEDURE

In the event that a clinical emergency situation arises within the Medical Center or within any University area designated in the Medical Center Policy #C-14 "Medical Emergency Response". Medical Staff are to follow specific duties as outlined in the policy.

~~I~~XI EMERGENCY MEDICAL SCREENING

Any individual who presents in the Emergency Department or other department of the Medical Center either by him or herself, or by way of an accompanied party, and requests an examination for treatment of a medical condition must be screened by an appropriate practitioner to determine whether or not an emergency medical condition exists. Individuals qualified to provide this medical screen include attending physicians, house staff, nurse practitioners, and physician assistants.

XII PATIENT SAFETY INITIATIVES

All members of the medical staff are required to follow all guidelines/policies related the National Patient Safety Goals and other patient safety initiatives. These policies include but are not limited to:

Patient Safety C-76
Verbal Orders - C-56
Notification of Critical Values - C-80
Time Out-Universal Protocol (Wrong Site, Wrong Procedure, Wrong Person Surgery/Procedure) C-25
Use of Abbreviations C-21
Sentinel Events C-49
Patient Identification C-58
Hand Hygiene IC-27
Medication Reconciliation C-146

XIII HOUSE STAFF/RESIDENT PHYSICIANS

House staff (post graduate physician practitioners in specialty or sub-specialty training) at the MUSC Medical Center shall not be eligible to become appointees of the active medical staff and shall not be eligible to admit patients. They are authorized to carry out those duties and functions normally engaged in by house staff according to their defined job descriptions and/or scope of practice under the supervision of an appointee of the active medical staff. Supervision of residents is required. Supervision includes but is not limited

to counter signature in the medical record by the attending, participation by the resident in rounds, one on one conference between the resident and attending, and the attending physician's observation of care being delivered by the resident. Active medical staff members are required to supervise students as specified in Medical Center policy C-74, Resident Supervision. Appropriately credentialed fellows while serving as attending physicians are excluded from these requirements.

XIV~~I~~ 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.

MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA

Credentials Manual Proposed Revisions

- Revised membership tenure of Credentials Committee Chairperson: The appointment for Chairperson shall be for a three (3) year term with eligibility for reappointment for two (2) additional terms (changed from 1 term to 2).

- Revised communication timeframes in accordance with NCQA requirements: after Board of Trustees' decisions on appointment and reappointment, the timeframe for notification to the practitioner changed from thirty (30) days to ten (10) days.

MUSC Medical Center

Credentialing
Policy and Procedure Manual

Revised: ~~May 2009~~October 2013
~~Reviewed: February 2011~~

I. Credentialing Process

The credentialing process involves the following: 1) assessment of the professional and personal background of each practitioner seeking privileges; 2) assignment of privileges appropriate for the clinician's training and experience; 3) ongoing monitoring of the professional activities of each staff member; and 4) periodic reappointment to the medical or professional staff on the basis of objectively measured performance.

A. Purpose

To define the policies and procedures used in the appointment, reappointment, and privileging of all licensed independent practitioners or allied health practitioners who provide patient care services at MUSC Medical Center and other designated clinical facilities. Credentialing is the process of determining whether an applicant for appointment is qualified for membership and/or clinical privileges based on established professional criteria. Credentialing involves a series of activities designed to verify and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical or professional staff, and /or recommendations to grant or deny initial or renewed privileges.

B. Scope

Although appointment or reappointment and the granting or renewal of clinical privileges generally happens at the same time, they are two different activities of the credentials process. Applicants to some categories of the Medical Staff may not necessarily request or be granted privileges, and applicants for privileges need not necessarily be members of the Medical Staff. Therefore, the MUSC Medical Center Credentialing Policy and Procedure Manual applies to all Medical Staff members with or without delineated clinical privileges as well as other licensed independent practitioners and allied health professionals, who while not Medical Staff members, are considered professional staff appointees and are credentialed through the organized Medical Staff credentials process.

C. Credentials Committee

1. Purpose

To review requests for initial appointments and reappointments to the Medical and Professional Staffs and to review all requests for initial or renewed clinical privileges. The Credentials Committee reviews completed applications for appointment and reappointment and for any clinical privilege request after approval by the appropriate Department Chairperson. The Credentials Committee may make recommendations to approve/deny or delay appointments, reappointments and/or privileges.

2. Membership

The Chairperson of the Credentials Committee is appointed by the Vice President for Medical Affairs (or his/her designee) as recommended by the Executive Medical Director of MUSC Medical Center. The appointment for Chairperson shall be for a three (3) year term with eligibility for reappointment for ~~one (1)~~two additional ~~year~~ terms. Members of the Credentials Committee are recommended by Department Chairpersons at the request of the President of the Medical Staff and /or the Executive Medical Director of MUSC Medical Center. Appointment for members shall be a three (3) year term, with eligibility for reappointment for an additional three (3) year term.

3. Reporting Channels

The Credentials Committee reports to and makes credentials recommendations directly to the Medical Executive Committee.

4. Meetings

The Credentials Committee meets monthly or at the request of the Chairperson.

5. Minutes

The Credentials Committee shall document meetings with minutes. Minutes of the meeting are reported to the Medical Executive Committee.

D. Confidentiality

All credentials files will be kept in cabinets in secured offices within the MSO. Access to credentials files is limited to the following: appropriate MSO staff, members of the Credentials Committee, members of the Medical Executive Committee, MUSC legal counsel, Medical Center Risk Management, Department/Division Chairpersons of physician's specialty, the President of the Medical Staff, the Executive Director, the Executive Medical Director and others who may be otherwise authorized. These files shall be privileged pursuant to Medical Staff credentials files are the property of the MUSC Medical Center.

II. CLASSIFICATION OF APPOINTED PRACTITIONERS

A. Conditions and Requirements for Appointment to the Medical Staff

Appointment to the Medical Staff of MUSC Medical Center is a prerogative that shall be extended only to competent professionals, who continuously meet the qualifications,

standards, and requirements set forth in the Bylaws, the Credentialing Manual and associated policies of the MUSC Medical Staff.

B. Qualifications for Medical Staff Membership

Only practitioners with Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD) degrees holding a current, valid license to practice in the State of South Carolina shall be qualified for clinical privileges and appointment to the Medical Staff. To be considered for appointment and clinical privileges at MUSC Medical Center, an applicant must meet all of the following criteria:

- Have a valid and unrestricted medical/dental license to practice in the State of South Carolina;
- Be board certified or eligible to obtain board certification in his/her respective specialty (AMNAONABMS APPROVED) unless the Department Chairperson requests otherwise based on demonstrated equivalent competency. A five 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 practitioners who are not board certified or are more than five years out from initial eligibility are required to attain board certification within 2 years. The exception to this is any medical staff member appointed before December 12, 1992;
- Maintain a Federal DEA number and State DHEC License/Certification where applicable;
- Be a faculty member of the Medical University of South Carolina;
- Provide satisfactory evidence of appropriate training, education, and competency in the designated specialty;
- Hold current professional malpractice insurance at levels acceptable to MUSC Medical Center.

C. Medical Staff Appointment with Privileges

1. Active Medical Staff

The Active Medical Staff shall consist of full-time and part-time practitioners with Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD) degrees who are professionally responsible for specific patient care and/or education and/or research activities in the healthcare system and who assume all the functions and responsibilities of membership on the active staff. Fellows who practice as attendings must be appointed to the Medical Staff and granted privileges through the credentials process for the services they provide as attendings.

Prerogatives: Members of the active medical staff shall be appointed to a specific

department or service line with the following prerogatives:

- Exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Bylaws, Rules and Regulations and Credentials Manual of the Medical Staff or by specific privilege restriction.
- Vote on all matters presented at general and special meetings of the Medical Staff, and of the Department and Committees on which he/she is appointed.
- Hold office, sit on or be Chairperson of any committee, unless otherwise specified elsewhere in Medical Staff Bylaws.
- May request admitting privileges. Dentists are not eligible for admitting privileges.

Responsibilities: Appointees to this category must:

- Contribute to the organizational and administrative affairs of the Medical Staff.
- Actively participate in recognized functions of staff appointment, including professional practice evaluation, performance improvement and other monitoring activities.
- Monitor practitioners with new privileges during a focused review period.
- Accept individual responsibilities in the supervision and training of students and House Staff members as assigned by their respective department, division or section head and according to Medical Center Policy C-74 “Resident Supervision”.
- Participate in the emergency room and other specialty coverage programs as scheduled or as required by the Executive Medical Director, Medical Executive Committee or Department Chairperson.

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 of the Medical Staff Bylaws.

2. Affiliate Medical Staff

The Affiliate Medical Staff shall consist of physicians and dentists, who are responsible for supplementing the practice of members of the active staff in their roles in education, patient care and/or research. Affiliate staff members may refer a patient to an active staff member, refer and follow a patient when appropriately privileged, or admit and attend to patients when appropriately privileged. Only those Affiliate Staff who admit or attend to patients shall be required to participate in professional practice evaluation including ongoing and focused review.

Prerogatives: Affiliate Medical Staff will be appointed to a specific department or service line with the following prerogatives:

- Exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Bylaws, Rules and Regulations and Credentialing Manual of the Medical Staff or by specific privilege restriction.
- Attend meetings of the Staff and Department to which he/she is appointed and any staff or MUSC Medical Center education programs.
- May request admitting privileges. Dentists are not eligible for admitting privileges.

Restrictions: Appointees to the Affiliate Category do not have general Medical Staff voting privileges.

D. Medical Staff Appointment Without Privileges

1. Honorary/Administrative Members

Honorary or administrative members are in administrative positions and have no clinical privileges. 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 in the MUSC Medical Center. They may, however, attend Medical Staff and department meetings. This category is exempt from the malpractice insurance requirements, Board Certification requirements, and routine clinical quality requirements unless required within their position description.

E. Professional Staff Appointment with Privileges

1. Allied Health Practitioners

Allied Health Practitioners are those health professionals who:

- Are licensed in the state with a doctorate in psychology, or are licensed as advanced practice nurses, physician assistants, optometrists, podiatrists, or acupuncturists;
- Are others who are appropriately licensed or certified and are designated as Allied Health Practitioners by the Governing Board;
- Are subject to licensure requirements or other legal limitations, exercise independent judgment within areas of their professional competence; and
- Are qualified to render direct or indirect care as delineated in their respective scopes of practice, job descriptions, or privileging forms.

All matters relating to delineated clinical privileges/protocols and responsibilities of these individuals shall be in accordance with information in this manual.

2. Physician Extenders (Allied Health External)

This category of practitioners shall consist of physician assistants, advanced practice nurses and or clinical technologists, who are employees of a Medical Staff Member. These physician extenders must be privileged through the Medical Staff credentials process. These physician extenders are qualified to render direct or indirect care only as

delineated in their respective scopes of practice, job descriptions, or privileging forms.

III. Initial Appointment Application

A. Pre-application Request Form

A written pre-application form furnished by the Medical Staff Office or the Credentials Verification Organization (CVO) must be completed and signed by the applicant and approved by the appropriate Department Chairperson for either Medical Staff or Professional Staff appointment and/or request for initial privileges. The applicant must be deemed qualified for membership and/or privileges as outlined in the MUSC Medical Staff Bylaws and Credentialing Manual before an application is given to the applicant.

B. Nature of the Application

Each applicant shall complete the online application provided by the Medical Staff Office via the CVO.

C. Application Requirements

The initial application shall include:

- Information pertaining to professional licensure including a request for information regarding previously successful or currently pending challenges, if any, to any licensure or registration or whether any of the following license or registration has ever been voluntarily or involuntarily revoked, suspended, reduced, denied, relinquished, or not renewed:
  - Board certification
  - License to practice
  - State DHEC and federal DEA license or certification;
- State DHEC and federal DEA license or certification, if applicable;
- Specialty board certification/eligibility;
- Professional education, training, and experience;
- Information pertaining to malpractice coverage and claims history including current and past liability insurance coverage in amounts that may be determined from time to time and at any time by the Board with relevant Medical Executive Committee input, and about current and past liability malpractice judgments, suits, claims, settlements and any pending liability action as well as any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final action against the applicant;
- Statement of current health status by the applicant that includes the ability to perform the requested privileges, any history of alcohol or substance abuse or conviction for DUI, and a current PPD;
- Information regarding any negative action by a governmental agency or conviction of a felony or a crime involving moral turpitude;

- Information about the applicant's loss, revocation, voluntary or involuntary relinquishment of clinical privileges at other institutions Information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, denied, relinquished, challenged, or not renewed at any other hospital or health care institution;
- Membership in professional societies;
- Documentation of faculty appointment (applicants for medical staff appointment only);
- Peer recommendations: Names and complete addresses of three (3) professional references from colleagues who have knowledge of current clinical abilities;
- Practice history: Any gaps exceeding 6 months will be reviewed and clarified either verbally or in writing. Lapses in service greater than 60 days may prompt review and request for additional information;
- Request for Medical Staff or Professional Staff membership category and/or clinical privileges;
- Release form; and
- Any additional information required by the Medical Executive Committee, relevant clinical department, Credentials Committee, and/or Board, to adequately evaluate the applicant. Failure by the applicant to provide truthful, accurate and complete information may in itself be grounds for denial or revocation of staff membership/appointment and clinical privileges.

D. Applicant's Responsibility for Producing Information:

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, ability to work with other professionals and non-professionals in the Medical Center, and other qualifications, and for resolving any doubts about such qualifications. This could include:

- Current copy of South Carolina license and DEA certificate;
- Copies of certificates showing evidence of completion of education and training, if available;
- Copy of Board Certification certificate, if applicable;
- Current and dated curriculum vitae (month/year format) outlining education and practice history with written explanations of gaps greater than thirty (30) days;
- Copy of certificate evidencing professional liability insurance coverage;
- A valid state identification card, drivers license, or passport photograph of self;
- Any additional information required in response to questions on the application form; and
- A statement as to the correctness and completeness of the application and a signed attestation of the penalty for misrepresenting, falsifying or concealing information.

E. Applicant's Agreement

The following is required of all applicants for appointment and/or initial privileges, for reappointment and/or renewal of privileges and when requesting an increase in privileges:

- That he/she has received, has read, and agrees to be bound by the MUSC Medical Staff bylaws, rules and regulations, Credentials manual and related policies;
- That he/she is willing to appear for an interview as part of the application process;
- That he/she is responsible for truth, accuracy and completeness of information provided;
- That he/she is responsible for conducting adequate medical/professional activity as determined by each Medical Staff Department to allow for evaluation by the Medical Executive Committee;
- That he/she is bound to the continuous care of patients under his/her care;
- That he/she will attest to their qualifications to perform the clinical privileges requested;
- That he/she will not practice outside the scope of his/her granted privileges including the settings in which such privileges may be practiced;
- That he/she will provide supervision and oversight of house staff and others for whom he/she has responsibility;
- That he/she will adhere to all MUSC Medical Center's policies and procedures that govern clinical practice; and
- That he/ she will adhere to the MUSC Standards of Behavior.

Release: In connection with the application, applicants agree to release from liability the Medical University of South Carolina, its employees, agents, Trustees, Medical Staff, and their representatives, for their acts performed in good faith and without malice, in connection with evaluating and making recommendations and decisions based upon their application, credentials, and qualifications for staff membership and clinical privileges. In addition, the applicant shall:

- Consent to inspection by MUSC Medical Center of all records and documents it may deem material to the evaluation of his/her qualifications and competence to carry out the privileges he/she is seeking, physical and mental health status, and professional and ethical qualifications;
- Release from any liability all authorized individuals and organizations who provide requested information to MUSC Medical Center or its representative concerning his/her competence, professional ethics, character, physical and mental health, quality of care, and other qualifications for appointment and/or privileges; and
- Authorize and consent to MUSC Medical Center representatives providing other authorized organizations, including managed care organizations, surveyors, and auditors, information concerning his/her professional competence, ethics, character and other qualifications, only as necessary to complete accreditation, contracting, and/or utilization reviews or as otherwise required by law. Such organizations will be required to hold the information as privileged and confidential (as defined in SC State Law) and such information may not be further released or utilized in any other manner.

F. Applicant's Rights Regarding Information:

The applicant for membership and/or privileges has the following rights:

- The right to review any information he/she submitted with the application for appointment, reappointment, or clinical privileges. If requested, the practitioner may be provided a summary of information gathered in the credentialing process without

identifying the source unless required to be released by law. Information may only be viewed in the Medical Staff Office under the supervision of an authorized representative of the MSO staff;
- The right to correct erroneous information;
- The right, upon request, to be informed of the status of his/her credentialing application.

G. Verification Process:

After receipt of the completed application for membership, the Medical Staff Office via the CVO will collect and verify the references, licensure and other qualification evidence submitted. Primary source verification will be conducted regarding current licensure, relevant training, and current competence. When collection and verification is completed, the CVO will promptly transmit the application and supporting material to the department in which the applicant seeks clinical privileges.
Verification will include the following:

- Verification of South Carolina license directly with the State Licensing Board, and other state licenses by receipt of information from either the appropriate State Licensing Board or the Federation of State Medical Boards;
- Verification of graduation from medical school (for Medical Staff appointees only);
- Verification of postgraduate professional training;
- Verification of board certification through the use of the Directory of the American Board of Medical Specialties, directly with the appropriate specialty board or via internet, where applicable (for Medical Staff appointees, only);
- Verification and status of past and current hospital affiliations;
- Group practice affiliations during the past seven years, if applicable;
- Current and past malpractice insurance information from malpractice carriers concerning coverage, claims, suits, and settlements during the past five years;
- Information from the National Practitioner Data Bank;
- Evidence of Medicare/Medicaid sanctions or investigations from websites of the Office of the Inspector General and Excluded Parties Listing System;
- Three peer references that are able to provide information about the applicant's current clinical competence, relationship with colleagues, and conduct. Professional references will include an assessment of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. Reference letters of an ambiguous or noncommittal nature may be acceptable grounds for refusal to grant Medical or Professional Staff membership or clinical privileges;
- Relevant practitioner specific data compared to aggregate when available including mortality and morbidity data; and,
- Any other relevant information requested from any person, organization, or society that has knowledge of the applicant's clinical ability, ethical character, and ability to work with others.

H. Inability to Obtain Information:

The practitioner has the burden of producing any information requested by the Medical Center or its authorized representatives that is reasonably necessary, in the sole discretion of the Medical Center, to evaluate whether or not the practitioner meets the criteria for Medical or Professional Staff membership or privileges.

If there is delay in obtaining such required information, or if the Medical Center requires clarification of such information, the MSO or CVO will request the applicant's assistance. Under these circumstances, the medical staff may modify its usual and customary time periods for processing the application or reapplication. The Medical Center has sole discretion for determining what constitutes an adequate response.

If, during the process of initial application or reapplication, the applicant fails to respond adequately within 15 days to a request for information or assistance, the Medical Center will deem the application or reapplication as being withdrawn voluntarily. The result of the withdrawal is automatic termination of the application or reapplication process. The Medical Center will not consider the termination an adverse action. Therefore, the applicant or re-applicant is not entitled to a fair hearing or appeal consistent with the Medical Staff's fair hearing plan. The Medical Center will not report the action to any external agency. The applicant shall be notified in writing that the application has been deemed a voluntary withdrawal.

When trying to verify the information supplied by the applicant, if a particular entry has closed or ceased to operate and information cannot be verified because the source no longer exists, and after all avenues have been thoroughly tried, the verification will be deemed complete. Due diligence is defined as the Medical Staff Office and/or the CVO attempting to obtain the verification at least three times. The file will be presented to the Department Chairperson for review and approval with the unverified item noted.

IV. Initial Appointment and Privileging Process

A. Review/Approval Process

All initial appointments and requests for initial privileges will be reviewed as outlined below. Final approval rests with the Governing Body of MUSC Medical Center. The time from the date of application attestation to final Board decision, including all the steps outlined in the appointment or privileging process, cannot exceed 180 days.

B. Departmental Chairperson Review

Once all required application documentation has been received and processed by the Medical Staff Office and/or the CVO, and all verifications and references confirmed, the Chairperson of the applicable Department or Division Chief, if appropriate, shall then review the application, and, at his/her discretion, conduct a personal interview. Upon completion of this review, the Chairperson shall make a recommendation as to the extent of clinical privileges and the proposed category of the Medical Staff or Professional Staff.

The application with his/her recommendation shall then be returned to the Medical Staff Office or CVO for transmission to the Credentials Committee.

C. Credentials Committee Review

Following review by the appropriate Department Chairperson, the Credentials Committee shall review the application and supporting documentation, including all written documentation, along with the recommendations made to the Credentials Committee by the Department Chairperson. The Credentials Committee then either defers action or prepares a written report for the Medical Executive Committee for consideration at its next regularly scheduled meeting. The written report will contain recommendations for approval or denial, or any special limitations on staff appointment, category of staff membership and prerogatives, clinical service affiliation, and/or scope of clinical privileges. If the Credentials Committee requires further information about an applicant, it may request the applicant to appear before the committee. Notification by the Credentials Committee Chairperson or the Executive Medical Director through the Medical Staff Office shall be promptly given to the applicant if the Credentials Committee requires further information about the applicant.

D. Medical Executive Committee Action

The Medical Executive Committee, at its next regular meeting, reviews the application, the supporting documentation, the reports and recommendations from the Department Chairperson and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee defers action on the application or prepares a written report with recommendations for approval or denial, or any special limitations on staff appointment, category of staff membership and prerogatives, departmental affiliation, and/or scope of clinical privileges.

Effect of Medical Executive Committee Action

1. Deferral
   Action by the Medical Executive Committee to defer the application for further consideration must be followed up in a timely manner with subsequent recommendations as to approval or denial of, or any special limitations on Staff appointment, category of Staff membership and prerogatives, department affiliation, and scope and setting of clinical privileges. The Executive Director or the Executive Medical Director through the Medical Staff Office promptly sends the applicant written notice of an action to defer.

2. Recommendation for Approval

When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the Medical Executive Committee promptly forwards it, together with supporting documentation, to the Board for review at the next scheduled Board Meeting.

3. Adverse Recommendation
   When the Medical Executive Committee's recommendation to the Board is adverse to the applicant, the Executive Director or the Executive Medical Director or their designee through the Medical Staff Office, so informs the applicant within 30 days by special notice with return receipt or written attestation required, and the applicant is then entitled to the procedural rights as provided in Article IX of the Bylaws. An "adverse recommendation" by the Medical Executive Committee is defined as a recommendation to deny, in full or in part, appointment, membership, requested staff category, requested departmental assignment, and/or requested clinical privileges. No such adverse recommendation needs to be forwarded to the Board until after the practitioner has exercised his procedural rights or has been deemed to have waived his/her right to a hearing as provided in the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

E. Board Action

The Board may adopt or reject, in whole or in part, a recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee.

Effect of Board Action

1. Deferral
   The Board may send a recommendation back to the Medical Executive Committee. Any such referral back, shall state the reasons therefore, shall set a time within thirty (30) days in which a subsequent recommendation to the Board shall be made, and may include a directive that a hearing be conducted to clarify issues which are in doubt. At its next regular meeting within ~~thirty (30~~ten (10) days after receipt of such subsequent recommendation and new evidence in the matter, if any, the Board shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for staff membership.

2. Approval
   When the Board has reached a favorable decision, the Executive Director or the Executive Medical Director or their designee through the Medical Staff Office, by written notice, will inform the applicant of that decision within ~~30~~10 days. Notice of the Board's decision is also given through the Medical Staff Office to the Medical Executive Committee, and to the Chairperson of the respective department.

   A decision and notice to appoint includes:

a) The Staff category to which the applicant is appointed (if applicable);
b) The clinical department to which he is assigned;
c) The clinical privileges he may exercise; and
d) Any special conditions attached to the appointment.

3. Adverse Action

"Adverse action" by the Board means action to deny, in full or in part, appointment, membership, requested staff category, requested departmental assignment, and/or requested clinical privileges.

If the Board's decision is adverse to the applicant, the Chief Executive Office or the Executive Medical Director or their designee through the Medical Staff Office, within ~~30~~10 days so informs the applicant by special notice, with return receipt or written attestation required, and the applicant is then entitled to the procedural rights as provided in Article IX of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

Report of adverse Board action shall be given by the Executive Director or the Executive Medical Director through the Medical Staff Office to the National Practitioner Data Bank.

4. Expedited Action

To expedite appointment, reappointment, or renewal or modification of clinical privileges, the governing body may delegate the authority to render those decisions to an ad hoc committee consisting of at least two governing body members.

Following a recommendation for approval from the Medical Executive Committee on an application, the committee of the governing body shall review and evaluate the qualifications and competency of the practitioner applying for appointment, reappointment, or renewal or modification of clinical privileges and render its decision. An approval by the committee will result in the status or privileges requested. The committee shall meet as often as necessary as determined by its Chairperson. The full governing body shall consider and, if appropriate, ratify all committee approvals at its next regularly scheduled meeting. If the committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

An applicant will be ineligible for the expedited process if at the time of appointment or reappointment, any of the following have occurred:

- The applicant submits an incomplete application;
- The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
- There is a current challenge or a previously successful challenge to licensure or registration;
- The applicant has received an involuntary termination of medical staff membership at another organization;

- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- When there has been an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.

F. Provisional Appointment and Initial Privileges

Each initial appointment of an applicant for Active or Affiliate Medical Staff Membership or for appointment to the Professional Staff shall be a provisional appointment for (1) year. For all privileged practitioners this provisional period shall include an initial period of focused professional practice evaluation. Criteria for the focused evaluation of all practitioners requesting new privileges shall be determined by the Department Chairperson and/or the Division Director or their designee. The focused evaluation will include a monitoring plan specific to the requested privileges, the duration of the monitoring plan, and circumstances under which monitoring by an external source is required. Focused evaluation may be conducted by using chart review, direct observation, monitoring of diagnostic or treatment techniques, feedback from other professionals involved in patient care or other methodology determined by the Department. All new appointees must complete a focused evaluation during the provisional year; however, the focused evaluation period will be for a time frame determined by the Department Chairperson and/or the Division Director or their designee. Upon satisfactory completion of a focused professional practice evaluation, appointees will be required to follow the reappointment process. If at the end of the focused evaluation period a decision is made to deny privileges to the practitioner, the practitioner is afforded the rights outlined in the Fair Hearing Plan of the MUSC Medical Staff Bylaws.

V. Reappointment/Renewal of Privileges Application

A. Nature of the Application

Each applicant for reappointment and/or renewal of privileges shall complete and electronically sign the online application provided by the Medical Staff Office via the CVO.

B. Review/Approval Process

Reappointments to the Medical and Professional Staffs shall be for a period not to exceed two years. Reappointments and/or the renewal of privileges are not automatic and shall be based on information concerning the individual's performance, ability to work with other professionals at MUSC Medical Center, judgment, quality of care, and clinical skills. The reappointment/renewal process from time of application attestation to final Board decision cannot exceed 180 days.

C. Application for Reappointment Requirements

The application for reappointment is completed online and electronically signed. The application and supporting information will include:

- Current copy of license and, if applicable, State DHEC and Federal DEA certificate or license;
- Certificate of professional liability coverage;
- Request for clinical privileges;
- Information pertaining to malpractice claims activity including malpractice claims pending, or judgments or settlements made, as well as any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final action against the applicant;
- CME: In accordance with South Carolina Medical Board guidelines (40 hours every 2 years are required for renewal of South Carolina Medical License). The predominant number of hours must be related to the clinician's specialty. Professional staff will be required to complete the number of hours dictated by their respective license;
- Peer Recommendations: Medical staff are required to submit two (2) peer references from practitioners in the applicant's field with knowledge of their clinical abilities. These recommendations must include an assessment of current competence, health status and any relevant training or experience as well as the six general competencies. Professional staff are required to submit three (3) references: two (2) from current peers and one (1) from the current supervising physician (as applicable);
- Health status relative to ability to perform the clinical privileges requested;
- Current PPD;
- Chairperson Recommendation: Evaluation form electronically completed by Chairperson/Chairperson designee recommending privileges including documentation of health status or the ability to perform the requested privileges;
- Information from the National Practitioner Data Bank and HIPDB;
- Hospital Affiliations: Evaluation of clinical activities from other hospital affiliations;
- Current board certification or eligibility as outlined in the Medical Staff Bylaws;
- Information since initial appointment or previous appointment that includes:
- Details regarding previously successful or currently pending challenges, if any, to any licensure or registration or whether any of the following licenses or registrations have been voluntarily or involuntarily revoked, suspended, reduced, denied, relinquished, or not renewed:
  - Board certification
  - License to practice
  - State DHEC and/or federal DEA license or certification;
- Details about the applicant's loss, revocation, voluntary or involuntary relinquishment of clinical privileges at other institutions, information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, denied, relinquished, challenged, or not renewed at any other hospital or health care institutions, and voluntary or involuntary changes in membership, privileges, or status at other healthcare organizations;
- The results of Ongoing Professional Practice Evaluation and the results of any Focused Professional Practice Evaluations;
- Any additional practitioner specific data as compared to aggregate data, when available;
- Morbidity and mortality data, when available;

- Release of information; and
- Any additional information required by the Medical Executive Committee, relevant clinical department, Credentials Committee, and/or Board, to adequately evaluate the applicant. Failure by the applicant to provide truthful, accurate and complete information may in itself be grounds for denial or revocation of staff membership/appointment and clinical privileges.

D. Continuing Duties of Medical Staff and Professional Staff Members

It shall be a continuing duty of all Medical Staff and Professional Staff members to promptly update credentials information on an ongoing basis. This information shall include but not be limited to the following:

- Voluntary or involuntary termination of appointment, limitation or reduction or loss of privileges at any hospital, healthcare organization, or managed care organization, or any restriction of practice or severance from employment by a medical practice;
- Any investigations, charges, limitations or revocation of professional license in the State of South Carolina or any other state;
- Any investigations, charges, limitations, or corrective action by any professional organization;
- Changes in physical or mental health which effect ability to practice medicine;
- Change of address;
- Name changes;
- Any investigations, convictions, arrests, or charges related to any crime (other than minor traffic violations), including crimes involving child abuse;
- Any "quality query" from any qualified peer review organization, or its equivalent;
- Any investigations regarding reimbursement or billing practices;
- Any professional investigations or sanctions including but not limited to Medicare or Medicaid sanctions;
- Notification of cancellation or proposed cancellation of professional liability insurance;
- Disclosure and updates of malpractice claims or other actions initiated or made known subsequent to appointment; and,
- Any information reasonably required by the Medical Executive Committee or Board to adequately evaluate the staff members.

E. Ongoing Professional Practice Evaluation

During the appointment cycle, each practitioner with clinical privileges will be reviewed on an ongoing basis. Ongoing Professional Practice Evaluation (OPPE) is an evidenced based evaluation system designed to evaluate a practitioner's professional performance. The Department Chairperson is responsible for conducting OPPE for all practitioners with clinical privileges within their Department and for insuring that OPPE is uniformly applied to all members within the department. The type of data to be collected is approved by the Medical Executive Committee but is determined by individual departments and is uniformly applied. The frequency of data collection must be more often than yearly with specific

timeframes determined by the Medical Executive Committee in collaboration with the Executive ~~Executive~~ Medical Director. Information from ongoing professional practice evaluation will be used to determine whether to continue, limit, or revoke any existing privileges. It may also be used to trigger a Focused Professional Practice Evaluation (FPPE).

F. Insufficient Activity for Evaluation

Reappointment and reappraisal of clinical privileges focuses on a member's clinical activity and demonstrated clinical competence as it relates to Medical and Professional Staff quality monitoring and evaluation activity. Therefore, a practitioner (except those appointed to categories of the Medical Staff without privileges) who has not utilized the Medical Center and/or participated in Medical Center clinical activities for a continuous period of six (6) months, or has ceased to maintain an active professional practice within the service area of the Medical Center, and does not initiate leave of absence as provided in the Bylaws, or initiate an application in change of status, may have his/her membership on the Medical Staff terminated or reduced to a category commensurate with his/her current practice.

The Credentials Committee shall, upon request from the Department Chairperson, the Medical Executive Committee, or the Executive Medical Director, or upon its own initiative, investigate any circumstances which would authorize termination or reduction of membership or category under this paragraph and shall recommend to the Medical Executive Committee such action as it considers appropriate. Prior to making a recommendation, however, it shall notify the affected member of its investigation and request information as to the current status and intentions of the members. Said notice and request shall be in writing, fax, or e-mail and directed to the affected member. Practitioners who can document admission(s), consultations, or cross coverage activity may be considered for reappointment. In such instances, objective reports of clinical activity at their primary practice site must be submitted to allow an appropriate evaluation of the practitioner's request for clinical privileges.

Failure of the member to respond within thirty (30) days of correspondence of said notice shall constitute sufficient basis for termination of membership or reduction of staff category. Failure to be reappointed as outlined in this section constitutes an administrative action that shall not require reporting to the National Practitioner Data Bank. In addition, it shall constitute a waiver of procedural rights as defined in the MUSC Medical Staff Bylaws Article IX from action taken pursuant to the provision of this paragraph.

G. Failure to Complete the Reappointment Application

Failure to complete the application for reappointment by the time the reappointment is scheduled for the first step in the review process (i.e. Department review) shall be deemed a voluntary resignation from the Medical Staff or the Professional Staff and the practitioner's membership and/or privileges shall lapse at the end of his/her current term. The Practitioner shall be notified prior to final action by the Board through the Executive Director or the

Executive Medical Director. This non-renewal shall constitute an administrative action that shall not require reporting to the National Practitioner Data Bank and shall not entitle the practitioner to the procedural rights afforded by the MUSC Medical Center Medical Bylaws. Termination of an appointment in this way does not preclude the submission of a reapplication for initial privileges or membership.

H. Reappointment Verification Process

Upon receipt of a completed (signed and dated) application, the Medical Staff Office via the CVO will collect and verify through accepted sources the references, licensure and other qualification evidence submitted. The CVO will promptly notify the applicant of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information. The CVO will also notify the practitioner about any information obtained during the credentialing process that varies substantially from the information provided by the practitioner. Failure of the applicant to furnish information within fifteen (15) days of a request shall be deemed a withdrawal of such application. When collection and verification is completed, the CVO will promptly transmit the application and supporting material to the department in which the applicant seeks clinical privileges. The CVO will verify the contents of the application by collecting the following information:

- Primary source verification of current South Carolina licensure;
- Primary source verification of any training necessary for increase of privileges;
- Status of current DEA;
- Specialty Board status;
- Status of affiliations with other hospitals or healthcare organizations;
- Status of group affiliations;
- Status of malpractice claims history for the past five years;
- Peer recommendations;
- Information from the National Practitioner Data Bank; and
- Medicare/Medicaid sanctions and investigations from websites of the Office of Inspector General and the Excluded Parties Listing System.

VI. Reappointment/Privilege Renewal Review Process

A. Department Chairperson Review

The Department Chairperson evaluation of the applicants request for reappointment or privilege renewal shall be based upon the applicant's education, demonstrated ~~clnical~~clinical competencies including clinical judgment, technical skills and ability, and utilization patterns and other relevant information. Once all required documentation has been received and processed by the Medical Staff Office and/or the CVO, and all verifications and references confirmed, the Chairperson of the applicable Department or Division Chief, if appropriate, shall then review the application. Upon completion of this review, the Chairperson shall make a recommendation as to the reappointment and/or the extent of clinical privileges. The application with his/her recommendation as well as results

of ongoing professional practice evaluation and focused professional practice evaluation shall then be submitted for transmission to the Credentials Committee.

If prior to reappointment of a member to the Medical Staff, the Department Chairperson anticipates recommending an involuntary reduction or total denial of previously granted privileges at MUSC Medical Center, the Department Chairperson is required to notify in writing the affected member of the specific deficiencies, failure to meet specific deficiencies, failure to meet specific criteria, and/or other documentation supporting the reduction or denial of privileges. Notice shall also be sent to the Executive Medical Director, President of the Medical Staff and the Executive Director. Such notification will include adequate supporting documentation of the basis for reduction or non-renewal of privileges. This notice will be given in writing to the practitioner at least thirty (30) days before his/her reappointment date, unless there is a delay caused by the actions or inactions of the applicant, such as failing to file the credentialing application and information in a timely manner. This notification by the Department Chairperson shall trigger a review of the information and circumstances by the Executive Medical Director and the President of the Medical Staff. In the event of non-resolution, the Department Chairperson's recommendations shall be forwarded to the Credentials Committee with the supporting documentation. The decision, if adverse to the member may be appealed by the practitioner as outlined in the Fair Hearing Plan of the MUSC Medical Staff Bylaws (Article IX).

At the time of reappointment a Department Chairperson may request, based on physician specific quality information including technical skills, clinical judgment and behavior with supporting documentation to the Credentials Committee and the Medical Executive Committee, that a practitioner within his/her department be placed on a focused professional practice evaluation with proctoring or reporting requirements. The timeframe for this specific focused evaluation will be determined by the Department Chairperson with approval by the Credentials Committee and the Medical Executive Committee but may not exceed one year.

B. Credentials Committee Review

After approval of completed reappointment application with all attachments by the Department Chairperson/Chairperson Designee, the application is presented at the next regularly scheduled Credentials Committee meeting. The Credentials Committee members shall review the completed application and make a recommendation to approve, deny, or defer pending further evaluation/information. If the recommendation is to deny or defer pending additional information, the applicant and Chairperson must be informed in writing within seven (7) days after the meeting. If the recommendation is to approve, the applicants are presented at the next regularly scheduled Medical Executive Committee meeting. At the time of reappointment, the Credentials Committee may request based on practitioner specific quality information including technical skills, clinical judgment and behavior with supporting documentation to the Medical Executive Committee, that a practitioner be placed on a focused professional practice evaluation with proctoring or reporting requirements. The timeframe for this specific focused evaluation will be determined by the by the Credentials Committee and the Medical Executive Committee but may not exceed one year.

C. Medical Executive Committee Action

The Medical Executive Committee, at its next regular meeting, reviews the application, the supporting documentation, the reports and recommendations from the Department Chairperson and Credentials Committee, and any other relevant information available to it. The Medical Executive Committee defers action on the application or prepares a written report with recommendations as to approval or denial, or any special limitations on staff reappointment, category of staff membership and prerogatives, and/or scope of clinical privileges.

Effect of Medical Executive Committee Action

1. Deferral
   Action by the Medical Executive Committee to defer the application for further consideration must be followed up in a timely manner with subsequent recommendations as to approval or denial, or any special limitations on staff re-appointment, category of staff membership and prerogatives, and scope and setting of clinical privileges. The Executive Director or the Executive Medical Director through the Medical Staff Office promptly sends the applicant written notice of an action to defer.

2. Recommendation for Approval
   When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the Medical Executive Committee promptly forwards it, together with supporting documentation, to the Board for review at the next scheduled Board Meeting.

3. Adverse Recommendation
   When the Medical Executive Committee's recommendation to the Board is adverse to the applicant, the Executive Director or the Executive Medical Director or their designee through the Medical Staff Office, so informs the applicant within 30 days by special notice with return receipt or written attestation required, and the applicant is then entitled to the procedural rights as provided in Article IX of the Bylaws. An "adverse recommendation" by the Medical Executive Committee is defined as a recommendation to deny, in full or in part, reappointment, requested staff category, and/or requested clinical privileges. No such adverse recommendation needs to be forwarded to the Board until after the practitioner has exercised his procedural rights or has been deemed to have waived his/her right to a hearing as provided in the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

   At the time of reappointment the Medical Executive Committee may request, based on physician specific quality information including technical skills, clinical judgment and behavior with supporting documentation, that a practitioner be placed on a focused professional practice evaluation with proctoring or reporting requirements. The timeframe for this specific focused evaluation will be determined by the Medical Executive Committee and the Executive Medical Director but may not exceed one year.

D. Board's Action

The Board may adopt or reject, in whole or in part, a recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee.

Effects of Board Action

1. Deferral
   The Board may send a recommendation back to the Medical Executive Committee. Any such referral back, shall state the reasons therefore, shall set a time within thirty (30) days in which a subsequent recommendation to the Board shall be made, and may include a directive that a hearing be conducted to clarify issues which are in doubt. At its next regular meeting within ~~thirty (30~~ ten (10) days after receipt of such subsequent recommendation, and new evidence in the matter, if any, the Board shall make a decision either to provisionally appoint the practitioner to the staff or to reject him/her for staff membership.

2. Approval
   When the Board has reached a favorable decision, the Executive Director or the Executive Medical Director or their designee through the Medical Staff Office, by written notice, inform the applicant of that decision within ~~30~~10 days. Notice of the Board's decision is also given through the Medical Staff Office to the Medical Executive Committee, and to the Chairperson of the respective department. A decision and notice to reappoint includes:
   a) The staff category to which the applicant is reappointed (if applicable);
   b) The clinical privileges he/she may exercise; and
   c) Any special conditions attached to the reappointment.

3. Adverse Action
   "Adverse action" by the Board means action to deny, in full or in part, reappointment, requested staff category, or requested clinical privileges.

   If the Board's decision is adverse to the applicant, the Chief Executive Office or the Executive Medical Director or their designee through the Medical Staff Office, within ~~30~~10 days so informs the applicant by special notice, with return receipt or written attestation required, and the applicant is then entitled to the procedural rights as provided in Article IX of the Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

   Report of adverse Board action shall be given by the Executive Director or the Executive Medical Director through the Medical Staff Office to the National Practitioner Data Bank.

4. Expedited Action
   To expedite, reappointment, or renewal or modification of clinical privileges, the governing body may delegate the authority to render those decisions to an ad hoc

committee consisting of at least two governing body members.

Following a recommendation for approval from the Medical Executive Committee on an application, the committee of the governing body shall review and evaluate the qualifications and competency of the practitioner applying for reappointment, or renewal or modification of clinical privileges and render its decision. Approval by the committee will result in the status or privileges requested. The committee shall meet as often as necessary as determined by its Chairperson. The full governing body shall consider and, if appropriate, ratify all committee approvals ~~-~~at its next regularly scheduled meeting. If the committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

An applicant will be ineligible for the expedited process if since the last appointment or reappointment, any of the following have occurred:

- The applicant submits an incomplete application;
- The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
- There is a current challenge or a previously successful challenge to licensure or registration;
- The applicant has received an involuntary termination of medical staff membership at another organization;
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- When there has been an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.

VII. Privileges

A. Granting of Privileges

Evaluation of applicants for the privileges requested shall be based upon the applicant's education, training, experience, references, demonstrated clinical competencies including clinical judgment, technical skills and ability, and utilization patterns and other relevant information. This information is used to determine the types of care, treatment, and services or procedures that a practitioner will be authorized to perform.

Privileges may only be granted when sufficient space, equipment, staffing, and financial resources are in place and available or will be available in a specific timeframe to support the requested privilege.

It is the responsibility of the Department Chairperson, Credentials Committee, and the Medical Executive Committee to insure that privileges for all privileged practitioners are current and accurate. Privilege sets are maintained by the MSO office. These privileges sets may be either paper or electronic. It is the responsibility of the MSO to communicate

privilege lists to Medical Center staff in order to insure that privileged practitioners practice within the scope of their respective granted privileges.

Renewal of privileges and the increase or curtailment of the same, shall be based upon direct observation, review of the records, or any portion thereof, of patients treated in this or other hospitals, and review of the records of the practitioner which may document the member's participation in Medical Staff or Professional Staff responsibilities. Ongoing professional practice evaluations and the results of any focused professional practice evaluation will be considered as well as both physical and mental capabilities. The foundation for the renewal of privileges and the increase or curtailment of the same are the core competencies of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems based practice. The nonuse of any privilege as well as the emergence of new technologies will also be considered.

Practitioners may request an increase of privileges at any time during the appointment period by completing a change in privileging form included with the reappointment application, or if not during reappointment by requesting a change in privileges form from the Medical Staff Office. When a request is received in the Medical Staff Office with appropriate documentation, including the Department Chairperson's recommendation, the request will be forwarded to the Credentials Committee for review as a part of the reappointment process. If a change is requested at another time during the appointment cycle, the Medical Staff Office via the CVO will verify the following prior to submitting the request to the Credentials Committee:

- Current license and challenges to any licensure or registration
- Voluntary or involuntary relinquishment of any license or registration, or medical staff membership
- Voluntary or involuntary limitation, reduction, or loss of clinical privileges
- Involvement in a professional liability action including any final judgment or settlement
- Documentation of health status
- Practitioner specific quality information including mortality and morbidity data, if available
- Peer recommendations, and
- National Practitioner Data Bank Healthcare Integrity Data Bank Query

Practitioners who have had their clinical privileges withdrawn or curtailed for alleged lack of competency in accordance with the procedures outlined in the Medical Staff Bylaws shall not have them reinstated until the following requirements have been met:

- Active participation in a training program approved by the Department Chairperson with written approval of the Credentials Committee;
- Successful completion of Focused Professional Practice Evaluation to allow demonstration of such competency to their specific Department, Credentials Committee, and the Medical Executive Committee; and
- If executed, the practitioner's submission of a fair hearing plea in accordance with the

Medical Staff Bylaws has been resolved.

B. Medical Staff Temporary Privileges

Circumstances: There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable include the following:

- To fulfill an important patient care, treatment, and service need; or
- When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and Board.

Therefore, temporary privileges will be granted in the following circumstances:

1. Care of Specific Patients

Upon written concurrence of the Chairperson of the Department where the privileges will be exercised, an appropriately licensed practitioner who is not an applicant for staff membership but who has specific expertise in a desired field, may request temporary privileges for the care of one or more specific patients.

Application forms for this request are available in the Medical Staff Office. Before granting temporary privileges, the practitioner's current license and current competency are verified. Such privileges cannot exceed 120 days. These privileges are only available one time during the 120 day time period.

2. New Applicants

Temporary privileges for new applicants may be granted while awaiting review and approval by the Medical Executive Committee and Board. These "interim" temporary privileges may only be granted for 120 days and only upon verification of the following:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- Other criteria required by the organized Medical Staff Bylaws
- A query and evaluation of the NPDB information
- A complete application
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

Granting of Temporary Privileges: The Executive Director or his designee and/or the Executive Medical Director may grant temporary privileges when the available information reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested. The Department Chairperson or his designee will be responsible for the supervision of the applicant for temporary privileges.

Temporary privileges will not be granted unless the practitioner has attested to abide by the Bylaws and the Rules and Regulations of the Medical Staff of the MUSC Medical Center in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, said Bylaws and Rules and Regulations control in all matters relating to the exercise of temporary privileges.

Termination of Temporary Privileges: The Executive Medical Director or his/her designee and/or the Executive Director, after consultation with the appropriate Department Chairperson or designee may terminate a practitioner's temporary privileges at any time, and must terminate a practitioner's temporary privileges upon the discovery of information or the occurrence of an event that raises questions about the practitioner's professional qualifications or ability to exercise any or all of his/her temporary privileges. If it is determined that the practitioner is endangering the life or well-being of a patient, any person who has the authority to impose summary suspension may terminate the practitioner's temporary privileges.

If the Medical Center terminates a practitioner's temporary privileges, the Department Chairperson who is responsible for supervising the practitioner will assign all of the practitioner's patients who are in the Medical Center to another practitioner. When feasible, the Department Chairperson will consider the patients' wishes in choosing a substitute practitioner.

Rights of the Practitioner Who Has Temporary Privileges: In the following cases, a practitioner is not entitled to the procedural rights afforded by the hearing and appeal procedures outlined in the Medical Staff Bylaws:

- When his/her request for temporary privileges is refused; or
- When all or any part of his/her temporary privileges are terminated or suspended.

C. Disaster Privileges

During disaster(s) in which the disaster plan has been activated, the Executive Director of the Medical Center, the Executive Medical Director, or the President of the Medical Staff or their designee(s) may, if the Medical Center is unable to handle immediate and emergent patient needs, grant disaster privileges to individuals deemed qualified and competent, for the duration of the disaster situation according to the Medical Staff Bylaws and Clinical Policy C-35 Disaster Privileges for Licensed Independent Practitioners. Granting of these

privileges will be handled on a case by case basis and is not a "right" of the requesting provider.

D. Emergency Privileges

For the purpose of this section, an “emergency” is defined as a condition in which serious and permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

In the case of an emergency any practitioner, to the degree permitted by his license and regardless of Staff status or lack of it, shall be permitted and assigned to do everything possible to prevent serious and permanent harm or to save the life of a patient, using every facility of the Medical Center necessary, including calling for any consultation necessary or desirable. When an emergency situation no longer exists, the practitioner must request the privileges to continue to treat the patient. In the event such privileges are denied or he does not wish to request such privileges, the patient shall be assigned to a member of the Medical Staff by the appropriate Department Chairperson.
Under conditions of extreme patient risk, the President of the Medical Staff, the Executive Medical Director the appropriate Department Chairperson, Credentials Committee Chairperson, or the Executive Director (or his/her designee) may grant emergency privileges for that patient alone. These conditions would apply if the physician in question was the only one capable of rendering appropriate professional services (i.e. no qualified staff members were available). Such privileges shall be based on the information then available which may reasonably be relied upon to affirm the competency, ethical standing and licensure of the physician who desires such emergency privileges. In the exercise of such privileges, such physician shall act under the direct supervision of the Department Chairperson to which he/she is assigned, or under the direct supervision of a member of that Department selected by the Department Chairperson.

Revised 05/2009
Reviewed 11/2011
Revised 10/2013

Hospital Plan for Provision of Patient Care Services
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

We improve health and maximize quality of life through education, research, and patient care.

III. VISION STATEMENT

MUSC will be nationally recognized as a premier academic medical center.

We will *change what's possible* by relentlessly transforming expertise, learning and discovery into unrivaled care. As the State's leader in advanced care, we will improve the health of South Carolinians. Interdisciplinary teamwork, coordination and accountability across our unified clinical enterprise will generate the performance and resources that fuel the rising trajectory of our reputation.

IV. VALUE PROPOSITION

We transform expertise, learning and discovery into unrivaled patient-centered care in every setting.

V. STRATEGIC INTENT

To be recognized in the top 25 among academic medical centers for reputation, quality, service and financial performance by the year 2015.

VI. STRATEGIC PLAN

- Strategic planning is a fundamental business process crucial for growth and success.
- The MUSC Clinical Enterprise reviews and updates goals and strategies to ensure long term success of our organization.
- Mission 2015 represents the most current iteration of the strategic planning process.
- Strategic planning is a perpetual process.

VII. ORGANIZATIONAL VALUES

MUSC values are:

- Integrity
- Trust
- Respect
- Social Responsibility
- Fiscal Responsibility
- Cultural Competence
- Adaptability
- Sustainability

VIII. LEADERSHIP

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

- Providing a culture that fosters safety as a priority for all who work 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

IX. 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

X. 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.

XI. SCOPE OF SERVICES

The MUSC Medical Center has 709 beds, over 6500 Hospital Employees. 855 physicians, and over 600 Residents and Fellows, providing a full continuum of inpatient and outpatient care including:

- Average Daily Census – 560
- Patient Admissions – 45,000
- Surgical Cases – 28,000
- Emergency Room Visits – 80,000
- Outpatient Visits – 1,100,000

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 and units/areas:

LOCATIONS:

Main Site Includes:
• **Medical University Hospital**
• **Children's Hospital**
• **Clinical Sciences Building**
• **Hollings Cancer Center**
• **Storm Eye Institute**
• **Rutledge Tower**
Cardiopulmonary Rehab at 122 Bee Street, Charleston, SC
Family Medicine at 650 Ellis Oaks Drive, Charleston, SC
Women's Services at 135 Cannon Street, Charleston, SC
Institute of Psychiatry at 67 President Street, Charleston, SC
Childrens Day Treatment at 1001B Michigan Ave., N. Chas., SC
HCC Mt. Pleasant Radiation Oncology at 1180 Hospital Drive, Mt. Pleasant, SC
Seasons Adult Partial at 326 Calhoun Street, Charleston, SC
Ambulatory Care Procedures at 735 Johnnie Dodds Blvd., Mt. Pleasant, SC
Ashley River Tower at 316 Courtney Street, Charleston, SC
North Area Infusion Services at 8992 University Blvd., N. Charleston, SC
North Area Pediatrics After Hours at 2750 Dantzler Drive, N. Charleston, SC
Mt. Pleasant Pediatrics After Hours at 2705 Highway 17 North, Mt. Pleasant, SC

UNITS/AREAS:

EMERGENCY DEPARTMENTS	
Pediatric Emergency	1 CSB/1W
Adult ED	1 UH
Chest Pain Center	1 ART
PROCEDURAL AREAS	
6 Echo and Vascular Lab	6 UH
3 Neuro-Interventional Radiology	3 UH
6 Peds Cath Lab	6 CH
5 Peds Procedure Area and Endoscopy	5 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
SURGICAL SERVICES	
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
INPATIENT UNITS	
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
8 NSICU	8 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
OUTPATIENT AREAS	
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/Prosthedontics	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 QA/ PI Activities
Past QA/PI Activities
PATIENT SAFETY INITIATIVES
Description
ADDITIONAL STANDARDS OF PRACTICE ADOPTED/ADAPTED
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 QA/PI Activities
Past QA/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

2013 - 2014

Table of Contents

Approved Hospital Quality Operations November 16, 2011, October 3, 2013

Approved Board of Trustees

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. 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. When projects are launched or completed, those project milestones are approved by the Hospital Quality Operations Committee, comprised of service line and senior leadership. Progress on these projects are monitored/reported to the IMPROVE committee, comprised of leaders from quality, performance improvement, service lines, and strategic partners.

The full 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, Chief Quality Officer, Officers of the Medical Staff, Applicable Medical Leadership or designee, Applicable Service Line Administrator or designee, Chief Nursing Executive, and the Clinical Services Director of the affected area. The Director of Risk Management and the Manager of Patient Safety 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 events 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 a champion, a process owner, and a performance improvement facilitator. The champion 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. 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. The list of PMRs are reviewed and approved by Hospital Quality Operations annually.

3. Quality Monitoring Reports (QMR)

Quality Monitoring Reports are <u>focused</u> 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 be senior leadership on whether there needs to be a QMR

Before a project can become a QMR, it must be brought before the Hospital Quality Operations 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 a champion, a process owner, and a performance improvement facilitator. The champion 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 every other year.

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's clinical enterprise.

6. THE HOSPITAL QUALITY OPERATIONS COMMITTEE

PURPOSE:

The MUSC Hospital Quality Operations Committee 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. CLINICAL QUALITY & SAFETY OVERSIGHT COMMITTEE

PURPOSE:

Support Clinical Departments and Service lines in becoming a top 25 academic medical center
Specific Responsibilities:

1. Establishes priorities for each Clinical Department and Service Line based on top 25 gap analysis.
2. Monitors progress in closing performance gaps through standard reports from QAPI leaders.
3. Provides alignment and integration of across the clinical enterprise.
4. Reports on overall progress to the Clinical Leadership Council quarterly.

8. QAPI – QUALITY AND PERFORMANCE IMPROVEMENT TEAMS

PURPOSE:

Achieve top 25 Performance benchmarks for their specific specialty and service line.

Specific Responsibilities:

1. Ensure progress to closing identified gaps in performance for their area of responsibility.
2. Develop improvement plans and removes barriers to effective action.
3. Collaborate with other specialties, service lines and strategic partners when necessary.
4. Report progress quarterly to Clinical Quality and Oversight Committee.

9. 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 committees oversees the Quality Monitoring Reports (QMRs) process and ensures that the process adheres to a standard quality improvement methodology such as IMPROVE, LEAN, or Six Sigma. The Committee receives QMRs from the Hospital Operations Quality Committee, schedules timely review of the QMR, ensures that the QMR actions are appropriate to the iden**tified 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.**

10. 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 (See Section VII below) , 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.

11. 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 outline in Section VI.

12. 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

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 Performance Improvement web page: http://mcintranet.musc.edu/meddirector/I.M.P.R.O.V.E./TemplatesAndTools/index.htm.

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 quality 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 Network. 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

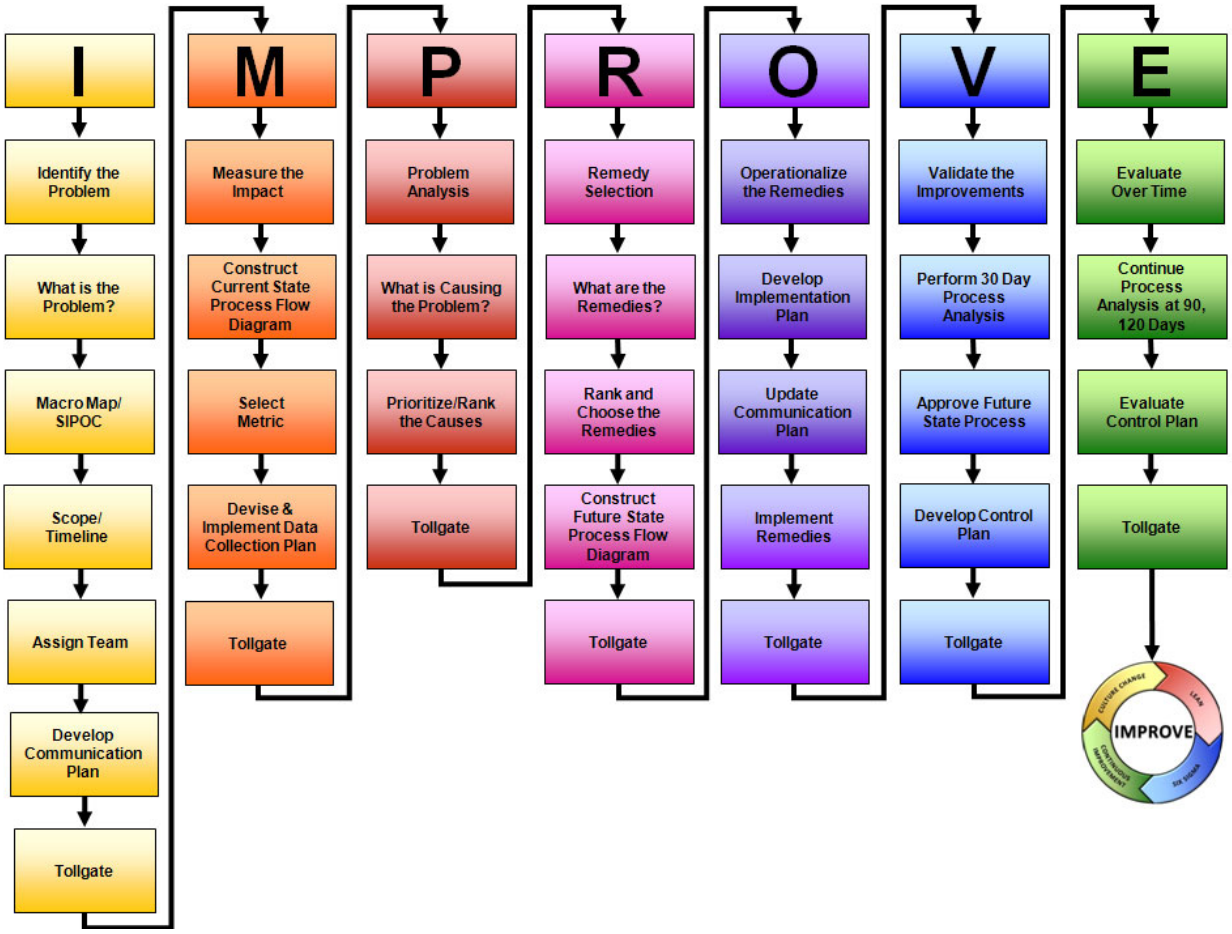
Multiple departments and disciplines contribute to the evaluation and improvement of clinical care delivery through their participation in the monitoring process and interdisciplinary committees and teams.

XI. ANNUAL EVALUATION

The Performance Improvement Plan will be reviewed and 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

APPENDIX A


I
Identify the Problem
What is the Problem?
Macro Map/ SIPOC
Scope/ Timeline
Assign Team
Develop Communication Plan
Tollgate
M
Measure the Impact
Construct Current State Process Flow Diagram
Select Metric
Devise & Implement Data Collection Plan
Tollgate
P
Problem Analysis
What is Causing the Problem?
Prioritize/Rank the Causes
Tollgate
R
Remedy Selection
What are the Remedies?
Rank and Choose the Remedies
Construct Future State Process Flow Diagram
Tollgate
O
Operationalize the Remedies
Develop Implementation Plan
Update Communication Plan
Implement Remedies
Tollgate
V
Validate the Improvements
Perform 30 Day Process Analysis
Approve Future State Process
Develop Control Plan
Tollgate
E
Evaluate Over Time
Continue Process Analysis at 90, 120 Days
Evaluate Control Plan
Tollgate
IMPROVE

Medical University of South Carolina
Solid Organ Transplant Service Line
Quality and Performance Improvement Plan

Design and Scope of Program

The Quality Assessment and Performance Improvement Plan (QAPI) encompass all solid organ transplant programs (kidney, pancreas, liver, heart and lung transplant) within the Transplant Service Line at the Medical University of South Carolina (MUSC). These programs aim to improve the quality of life of patients with end stage organ failure, MUSC has a dedicated multidisciplinary health care team to assist and facilitate patients through all three phases of their transplant experience (pre transplant, transplant, and post-transplant phases). These services are provided by medical physicians, surgeons, who are supported by nursing coordinators, financial counselors, Pharmacists, dieticians, social workers, data coordinators, clerical staff, research personnel, and Transplant Administration.

The Service Line is governed by a Service Line Administrator, and a Transplant surgeon/physician who is the Medical Director. The Management team of the service line consists of a Clinical Manager, and Quality, Compliance coordinators, and a Business Manager.

The Transplant Executive Quality Council- ALL QAPI oversees the quality, assessment, and performance improvement functions within the service line and is responsible for facilitating clinical, procedural, or operational change for enhanced clinical outcomes for our patients. It is chaired by the Transplant Service Line Administrator and the Service Line Medical Director. Membership of the Transplant Executive Quality Council- ALL QAPI includes the following:

- Service Line Medical Director - Committee Chair –Prabhakar Baliga, M.D.
- Service Line Administrator, Transplant Service Line- Nancy Tassin, RN
- Primary Medical Directors of Organ Programs
    - Heart Program- Adrian Van Bakel, M.D.
    - Kidney Program- Titte Srinivas, M.D.
    - Liver Program- Ira Willner, M.D.
    - Living Donor Program- Titte Srinivas, M.D.
    - Lung Program- Timothy Whelan, M.D.
    - Pancreas Program- Titte Srinivas, M.D.
- Primary Surgical Directors of Organ Programs
    - Heart Program- John M. Toole, M.D.
    - Kidney Program- Prabhakar Baliga, M.D.
    - Liver Program- Kenneth Chavin, M.D., Ph.D
    - Living Donor Program- Kenneth Chavin, M.D., Ph.D
    - Lung Program- Chad Denlinger, M.D.
    - Pancreas Program- Charles Bratton, M.D.
- Clinical Transplant Manager- Cindy Hough, RN
- Quality and Compliance Coordinators, Transplant Service Line

    - Compliance Coordinator- Sharon Knowles
    - QAPI Coordinator- Lorraine Kemp, RN
- Lead Transplant Coordinator(s) from each program
    - Heart Program- Hwajoo Haynes, RN
    - Kidney Program- TBD
    - Liver Program- Heather Crego, RN
    - Living Donor Program- TBD
    - Lung Program- Jason Ferro, RN
    - Pancreas Program- TBD
- Transplant Clinical Pharmacist- Nicole Ann Pilch, PharmD
- Transplant Dietician representative
- Transplant Social Worker- Sharon Woods, LCSW or Jodi Schwartz, LCSW
- Nurse Manager, Inpatient Transplant Unit – Deb Cassidy, RN
- Transplant Patient Care Coordinator- Operating Room- Dana Gratton, RN

The purpose of the Transplant Executive Quality Council- ALL QAPI is to oversee and govern the Quality Program of the MUSC Transplant Center. The Council is responsible for the measurement and analysis of critical processes and outcomes to ultimately enhance patient care. This is accomplished through the use of continual monitoring of the quality of services provided with the goal being to create exceptional outcomes within a patient centered environment. The Transplant Quality Assessment and Performance Improvement Council will meet at least quarterly or more frequently as deemed necessary.
Each member is responsible for identifying opportunities and reporting key findings relevant to their disciplines to the Transplant Executive Quality Council- ALL QAPI. In addition, the members of the Transplant Executive Quality Council-ALL QAPI with the support of the QAPI Coordinator are responsible for:

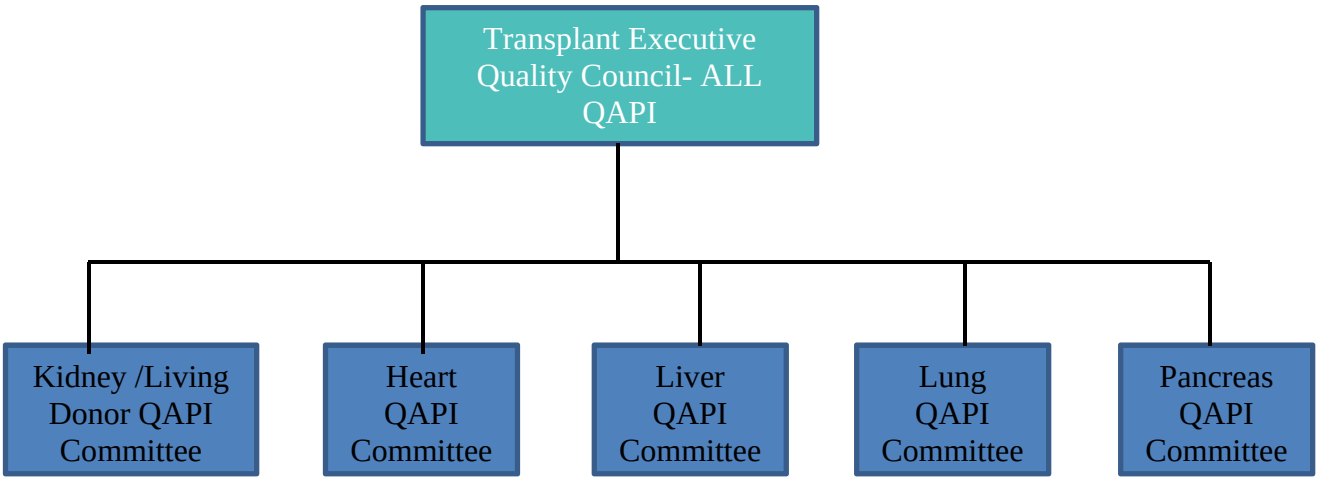
- Establishing a planned, systematic, and system-wide approach to performance improvement that is integrated and collaborative
- Overseeing the development of policies and procedures for the Transplant Program to promote consistency with system-wide policies and procedures
- Assessing, analyzing and implementing quality improvement measures in accordance with the Organ Procurement and Transplantation Network requirements
- Ongoing monitoring and assessment of key performance measures
- Prioritizing improvement efforts and developing corrective actions
- Incorporating internal and external sources of benchmarking data
- Maintaining compliance with Joint Commission National Patient Safety Goals
- Identifying educational needs and assuring staff education is provided
- Reporting on ongoing findings, trends and recommendations as indicated above
- Reporting relevant findings to appropriate Departments (Surgery and Medicine) for case review when indicated

The Transplant Executive Quality Council-ALL QAPI may also report events related to changes in transplant service line structure and staffing as well as transplant adverse events to the external regulatory agencies including South Carolina Department of Health and Environmental Control (DHEC), OPTN, Centers for Disease Control (CDC) and the

Center for Medicare and Medicaid Services as directed by the Risk Management and Legal Departments for MUHA.

There are separate QAPI Committee for each solid organ program that consists of the Surgical and Medical Director, Clinical Nurse Manager, Outcome and Quality Coordinators, Lead Transplant Coordinator for that specific organ, dietary, social work and pharmacy representation. The committees are chaired by both the Surgical and Medical Directors for that specific organ with support from the QAPI Coordinator. The committee reviews the quality indicators that are service line required as well as organ specific, reported adverse events and updates on any ongoing PI projects. The committee meets at a minimum quarterly. Summary reports for each specific organ QAPI program are reported to the Transplant QAPI Council at a minimum quarterly.

Transplant Service Line Quality and Performance Improvement Structure

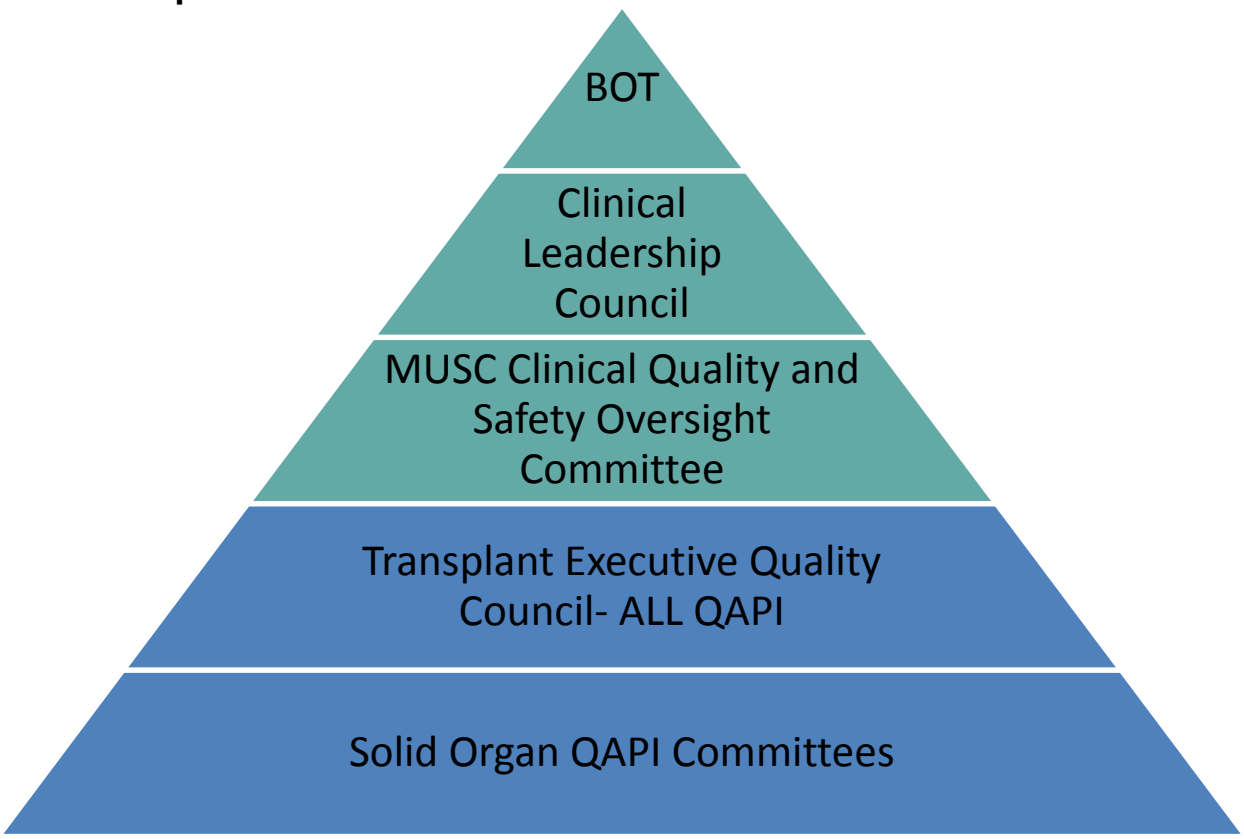


Executive Responsibilities

The Transplant Service Line reports to the Executive Medical Director of the Medical University of South Carolina. The Transplant Executive Quality Council- ALL QAPI reports to the MUSC Clinical Quality and Safety Oversight Committee within Medical University Hospital Authority (MUHA). The MUSC Quality and Safety Council are co-chaired by the Chief Medical Officer for MUHA and MUSC-Physicians. The Council is responsible for reviewing and approving quality incentives plan across all service lines, evaluating performance improvement plans and addressing gaps in performance. The Council is also responsible for recommending to the Clinical Leadership Council resources necessary to eliminate gaps in performance.
Minutes of the MUSC Clinical Quality and Safety Oversight Committee are reviewed and discussed during the Clinical Leadership Council which members includes senior

leadership from the MUHA, MUSC Physicians, and College of Medicine representatives. The committee is responsible for oversight of MUSC Health.

Transplant Service Line QAPI Reporting Structure to MUHA Leadership



Feedback and Data Systems

The Transplant Service Line metrics are monitored, reviewed and reported at each organ specific QAPI committee as well as organ specific metrics. Metrics are re-assessed annually for ongoing compliance, feasibility of data capture and impact on overall program growth. Key metrics for the Transplant Service Line for 2013 include but are not limited to:

Pre- Transplant Phase

- Transplant Volume
- Waitlist Mortality (all but Live Donor)

Peri-Transplant Phase

- Length of stay Index
- Cost per CMI adjusted discharge

Post-Transplant Phase

- SRTR Outcomes
- Readmission Rate- as defined by UHC

Organ Specific metrics for 2013 include but are not limited to:

Kidney

Pre- Transplant Phase

- Data Accuracy with Listing

Peri-Transplant Phase

- Delayed Graft Function
- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- SRTR Outcomes
- Readmission Rate- as defined by UHC

Living Donor

Pre- Transplant Phase

- Data Accuracy with Listing
- Completion of the Patient Acknowledgment Form

Peri-Transplant Phase

- Delayed Graft Function
- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- SRTR Outcomes
- Readmission Rate- as defined by UHC

Heart

Pre- Transplant Phase

- Data Accuracy with Listing
- UNOS Notification Letters with 10 business days
- CDC High Risk Consent

Peri-Transplant Phase

- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- SRTR Outcomes
- Readmission Rate- as defined by UHC

Liver

Pre- Transplant Phase

- Data Accuracy with Listing
- UNOS Notification Letters within 10 business days
- CDC High Risk Consent
- Patient Acknowledgement Form Complete

Peri-Transplant Phase

- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- Vessel Disposal within 14 days of receipt
- SRTR Outcomes
- Readmission Rate- as defined by UHC

Lung

Pre- Transplant Phase

- Time from referral to notification letter sent
- UNOS Notification letters with 10 business days
- Data Accuracy with Listing

Peri-Transplant Phase

- Ventilator Hours- average number of hours on vent post- transplant
- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- Multidisciplinary Discharge Documentation-Percentage of patients with all paperwork complete
- SRTR Outcomes
- Readmission Rate- as defined by UHC

Pancreas

Pre- Transplant Phase

- Data Accuracy with Listing

Peri-Transplant Phase

- ABO Verification Prior to Anastomosis

Post-Transplant Phase

- SRTR Outcomes
- Readmission Rate- as defined by UHC

See attached Quality Metric grids for metric details.

Contracted Services

The Medical University of South Carolina in 2013 developed a contractual agreement with Statline. Statline, a division of Musculoskeletal Transplant Foundation, offers a 24/7 specialized communication center, where they screen donors, triage organ offers, answer incoming calls and generate detailed reporting for organ. Quality metrics for Statline include:

- Receiving Organ Offer Sequence
- Accuracy of documentation of Patient Demographics and UNOS ID and Match
- Timely surgeon, recipient and coordinator contact
- Accuracy of documentation in UNET, handoff reports and offer logs
- Customer Service

ADVERSE/SENTINEL EVENTS:

The Centers for Medicare and Medicaid Services defines an adverse event in transplant as: *an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof*. *As applied to transplant centers, examples of adverse events include (but are not limited to) serious medical complications or death caused by living donation; unintentional transplantation of organs of mismatched blood types; transplantation of organs to unintended recipients; and unintended transmission of infectious disease to a recipient.*

To ensure the highest quality care and outcomes for the transplant recipients and living donors, adverse events are reported through the Quality and Outcomes Office within the Transplant Service Line. The Transplant Service Line follows the hospital Event Investigation and Analysis policy https://www.musc.edu/medcenter/policy/Med/C049.pdf . All Adverse Events are initially reviewed by the QAPI Coordinator. After the initial review, the Medical and/or Surgical Director conducts a physician based review and determines the final disposition of the review process. Adverse Events will be tracked and monitored through the Outcomes and Quality Office of the Transplant Service Line. Adverse Events will be reviewed during the organ specific Quality and Performance Improvement Committees. A quarterly summary report will be provided to the Transplant Executive Quality Council-ALL QAPI. Adverse events include but are not limited to:

- Primary graft non-function
- Graft Loss
- Re-transplant within 30 days for any cause
- ABO incompatibilities- exception- pediatrics and fulminating
- Death within 30 days of transplant

- Unplanned return to OR within 30 days of transplant
- Surgical Infections
- Donor Disease Transmission
- Loss to follow up within 1 year of transplant

Analysis of Data

Performance measures of key processes and outcomes of care are monitored, analyzed and assessed at the pre transplant, transplant event and post-transplant phase. The measures are established to evaluate processes, outcomes, procedures, and services provided to the transplant population including services provided under contract or arrangement. Patient level events are reported through the hospital event reporting database, Patient Safety Net. Events are reviewed for corrective actions and trends during each organ specific QAPI committee meetings. Trends and corrective actions are reviewed across all solid organ programs for best practices and performance improvement activities.

Performance Improvement Activities

The Transplantation Program, through the utilization of the I.M.P.R.O.V.E. Model, will identify opportunities for improvement and implement necessary measures to sustain improvements. The principles that support this effort are:

- Key performance measures will be monitored at least quarterly
- Improvement will be data-driven
- Activities will support system-wide performance and patient safety improvement initiatives
- The governing body and organizational leaders will be kept informed through the provision of aggregate data
- The integration of evidence-based practice
- Utilizing comparative data from external benchmarking sources (UNOS) and (UHC)
- Integration of applicable sentinel event alerts and lessons learned from the larger organization

The Transplant Service Line also utilizes LEAN methodology to improve processes, reduce waste and improve outcomes for our patients.

Medical Executive Committee **Presiding:** Dr. Gillespie **Date:** September 18th, 2013 **Meeting Place:** 628 CSB **Recording:** Stephanie Brown	**Meeting Time:** 7:32am **Adjournment:** 8:32am **Members present**: Dr. Gillespie; Dr. Hoffman; Dr. Boylan , Dr. Cawley; Dr. Clyburn; Dr. Crumbley; Dr. Elliott; Dr. Gray; Dr. Jauch; Heather Kokko; Dr. Lewis; Dr. Reeves; Dr. Richardson; Dr. Rockey; Dr. Rublee; Dr. Ryan; Dr. Sachs; Dr. Salgado; S. Scarbrough; Dr. Scheurer; Dr. Streck; Dr. Uhde; C. Younker; Dr. Zwerner **Members excused:** Dr. Baliga; Dr. Basco; Dr, Clarke; Dr. Cole; Dr. Costello; Dr. Deas; A. Drachman; Terri Ellis; Dr. Feussner; Dr. Habib; Dr. Harvey; L. Kindy; Dr. Lambert; D McLean; D. Neff; Dr. Pellegrini; Dr. Pisano; Dr. Powers; C. Rees; M. Schaffner; Dr. Valerio; Dr. Vandergrift; Dr. Warren; Dr. Yoe; **Guests: Lauren Kuckewich, Laura Parsons**

Agenda/Topic	**Debate & Discussion**	**Conclusions**	**Recommendations/ Follow-Up What/When/Who**
Executive Session	Sheila Scarborough presented 1 event.	**Approved.**	
Wins	MUSC received 4.5 million from the state for Telemedicine. This is the first of a series of investments in Telemedicine for MUSC. Nationally the USMLE 3 Exam residents take pass rate was at 97% (Very high). This year (having heard about 133/134) we have had zero failures out of the current second years.	**Accepted as Information**	
Review of Minutes	MEC minutes were reviewed.	**Minutes of the August 21st, 2013 MEC meeting were approved.**	
Credentials Committee	Dr. Gray reported on staff changes: Medical Staff Initial Appointment and Privileges: 12 Medical Staff Reappointment and Privileges: 18 Medical Staff Reappointment and Change in Privileges: 1 Medical Staff Change in Privileges: 15 Professional Staff Initial Appointment and Privileges: 7 Professional Staff Reappointment and Privileges: 12 Professional Staff Changes in Privileges: 0 Dr. Jussuf Kaifi requesting initial appointment and privileges; waiver of the Board Certification at MUSC. Dr. Rupal H. Trivedi is requesting reappointment and privileges; waiver of the Board Certification at MUSC. Dr. Dorothea Rosenberger is requesting reappointment and privileges; waiver of the Board Certification at MUSC.	**The Medical Executive Committee recommends the appointments, reappointments, and delineation of clinical privileges to the Board of Trustees for approval.** **Approved**	
GME Report	Dr. Clyburn provided GME update. Dr. Clyburn discussed the learning environment visit "clear visits" (unannounced visit, 5-9 days' notice) that will be every 18 month. This information was presented to hospital leadership August 26th 2013. Dr. Clyburn is currently working with Lois Kerr and Dr. Scheurer to create gap analysis. Currently finding – We are good shape however, Dr. Clyburn will present future data as they get future along in the gap analysis. Dr. Sachs noted we are currently looking at the call rooms. It has come up as an issue and there are	**Accepted as Information**	

	request from several departments and divisions concerning the call room status for house officers and house staff. We are investigating and will do an assessment of all call rooms next week to come up with a list and further assignments to meet the requested needs.		
Hand Hygiene	Dr. Salgado presented hand hygiene compliance. Housewide hand hygiene compliance for January 2012 – August 2013 reviewed. August Housewide rate is 90.9% mean 88.8%. Service line compliance rates trend from 96% to 82.3%, and occupational compliance rates trend from 100% to 91% (Please note data does not include secret shopper). Outpatient Hand Hygiene Monthly Compliance for August 2013 is above 90% for each area. Dr. Gillespie noted - Handy hygiene report will be every other month and we will now report on CAUTI for off months.	**Accepted as Information**	
Hospital Update	Dr. Cawley provided hospital update and overview of 2014 goals. – New UHC final ranking for past year to come in 6 weeks. – Service - HCAHPS Composite at or above the 75th percentile, Goal is 7 of 11, Results are 5 of 11. CG-CAHPS is currently having an issue – Low Data. Surveys went out but the survey company is having trouble processing data. Avatar is aware we are not pleased; Avatar – Adult Outpatient / Ancillary to be determined) YTD 92.18; Press Ganey- Pediatric Inpatient goal is to rank 85th percentile, results are 95%. Press Ganey – Pediatric Outpatient goal is to rank 75th percentile, results are 74%. Care transition is new measure. This is a patient's perception of how we transition them between inpatient to outpatient. – People – Increase Morehead Employee Commitment Score by .05. We are currently in the yellow. – Quality – Ideal Care Achieve a weighted composite score of 3.0. Hand Hygiene Audits Compliance Rate of 90% or higher; Results are 92%. – Finance – Achieve cost per adjusted discharge of $8,743, Results for July are $9,529; Achieve an operating margin of 3% (Year End), Results for July are 5.9%; Currently in the red however we haven't realized all of our savings from Huron so we won't see this until half way through the year. All of it in 18 months. – Growth – Achieve .5% growth in inpatient discharge (excludes observation), Results for August are 2.03%; Achieve 3% growth in new patient visits (includes hospital based outreach and CFC), Results for August are 10.3% – Ideal Care Goal is 3.0 to include: • Mortality Rank Goal is Top 25 in UHC, Result YTD 16TH. • Readmissions Goal is 13.4 Adult 30 Day Readmissions, Result YTD – No Data • CLABSI Goal is ≤ 43 Infections Annually, Result YTD 36. • CAUTI Goal is ≤ 7.3 Infections per 1000 Foley days, Result YTD 10.1 • Vent Days Goal is 3% Reduction in Vent Days, Result YTD – No Data • Core Measures Goal is 96.5% received appropriate care, Result YTD 92.5% • Culture of Safety Goal is 62% positive responses on perception of safety, Results YTD – No Data • Meaningful Use Goal is 95% compliance, Result YTD – No Data Questions: – Dr. Uhde had question regarding Mortality Ranking. Recommended designating beds	**Accepted as Information**	

	for Hospice. • This topic will be discussed further in another meeting format.		
Youth Protection for Vulnerable Patients	Dr. Thomas Uhde presented on Youth Protection – Strategies for Reducing Volunteer and Employee Risk in Youth-Serving Organization. At a department level this topic was stimulated by the events at Penn State, the Citadel and elsewhere. We began to look at what procedures and policies we have in place and determined steps need to be taken o create policies regarding protection for vulnerable patients. The presentation packet created by Benjamin E. Saunders, Ph.D. goes into more detail of this topic. Dr. Saunders travels to different institutions, organizations, and agencies throughout the United States to discuss organizational procedures of policies to reduce these events. We must take measures to prevent abuse and protect patients. It is a costly and can be devastating to the patient and organization. We need to determine: "What is our vulnerability". On page 24 of the packet, Dr. Uhde noted Dr. Benjamin Saunders question: "Who would you like to get sued by and for what?" In an organization of this size abuse could happen and will happen however we should take the steps and need to create policies to prevent these kinds of tragedies. Dr. Gillespie recommended having Dr. Saunders speak at the Medical Staff Meeting on this topic. Pediatrics, Psychiatry, Surgical Services and departments that have sedated patients could benefit from learning more. Dr. Cawley suggests putting together a taskforce containing members from the College of Medicine, Practice Planning, and Hospital. MEC Committee in agreement with forming a taskforce.	**Accepted as Information. Taskforce to be created to work on policies for Youth Protection for Vulnerable Patients.**	
Changing the Culture of Bed Flow & Patient Discharge at MUSC	Dr. Sachs presented on Changing the Culture of Bed Flow & Patient discharge at MUSC. Reason for changing the discharge process include: Dissatisfaction of patients, families, & staff; Inefficiency of current D/C process, Patients maintain bed space on floors awaiting lengthy process of D/C, Increased cost of delayed patient D/C; Inability to decompress patients holding in ED, ICUs, & PACU, Unable to move to an open bed on the floor; Inability to accommodate patients ad admits from outside hospital; Reasons for change – Our financial dollars are at risk. If we decrease overall length of stay by ½ day we will have a cost savings of $10million in 1 year. (Based on our current number of discharges). CMS Readmission Reduction Program – 3 year total dollars at risk is $4,928,960, FY2013; FY2014; FY2015 equal 1%+2%+#%/year. We have approx. 120 discharges per day; approximately 60% patients from specialty services; approximately 40% patients gen.-med. Services - 2/3 gen.-med. pats. covered by house-staff and 1/3 gen.-med. pats. covered only by attending private service physicians. A baseline data lead time graph created 18 months ago by the PI group was presented to show discharge process/steps from time MD informs the patient they are going home. The goal is to reduce this time. Currently there is not standards discharge (every floor and department does discharge differently. The proposed recommendation from the Bed Flow committee is 10:00 am time of day for written D/C orders on patient chart, 180 minutes (3 hour) from time D/C orders written until patient actually discharged from hospital. In conclusion This can be done, but it is a team effort. Set Standard D/C timed goals. Modify daily work to accommodate meeting the goals. Follow & report data for each hospital unit, service, specialty, etc. Everyone will have access to accurate data in a timely fashion. Make everyone accountable to improve! This is a proposal to give us a target to shoot for and gives standards across the board the institution to follow, charging each inpatient unit to up with a plan to meet the standard. This topic was presented to MEC prior to moving forward with the proposal to ensure there wasn't any opposition to the new times and standard. The Bed Flow Committee will begin to monitor these metrics and try to hold each unit accountable.	**Accepted as Information.**	

Core Measures	Dr. Scheurer presented on Core Measures. Core measures are standardized sets of valid, reliable and evidence-based performance measures that were introduced by The Joint Commission to address the challenges of standardization and benchmark comparisons. Core measures have standardized data collection and analysis protocols to permit uniform implementation and reporting across accredited healthcare organizations. (Page 51 of the packet) A graph of the trending for 2012, 2013, and 2014 was provided to the group and reviewed by Dr. Scheurer to include AMI, CAC, HF, IMM, PN, SCIP IP, SCIP OP, VTE. Dr. Scheurer noted that all of the data can be found online. Email her if you would like the link to the data. Dr. Scheurer noted Flu public reporting starts October 1st 2013, screen and vaccinating will begin September 23rd 2013 pending vaccine supply.	**Accepted as Information**	
CAUTI	Dr. Scheurer presented on CAUTI (Catheter Associated Urinary Tract Infection). Three ways that we measure UTI: 1. UTI coded by medical records (all patients) 2. Catheter associated-UTI Surveillance by infection prevention (only for ICU patients) 3. Post-op UTI abstracted for NSQIP (only for surgical patients). We are outliner on all three. Dr. Scheurer provided the ICU CAUTI rates as of July 2013. Red is NHSN benchmark. Brown is NHSN unit specific benchmark and Blue is MUSC rates for our units. Overall ICU CAUTI rates continue to go up. Dr. Scheurer provided graphs to show CAUTI rates for CCICU, CTICU, MICU, MSICU, NSICU, STICU, PCICU, and PICU. She also should the percent of CAUTI that are early and late: Jan–July 2013 by unit (% within 7 days) 88% are inserted in the ICU: NSICU: 34 (53% early); STICU: 23 (39% early); MICU: 19 (26% early); MSICU: 7 (71% early); CCICU: 5 (60% early); CTICU: 2 (50% early); PICU: 2 (100% early); PCICU: 2 (0% early); – Reduction efforts: Insertion: Education for inserters, Insertion bundle checklist in the medical record, Accountability (similar to CLA-BSI) – Maintenance: Bundle checklist in the medical record – Removal: Bladder scanners for every unit – bladder mgt protocol, Absorbent pads for incontinence, Lift team – equipment assessments, Nurse removal protocol	**Accepted as Information**	
Data reports	Reports reviewed: Bed Capacity Summary Admit Transfer Center Quality of H&P by Department	**Approved**	
Subcommittee Minute Review	Subcommittee reports were reviewed: Bed Flow Team – July 2013 Clinical Lab Advisory Committee – July 2013 Credentials Committee –August 2013 Graduate Medical Education Committee – July 2013 Hospital Operations Committee – June 2013 Sedation Committee – May 2013 Peer Review Committee – July 2013 Perinatal Quality Committee – July 2013 Emergency Management Committee – June 2013	**Approved**	
Polices (Consent)	C-152 Discharge Planning C-117 Labeling Medications in Non-Pharmacy Areas	**Approved**	
Standing Orders	C-68 Standing Orders	**Approved**	
Adjourned 8:26am	The next meeting of the Medical Executive Committee will be Wednesday, October 16th 2013 at		

	7:30am in 628CSB.		

David Habib, MD, Secretary of the Medical Staff

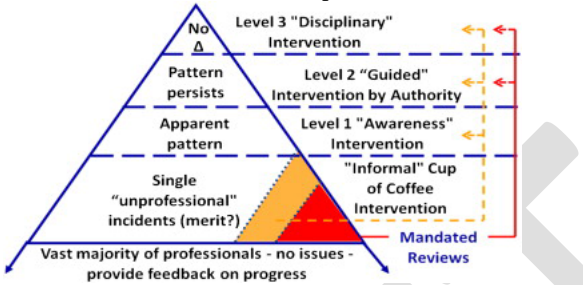
Medical Executive Committee **Presiding:** Dr. Gillespie **Date:** October 16th 2013 **Meeting Place:** 628 CSB **Recording:** Stephanie Brown	**Meeting Time:** 7:30 **Adjournment:** 8:32am **Members present**: Dr. Gillespie; Dr. Basco; Dr. Boylan , Dr. Clyburn; Dr. Cole; Dr. Crumbley; Dr. Elliott; Dr. Gray; Heather Kokko; Dr. Lewis; D McLean; Dr. Pellegrini; C. Rees; Dr. Richardson; Dr. Rockey; Dr. Rublee; Dr. Ryan; S. Scarbrough; Dr. Scheurer; Dr. Streck; Dr. Uhde; Dr. Warren; Dr. Yoe; **Members excused:** Dr. Baliga; Dr. Cawley; Dr, Clarke; Dr. Costello; Dr. Deas; A. Drachman; Terri Ellis; Dr. Feussner; Dr. Habib; Dr. Harvey; Dr. Hoffman; Dr. Jauch; L. Kindy; Dr. Lambert; D. Neff; Dr. Pisano; Dr. Powers; Dr. Reeves; Dr. Sachs; Dr. Salgado; M. Schaffner; Dr. Valerio; Dr. Vandergrift; C. Younker; Dr. Zwerner **Guests: Christine Lewis, Jairy Hunter, Lois Kerr, Matt Wain, Jamie Sebaaly, and Lauren Kuckewich,**

Agenda/Topic	Debate & Discussion	Conclusions	Recommendations/ Follow-Up What/When/Who
Executive Session	No Events	**N/A**	
Wins	No Events	**Accepted as Information**	
Review of Minutes	MEC minutes were reviewed.	**Minutes of the August 21st, 2013 MEC meeting were approved.**	
Credentials Committee	Dr. Gray reported on staff changes: Medical Staff Initial Appointment and Privileges: 16 Medical Staff Reappointment and Privileges: 12 Medical Staff Reappointment and Change in Privileges: 1 Medical Staff Change in Privileges: 17 Professional Staff Initial Appointment and Privileges: 6 Professional Staff Reappointment and Privileges: 11 Professional Staff Changes in Privileges: 1 Dr. William Moran requested a temporary waiver for Cheryl P Lynch, MD, MPH, and Assistant Professor in the Department of Medicine's Division of General Medicine for the requirement of her board certification. Dr. Lynch plans to take the exam for Internal Medicine scheduled for August 2014. A proposed extension of 1 year is requested in order for Dr. Lynch to prepare and pass her board certification. (Approved)	**The Medical Executive Committee recommends the appointments, reappointments, and delineation of clinical privileges to the Board of Trustees for approval.** **Approved**	
GME Report	Dr. Clyburn provided GME update. Dr. Clyburn met with Dr. Scheurer and Jane Lynn. Dr. Cawley agreed to move forward with "Pager to Texting" for pager to cell phone text message for residents. Allow residents to receive text page to their cell phones. Biggest implications will be for "Call Calendar Paging" for emergency groups. May result in dull paging for teams. Within 6 – 9 months may have an app that will be safe for use by residents?	**Accepted as Information**	

Hospital Update	Dr. Scheurer provided hospital update and overview of 2014 goals. – UHC – Goals/target is ranking of top 25; more information to come at next MEC. – Service – Ideal Patient Service Achieve a weighted composite score of 3.0, Thru August goal was 2.35. • HCAHPS – Composite at or above the 75th percentile, Goal is 7 of 11, Results are 5 of 11. • CG-CAHPS – Composite Have Top Box Results at or above 75th percentile, Goal is 3 of 6, Results are 1. • Avatar – Adult Outpatient / Ancillary – Goal overall mean score of 93.87; YTD 91.59 • Press Ganey-Pediatric Inpatient – Goal is to rank 85th percentile, results are 95% • Press Ganey-Pediatric Outpatient – Goal is to rank 75th percentile, results are 75%. • Total Goal for Service 3.0; Results 2.35 YTD – People – Increase Morehead Employee Commitment Score by .05. We are currently in the white. – Quality – Ideal Care Achieve a weighted composite score of 3.0; Results are 2.7 Hand Hygiene Audits Compliance Rate of 90% or higher; Results thru September are 90%. – Finance – Achieve cost per adjusted discharge of $8,743, Results thru August are $9,358; Achieve an operating margin of 3% (Year End), Results thru August are 4.9%; – Growth – Achieve .5% growth in inpatient discharge (excludes observation), Results thru August are .3%; Achieve 3% growth in new patient visits (includes hospital based outreach and CFC), Results for August are 10.3% – Ideal Care Goal is 3.0; Results are 2.7: (Includes the following) • Mortality Rank Goal is Top 25 in UHC, Result YTD 16TH. • Readmissions Goal is 13.4 Adult 30 Day Readmissions, Result YTD 14.1 • CLABSI Goal is ≤ 43 Infections Annually, Result YTD 36. • CAUTI Goal is ≤ 7.3 Infections per 1000 Foley days, Result YTD 10.1 • Vent Days Goal is 3% Reduction in Vent Days, Result YTD 0.1 • Core Measures Goal is 96.5% received appropriate care, Result YTD 92.5% • Culture of Safety Goal is 62% positive responses on perception of safety, Results YTD 61 • Meaningful Use Goal is 95% compliance, Result YTD 90 – Housewide Hand Hygiene compliance – Current Rate is 88.1%; Mean 90%	**Accepted as Information**	
CAUTI Update	Dr. Scheurer provided update on CAUTI. Jan–July 2013 by unit (% within 7 days) 88% are inserted in the ICU: NSICU: 34 (53% early); STICU: 23(39% early); MICU: 19 (26% early); MSICU: 7 (71% early); CCICU: 5 (60% early); CTICU: 2 (50% early); PICU: 2 (100% early); PCICU: 2 (0% early) Reduction Efforts are: – Insertion: Education for inserters, Insertion bundle checklist in the medical record; Accountability (similar to CLA-BSI)	**Accepted as Information.**	

	– Maintenance: Bundle checklist in the medical record; – Removal: Bladder scanners for every unit – bladder management protocol; Absorbent pads for incontinence; Lift team – equipment assessments; Nurse removal protocol		
E Care Net Update	Dr. Warren provided E-Care Net Update: ECare Net is following the data outage that occurred 1 year ago in September and the Strategic Plan of reliable infrastructure. E Care net was given an updated on Monday October 14th 2013 and can provide further detail upon request. Ambulatory EPIC – More than ¾ of all attending medical staff have had individual contact with "Optimizer". Satisfaction process is 89% overall. Feedback for improvement is welcomed. Inpatient EPIC – On schedule. October 11th 2013 we successfully hit first critical milestone for order set build. We had our first issue that required executive intervention – serious issues dealing with change in scope that requires EPIC and Primus (Bed Management System) to work together. Close oversight continues and all interventions have been taken.	**Accepted as Information.**	
Medical Records Completions – Op Notes, Death Notes, D/C Summary	Christine Lewis presented on Medical Records Completions – Op Notes, Death Note, D/C Summary. Delinquent Medical Records: MUHA adopts the Joint Commission definition for delinquent medical records: Goal is no more than 50% of monthly discharges/visit notes are delinquent. Delinquent defined as: (>than 30 days after discharge/visits - Since October 1, 2008 delinquency per MUSC Rules and Regulations, defined as >14 after discharge). Effective February 2011, Medical Staff Bylaws have decreased the number of days for clinician dictation of discharge summaries/operative notes to 72 hours after discharge/procedure and signed within 7 days. Average Delinquent Record rate includes a running average of delinquent dictation (operative reports and discharge summaries) and signatures. (H&P, VO, etc.) Analysis: Hospital-wide delinquencies are above control limits for the last eight months, except for Feb 2013 and May 2013. The incomplete record area is working with physicians to reduce these delinquencies. Delinquencies are still well below threshold for Joint Commission Delinquent Discharge Summaries: Discharge summaries not dictated within 72 hours of discharge. (Number of discharges updated and observation discharges divided by # of delinquent discharge summaries not dictated) Analysis: Delinquent Discharge Summaries are decreasing. Daily focused audits of all discharge summaries now occurring to ensure dictation within 72 hours. Discharge summaries to be transcribed within 12 hours of dictation to help facilitate signing. Delinquent Operative Reports: Joint Commission requires that operative reports be dictated as defined by the organization. Analysis: Delinquent Operative Reports show some notes not being dictated within 72 hours Death Note/Palliative Care Status chart was reviewed. Redline representing No Death Note and Blue representing No PC Status. – We are looking for this documentation at time of Death and Palliative care documentation. This information is used by coders.	**Accepted as Information**	

	Action Plan: 1. Discharge Summaries are not always dictated within 72 hours as per Medical Staff Rules and Regulations. Reporting out of compliance discharge summaries to clinician and then suspension to occur. EPIC to interface IP-DISC into MPH. 2. Improve turnaround time of discharge summaries to referring physicians. Physician days to sign, striving for seven (7) days of less. Notice, warning, and then suspension to occur. 3. MPH Delinquent medical records deficiency monitoring. Notice, Warning then suspension to occur.		
Vulnerable Patients Committee	Dr. Gillespie proposed a formal Vulnerable Patients Committee to create a policy in the next three month and present new policy to MEC for feedback. Recommended membership: Dr. Benjamin Saunders, Terry Wilson, Alice Boylan, Bruce Crooks, and Edward Lewis. Also a hospital administrator and someone from legal, and the community i.e. (Womens Auxiliary, Patient Family Advisory Council). Recommendation can be sent to Dr. Gillespie.	**Approved to form Vulnerable Patients Committee. Provide feedback in 3 months.**	
Peer Review	Dr. Scheurer provided update for Peer Review Policy C-164. Noted changes: – Composition and function of Medical Center Peer Review: • Recommendation from Faculty Senate to make the Vice President of Peer Review - Chief Quality Officer, and the Associate Dean for Clinical Affairs non-voting members – Provider notifications by Peer Review: • Peer Reviewer will now hand letter to provider and have discussion about the case. • Every Dept. will have a Peer Review committee to consist of a Chair, PRC member, and other members as deemed appropriate. The departmental PR committee will keep minutes of the meetings. – Appeals Process: • Appeals will be review by a 3-member independent committee consisting of (1) Hospital Chief Medical Officer (2) Highest ranking medical staff physician in the faculty senate (3) a 3rd member dually appointed by the first 2 members. If either member of the appeals committee has a conflict of interest, they would delegate the appeals responsibility to their designee (the associate Chief Medical Officer, and the 2nd highest ranking medical staff physician in the faculty senate). Level of findings from the appeals committee. – Professionalism: • For professionalism concerns, any single event will be referred to the Chairman for • Intervention. Referral to Peer Review will occur only for recurrent professionalism • issues that occur within the 12 months after referral/intervention from the Chairman • (Level 1 intervention; see appendix A “Hickson model”	**Accepted as Information**	

	Appendix A: Hickson Model for Disruptive Behavior  – For cases that cannot be reviewed internally, an external peer review can be initiated. This process will be administratively overseen by the Chief Quality Officer or designee. Once the external review is completed, the external review will be submitted to, and reviewed by, the Peer Review Committee, in the same manner as internal reviews.		
Hospital Readmissions	Dr. Hunter presented the Readmissions Update: – Chart of 7 day, 14 day and 30 day readmissions rates was reviewed for CY2012/CY2013. Currently focusing on strategies and tactics to as to address high rates. 2 years ago 17 tactics teams formed to look at systems and processes for readmissions. – MUSC vs. UHC 2013 chart was reviewed. MUSC ranked 85, Cases 16317 total; 2,107 – 30 Day Readmit (15.04 %), 1335 – 14 Day Readmit (9.53%); 834 – 7 Day Readmit (5.95%); – High Impact Tactics: • Readmissions Leadership Team focus → Risk prediction models; Timely notification of PCP; Timely follow-up apt., scheduled prior to D/C; Post-acute care accountability; Dx-specific programs: Sickle Cell, Chronic Pancreatitis, CHF – Medium/Long Range: • Patient Hotline; Transitions Coach/Complex Case Manager; Patient-education programs; Discharge Planning; Innovations : med rec, leverage technology – Take-Always: • Foster a culture of preventing avoidable readmissions; Innovations; Make D/C Planning an essential focus; Collaborate individuals leading these efforts	**Accepted as Information**	
Hospital Bylaws and Credentials	Dr. Scheurer presented Medical Staff By-Law Proposed Revisions and Credentials Manual Proposed Revisions: Recommendations **Medical Staff By-Laws Proposed Revisions** 1. Revised Membership • Added Chief Operating Officer, Chief Medical Information Officer • Corrected titles of other members 2. Added provision required by Joint Commission standards: The organized medical	**Approved**	

	staff has the ability to adopt medical staff by-Jaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body after communicating the proposed changes to the Medical Executive Committee. 3. Per Joint Commission and CMS requirements: Revised updating of History & Physical to include "re-examination of the patient must take place as a part of the history and physical update within 24 hours of admission" (must include the word "RE-EXAMINED" in the update). **Credentials Manual Proposed Revisions** 1. Revised Membership Tenure of Credentials Committee Chairperson: The appointment for Chairperson shall be for a three (3) year term with eligibility for reappointment for two (2) additional terms (changed from 1 term to 2). 2. Revised communication timeframes in accordance with NCQA requirements: After Board decisions on appointment and reappointment, the timeframe for notification to the practitioner changed from 30 days to 10 days.		
Data reports	Reports reviewed: Bed Capacity Summary Admit Transfer Center Quality of H&P by Department Hand Hygiene Report Daily Admissions Reports Discharge Summary Reports	**Approved**	
Subcommittee Minute Review	Subcommittee reports were reviewed: Clinical Lab Advisory Committee – September 2013 Credentials Committee – September 2013 Graduate Medical Education Committee – September 2013 Pharmacy and Therapeutics Committee – August 2013 Hospital Operations Committee – September 2013 Clinical Documentation Improve Committee – September 2013	**Approved**	
Polices (Consent)	C – ??? Donate Device Policy and Procedure C – ??? CAUTI – Catheter Associated UTI C – 164 Peer Review Policies C – 080 Critical Results: Reporting and Receiving C – C??? Organizational Transparency	**Approved**	
Standing Orders	Transplant – Standing/Routine Order Set – Kidney/Pancreas; Liver; Employee Template Request – Transplant Program Assistants	**Approved**	
Adjourned 8:26am	The next meeting of the Medical Executive Committee will be Wednesday, November 20th 2013 at 7:30am in 628CSB.		

David Habib, MD, Secretary of the Medical Staff

AGREEMENTS ENTERED INTO BY THE MEDICAL UNIVERSITY HOSPITAL AUTHORITY SINCE THE OCTOBER 2013 MEETING OF THE BOARD OF TRUSTEES

Hospital Services - Any contract involving the exchange of Hospital services either for money or other services.

Managed Care - The Medical Center has entered a Managed Care Agreement with the following:

Transplant Agreements - For the institution(s) listed below, the Medical Center Transplant Unit agrees to provide tissue typing and transplantation to those patients who are medically suitable and to follow those patients in the transplant clinic at MUSC.

Transfer Agreements - MUHA agrees to accept the admission of individuals requiring specialized care and meet certain criteria from the following facilities:

Roper St. Francis Mt. Pleasant Hospital

Affiliation Agreements –

Francis Marion University
Virginia College
Old Dominion University
Western Governors University

Shared Services Agreements –

Medical University Hospital Authority
Construction Contracts
December 13, 2013

M B Kahn Construction Co. UH - Spec CT 3rd Fl.	$309,000.00
Stenstrom & Associates CH - 6th Fl. Cath Lab	$106,383.20

Medical University Hospital Authority
IDC Professional Services Contracts
December 13, 2013

McMillan Pazdan Smith N. Charleston Oncology Provide architectural and engineering services	$85,029.00

MEDICAL UNIVERSITY OF SOUTH CAROLINA

REGULAR AGENDA

Board of Trustees Meeting
Friday, December 13, 2013
101 Colcock Hall

Members of the Board of Trustees

Thomas L. Stephenson, Esquire, Chairman
Dr. James E. Wiseman, Jr., V-Chairman
Dr. Stanley C. Baker, Jr.
The Honorable James A. Battle
Mr. William H. Bingham, Sr.
Mr. William B. Hewitt
Dr. Harold W. Jablon
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. Ragin C. Monteith
Dr. E. Conyers O'Bryan, Jr.
Mr. Charles W. Schulze
The Honorable Robin M. Tallon
Dr. Thomas C. Rowland, Jr.
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Dr. Charles B. Thomas, Jr.

Trustees Emeriti
Mrs. Margaret M. Addison
Dr. Cotesworth P. Fishburne, Jr.
Mrs. Claudia W. Peeples
Mr. Allan E. Stalvey

Item 1. Call to Order-Roll Call.

Item 2. Secretary to Report Date of Next Meeting.

Regular Meeting: Friday, February 14, 2014.

Item 3. Approval of Minutes of the Regular Meeting of the Medical University of South Carolina Board of Trustees of October 11, 2013.

Board Action:

RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT

OLD BUSINESS:

NEW BUSINESS:

Item 4. General Informational Report of the Interim President.

Statement: Dr. Sothmann will present a general report.

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

Board Action:

Item 5. Other Business.

RESEARCH AND INSTITUTIONAL ADVANCEMENT COMMITTEE. CHAIRMAN: DR. CHARLES B. THOMAS, JR.

OLD BUSINESS:

NEW BUSINESS:

Item 6. General Report of the Associate Provost for Research.

Statement: Dr. Steve Lanier will report on research activities.

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

Recommendation of Committee:

Board Action:

Item 7. General Report of the Vice President for Development.

Statement: Mr. Jim Fisher will provide a general report on institutional advancement activities.

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

Recommendation of Committee:

Board Action:

Item 8. General Report of the CEO of the MUSC Foundation.

Statement: Mr. Tom Anderson will provide a general report on the MUSC Foundation's activities.

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

Recommendation of Committee:

Board Action:

Item 9. Other Committee Business.

EDUCATION, FACULTY AND STUDENT AFFAIRS COMMITTEE. CHAIRMAN: DR. E CONYERS O'BRYAN, JR.

OLD BUSINESS:

NEW BUSINESS:

Item 10. General Report of the Vice President for Academic Affairs and Provost.

Statement: A general report will be given by Dr. Mark Sothmann.

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

Recommendation of Committee:

Board Action:

Item 11. Other Committee Business.

CONSENT AGENDA ITEMS FOR APPROVAL:

Item 12. Conferring of Degrees.

Item 13. Department Name Change.

Item 14. Revision to MUSC's Student Equal Opportunity Policy.

Item 15. Faculty Appointments.

Item 16. Change in Faculty Status.

Item 17. Endowed Professorships.

FINANCE AND ADMINISTRATION COMMITTEE. CHAIRMAN: MR. CHARLES W. SCHULZE

OLD BUSINESS:

NEW BUSINESS:

Item 18. Financial Status Report of the Medical University of South Carolina.

Statement: Mr. Patrick Wamsley will report on the financial status of the Medical University of South Carolina.

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

Recommendation of Committee:

Board Action:

Item 19. Financial Status Report of MUSC Physicians.

Statement: A report on the financial status of MUSC Physicians will be presented by Ms. Gina Ramsey.

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

Recommendation of Committee:

Board Action:

Item 20. Other Committee Business.

CONSENT AGENDA ITEMS FOR INFORMATION:

Item 21. Financial Status Report of the MUSC Foundation for Research Development.

UNIVERSITY PHYSICAL FACILITIES COMMITTEE. CHAIRMAN: MR. WILLIAM H. BINGHAM, SR.

OLD BUSINESS:

NEW BUSINESS:

Item 22. Facilities Procurements/Contracts Proposed.

Statement: Mr. Greg Weigle will present procurements/contracts for approval.

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

Recommendation of Committee:

Board Action:

Item 23. Update on Projects.

Statement: Mr. Greg Weigle will present an update on Medical University of South Carolina facilities projects.

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

Recommendation of Committee:

Board Action:

Item 24. Other Committee Business.

CONSENT AGENDA ITEMS FOR INFORMATION:

Item 25. Facilities Contracts Awarded.

MEDICAL UNIVERSITY OF SOUTH CAROLINA AUDIT COMMITTEE, CHAIRMAN: Mr. WILLIAM B. HEWITT.

OLD BUSINESS:

NEW BUSINESS:

Item 26. External Financial Statement and Audit Report of MUSC for Fiscal Year End June 30, 2013.

Statement: Representatives from KPMG will present the results of the MUSC annual external audit for the period ending June 30, 2013.

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

Recommendation of Committee:

Board Action:

Item 27. Report of the Office of Internal Audit.

Statement: Ms. Susan Barnhart will report on the activities of the Office of Internal Audit.

Recommendation of Administration: That this be received as information.

Recommendation of Committee:

Board Action:

Item 28. Other Committee Business.

OTHER BUSINESS FOR THE BOARD OF TRUSTEES:

Item 29. Approval of Consent Agenda.

Statement: Approval of the Consent Agenda is requested.

Recommendation of Administration: That the consent agenda be approved.

Board Action:

Item 30. New Business for the Board of Trustees.

Item 31. Report from the Chairman.

BOARD OF TRUSTEES
MEDICAL UNIVERSITY OF SOUTH CAROLINA
RESEARCH AND INSTITUTIONAL ADVANCEMENT COMMITTEE
December 12, 2013

Through November 12, 2013, the Medical University of South Carolina has received about $10 million in private gifts and pledges. We also can report about $20 million in outstanding verbal commitments, which our team is working hard to close over the upcoming few months.

The following highlights reflect key accomplishments that have transpired since the October 2013 Board of Trustees meeting:

DEPARTMENT OF SURGERY

- The Department of Surgery received a verbal pledge from a College of Medicine alumnus for a gift of real estate valued at $2.7 million dollars.

- A retirement reception was held to recognize the 39-year career of one of MUSC's first transplant surgeons and namesake of the Fitts-Raja Endowed Chair in Transplant Surgery, Dr. PR Rajagopalan. Thus far, $78,000 has been raised for the separate Fitts-Raja Investment in Transplant Research Fund in honor of Dr. Raja's retirement.

- At a memorial tribute honoring Dr. Paul H. O'Brien at the American College of Surgeons Clinical Congress in Washington, DC, an additional $25,000 in gifts and pledges was contributed to the Paul H. O'Brien Endowment in Surgical Oncology.

MUSC CHILDREN'S HOSPITAL

- The Children's Hospital Fund received an additional planned gift from the parents of an alumnus in the amount of $869,000, bringing their total deferred gift to over $1.7 million.

- The Children's Hospital Fund received a gift of real estate valued at $270,000 and the Fund was also the beneficiary of $62,000 raised through the Hugs for Harper Tennis Tournament. All funds were designated for research in pediatric oncology.

- The Department of Pediatrics received a $25,000 gift from a member of the Children's Hospital Fund's Advisory Board.

COLLEGE OF MEDICINE

- The Medical Center's Intensive Care Unit received a pledge of $1.4 million to support its telemedicine initiative. This program will allow our ICU physicians the ability to provide consults with other hospital ICUs located throughout the state.

- The College of Medicine received an additional commitment of $280,000 from the Medical Society of South Carolina. This gift will fund three additional Roper St. Francis Physicians Medical Scholarships.

STORM EYE INSTITUTE

- The Storm Eye Institute received $250,000 in gifts and pledges to match the $250,000 challenge grant from Bill and Ruth Baker to purchase a CATALYS Laser for the Magill Vision Center. The CATALYS Precision Laser System is the world's most sophisticated laser cataract surgery system and the first of its kind in the state.

- A grateful patient of the Department of Ophthalmology created an additional $25,000 charitable gift annuity for the benefit of the Storm Eye Institute, bringing her total commitment this year to $85,000. These gifts are in addition to a $500,000 bequest also received from this benefactress.

DEPARTMENT OF MEDICINE

- The Department of Medicine received nearly $200,000 toward its $500,000 goal to establish the Jay Brzezinski, MD, Clinical Educator Professorship in honor of the clinical and educational achievements of Dr. Brzezinski.

- The MUSC Division of Rheumatology and Immunology received a gift of $25,000 from a grateful patient in honor of Dr. Richard M. Silver.

- The Department of Medicine hosted a celebratory dinner to introduce and announce the appointment of Dr. Carol Feghali-Bostwick to friends and family who helped establish the Kitty Trask Holt Endowed Chair for Scleroderma Research. This chair was established through $1.5 million in philanthropy given in memory of Ms. Holt.

- The Department of Medicine's Lupus Research and Education Fund was the recipient of a $2,500 gift given by the Dorman High School Volleyball Team from Spartanburg. The gift was made in memory of one of the team's family friends, Ms. Enyasha Walls, who passed away last year.

COLLEGE OF NURSING

- The MUSC College of Nursing received an anonymous gift of $206,100 earmarked for an endowed chair.

- The College received a gift $100,000 from a Greenville couple designated for the College of Nursing Building Fund.

- A College of Nursing alumna contributed $10,000 to support nursing scholarships.

HOLLINGS CANCER CENTER

- The 18th Annual Hollings Cancer Center Golf Tournament was held on September 16, 2013, at Turtle Point on Kiawah Island. The tournament raised $127,000 in support of cancer research.

- Hollings Cancer Center's signature fundraising event, Gourmet and Grapes, will be held February 7-9, 2014, at The Sanctuary on Kiawah Island Golf Resort. The weekend festivities will feature award-winning, local and regional chefs.

    - An Epicurean Affair - Friday evening exclusive and private dinner with the chefs of Kiawah; Saturday Gourmet Culinary Luncheon – where Colin Bedford of the Fearrington House, NC, will demonstrate and prepare lunch while winemakers will pour specially selected wines.

    - The Wine Odyssey Gala is the highlight of the weekend with 10-15 regional and local chefs who will prepare and serve food after a silent and live auction

    - The weekend concludes with a Farewell Brunch at Jasmine Porch.

JAMES B. EDWARDS COLLEGE OF DENTAL MEDICINE

- The Alliance to the South Carolina Dental Association, which is comprised of spouses of the members of the South Carolina Dental Association, pledged $50,000 to endow the C.A.R.E. Fund to provide financial assistance for dental patients who are struggling to pay for care. The acronym C.A.R.E. stands for Compassion, Access, Responsibility, and Excellence. The fund will not only assist a vulnerable population, but also help ensure that dental students have continuity in their clinical training. The effort to endow the fund is being led by Ms. Sherrie Fair (wife of Dr. J. Hal Fair, III, Class of '78) and Ms. Letha Edmonds (wife of Dr. Thomas R. Edmonds, Class of '78).

- A reception to honor the College's part-time faculty was held on October 24. Approximately 75 guests attended the event. Those part-time faculty who have served the college for 10 years or more were presented with a certificate of recognition from Dean Jack Sanders. The College depends upon its part-time faculty for clinical instruction of its students. Many are volunteers who receive no pay. Others receive only a small stipend. More than 300 part-time faculty are on record, some having taught for more than 40 years.

COLLEGE OF HEALTH PROFESSIONS

- The College of Health Professions received a $10,000 tribute gift in support of the Sushma Rao Memorial Scholarship Fund. Mr. Santhosh Rao contributed $5,000 to his late sister's fund, which was matched by his employer with another $5,000.

- Dr. and Mrs. Robert Curtis gave $10,000 in support of the Department of Healthcare Leadership and Management. To honor their commitment, The Dr. Robert S. & Marilyn C. Curtis Keynote Address in Healthcare Innovation & Entrepreneurship was established by the Department and the inaugural address was given at the 16th Annual MUSC Healthcare Leadership Conference on November 1.

COLLEGE OF PHARMACY

- The Student Legacy Committee, a subcommittee of the College of Pharmacy's Building Leadership Committee made up of members of the class of 2014, hosted the College's first "Donor Appreciation Week" during the week of October 7-11. With the help of classmates, they called more than 100 alumni and wrote approximately 150 notes to donors thanking them for their support of the College of Pharmacy.

ALUMNI AFFAIRS

- The first quarter of 2013 reflected aggregate alumni association membership of all six colleges at 25 percent.

- The Alumni Association's Joint Board met on October 11, 2013. Updates from each alumni association board were presented. The board approved the funds received from the sale of license plates to fund the Elizabeth P. Waters Joint Alumni Scholarship. The gavel of leadership was passed from Joint Board president Dr. Jeffrey Bayme (DMD) to Dr. Rowena Sobczyk (MD).

- The College of Medicine Class of 1953 held a "Diamond Jubilee" reunion celebration on November 2, 2013. Arrangements were made so that those who could not attend were able to "conference in" to join in the festivities. The event was led by the efforts of class member Dr. H. Biemann Othersen.

- In conjunction with the South Carolina College of Pharmacy, MUSC's College of Pharmacy Alumni Association co-sponsored a Pharmacy Appreciation Oyster Roast on October 11, 2013. The event was held at Bowen's Island with more than 250 people in attendance, including many alumni and preceptors.

- We are currently recruiting for an executive director of Alumni Affairs. We hope to have that position filled within the next six months.

MUSC BOARD OF VISITORS

- The MUSC Board of Visitors Agenda for December 13th follows:

o *Welcome*	Dr. Mark Sothmann
o *Neuroscience Technology Transfer*	Dr. Bruce Frankel
o *Carolina eHealth Alliance*	Dr. Chris Carr
o *Admissions Process for the College of Medicine*	Dr. Paul Underwood
o *Health, Illness and the Presidency*	Dr. Larry Mohr
o *Tour of MUSC Healthcare Simulation Center*	Mr. John Walker

- The next meeting of the MUSC Board of Visitors has been scheduled for May 2, 2014.
    - This is two weeks prior to the May meeting of the Board of Trustees

1. CEO of the MUSC Foundation – Thomas P. Anderson

- Realized endowment investment at October 31, 2013 of:

	1 YR	3 YR	5 YR
MUSCF	14.1%	10.7%	10.2%
Allocation Benchmark *	13.9%	9.7%	8.9%

* Russell 3000, EAFE (net), HFRI Eq Hedge, Cambridge PE, Barclays Agg, HFRI Relative Value, HFRI FOF, NCREIF – Property, 90 day T-Bills.
NOTE: Benchmark allocations change quarterly based on beginning of quarter weights.

- Increased total assets by $46.2 million or 10.8% for trailing 12 months at 10/31/13 to a record $471.8 million.

- Elected new Board leaderships.

  - Chairman
    Carlos E. Evans
    Executive Vice President, WellsFargo
    Charlotte, NC

  - Vice Chairman
    Daniel J. Sullivan
    Retired Founder – FedEx Home Delivery
    Kiawah Island, SC

- Approved purchase of 382 Spring Street, Crosby's Seafood at the corner of Spring Street and Lockwood Boulevard, as final assemblage of MUSC Foundation land for Horizon Project.

  - Price: $772,000

- Received Unqualified Opinion with no material weaknesses cited on independent audit report at FYE June 30, 2013.

THE MEDICAL UNIVERSITY OF SOUTH CAROLINA

Monthly Financial Reports

Table of Contents

For the Four (4) Month Period Ended October 31, 2013

The Medical University of South Carolina and Affiliated Organizations
Statement of Net Position
As of October 31, 2013

	University	Area Health Education Consortium	Facilities Corporation	CHS Development Company
Assets & Deferred Outflows				
Cash and Cash Equivalents	$ 182,439,907	$ 6,850,543	$ -	$ -
Cash and Cash Equivalents - Restricted	18,583,625	-	16,474	496,994
State Appropriation Receivable	50,204,661	4,469,499	-	-
Student Tuition and Fees Receivable	500,596	-	-	-
Student Loan Receivable	12,872,276	-	-	-
Grants and Contracts Receivable	48,338,597	48,740	-	-
Capital Improvement Bond Proceeds Receivable	229,762	-	-	-
Capital Lease Receivable	-	-	3,232,653	16,666,566
Other Receivables	1,313,275	-	7,348	-
Investments	-	-	320,033	1,284,894
Prepaid Items	5,182,342	-	-	1,594,085
Capital Assets, net of Accumulated Depreciation	542,771,032	-	-	-
Due from Hospital Authority	12,096,142	-	-	-
Due from Other Funds	92,325,504	-	-	-
Bond Issue Costs	725,024	-	49,373	302,838
Other Assets	-	-	-	-
Total Assets & Deferred Outflows	**$ 967,582,743**	**$ 11,368,782**	**$ 3,625,881**	**$ 20,345,377**
Liabilities & Deferred Inflows				
Accounts Payable	$ 8,559,696	$ 643,371	$ -	$ -
Accrued Payroll and Other Payroll Liabilities	5,761,849	-	-	-
Accrued Compensated Absences	28,844,732	200,016	-	-
Deferred Revenue	72,864,173	6,420,022	-	-
Retainages Payable	-	-	-	-
Long-Term Debt	173,020,197	-	3,544,000	18,756,171
Interest Payable	935,575	-	22,008	192,900
Deposits Held for Others	4,305,482	166,807	-	-
Due to Hospital Authority	-	-	-	-
Due to Other Funds	8,966,892	-	-	-
Federal Loan Program Liability	14,305,947	-	-	-
Other Liabilities	33,408,081	1,504	-	-
Total Liabilities & Deferred Inflows	**$ 350,972,624**	**$ 7,431,720**	**$ 3,566,008**	**$ 18,949,071**
Net Position	**$ 616,610,119**	**$ 3,937,062**	**$ 59,873**	**$ 1,396,306**
Total Liabilities & Deferred Inflows and Net Position	**$ 967,582,743**	**$ 11,368,782**	**$ 3,625,881**	**$ 20,345,377**

The Medical University of South Carolina and Affiliated Organizations
Statement of Revenues, Expenses and Changes in Net Position
For the Four (4) Month Period Ending October 31, 2013

	University	Area Health Education Consortium	Facilities Corporation	CHS Development Company
Operating Revenues				
Student Tuition and Fees	$ 30,311,549	$ -	$ -	$ -
Federal Grants and Contracts	44,048,389	125,275	-	-
State Grants and Contracts	2,093,100	(43,622)	-	-
Local Government Grants and Contracts	5,550	-	-	-
Nongovernmental Grants and Contracts	12,386,296	233,650	-	-
Sales and Services to Hospital Authority	34,201,692	180	-	-
Sales and Services of Educational and Other Activities	19,312,369	340	-	-
Sales and Services of Auxiliary Enterprises	4,063,056	-	-	-
Interest Income	-	-	128,000	292,893
Other Operating Revenues	5,569,391	34,162	-	-
Total Operating Revenues	**151,991,392**	**349,985**	**128,000**	**292,893**
Operating Expenses				
Compensation and Employee Benefits	111,877,240	831,448	-	-
Services and Supplies	62,308,984	1,184,322	-	(10)
Utilities	5,137,800	-	-	-
Scholarships and Fellowships	6,497,690	(800)	-	-
Refunds to Grantors	53,718	-	-	-
Interest Expense	-	-	97,103	222,540
Depreciation and Amortization	13,313,909	-	5,643	61,156
Total Operating Expenses	**199,189,341**	**2,014,970**	**102,746**	**283,686**
Operating Income (Loss)	**(47,197,949)**	**(1,664,985)**	**25,254**	**9,207**
Nonoperating Revenues (Expenses)				
State Appropriations	19,442,735	3,210,011	-	-
State Appropriations - MUHA	9,084,569	-	-	-
Gifts and Grants Received	3,718,584	-	-	-
Investment Income	2,630,388	-	-	-
Interest Expense	(2,670,813)	-	-	-
Gain (Loss) on Disposal of Capital Assets	(1,435,268)	-	-	-
Transfers From (To) Other State Agencies	(150,707)	(1,504)	-	-
Other Nonoperating Revenues (Expenses), net	(2,836,742)	-	-	-
Net Nonoperating Revenues (Expenses)	**27,782,746**	**3,208,507**	**-**	**-**
Income (Loss) Before Other Revenues, Expenses, Gains, Losses and Transfers	**(19,415,203)**	**1,543,522**	**25,254**	**9,207**
Capital Appropriations	356,509	-	-	-
Capital Grants and Gifts	293,222	-	-	-
Additions to Permanent Endowments	2,195,054	-	-	-
Transfers From (To) MUSC Physicians (UMA)	17,009,425	-	-	-
Transfers From (To) AHEC	(1,075)	1,075	-	-
Transfers From (To) CHS Development	(144,775)	-	-	144,775
Transfers From (To) Facilities Corporation	-	-	-	-
Increase (Decrease) In Net Position	**$ 293,157**	**$ 1,544,597**	**$ 25,254**	**$ 153,982**

The Medical University of South Carolina
Budgeted Funds Comparison to Budget
For the period ending October 31, 2013

	Budget	Prorated Budget (Note)	Actual	Variance	
REVENUES					
State					
State Appropriations	58,237,887	19,412,629	19,442,735	30,106	F
State Appropriations - MUHA	31,253,707	10,417,902	9,084,569	(1,333,333)	U
State Grants & Contracts	6,982,424	2,327,475	2,093,100	(234,375)	U
Total State	**96,474,018**	**32,158,006**	**30,620,404**	**(1,537,602)**	**U**
Federal					
Federal Grants & Contracts	102,725,201	34,241,734	33,814,346	(427,388)	U
Federal Grants Indirect Cost Recoveries	32,303,824	10,767,941	10,234,043	(533,898)	U
Total Federal	**135,029,025**	**45,009,675**	**44,048,389**	**(961,286)**	**U**
Other					
Private Grants & Contracts	23,700,418	7,900,139	10,873,894	2,973,755	F
Private Grants Indirect Cost Recoveries	4,070,766	1,356,922	1,517,952	161,030	F
Gifts	12,267,774	4,089,258	3,718,584	(370,674)	U
Tuition and Fees	86,207,825	28,943,754	30,311,549	1,367,795	F
Sales and Services of Educational Departments	55,694,554	18,564,851	19,312,369	747,518	F
Sales and Services of Auxiliary Enterprises	13,380,049	4,460,016	4,063,056	(396,960)	U
Interest and Investment Income	124,747	41,582	(4,676)	(46,258)	U
Endowment Income	798,472	266,157	827,994	561,837	F
Miscellaneous	10,271,135	3,423,712	3,843,559	419,847	F
Miscellaneous - Residents	4,652,943	1,550,981	1,613,214	62,233	F
Authority Revenue	67,377,588	22,459,196	21,414,653	(1,044,543)	U
Authority Revenue - Residents	40,149,609	13,383,203	15,423,451	2,040,248	F
Intra-Institutional Sales	37,142,811	12,380,937	10,848,184	(1,532,753)	U
Total Other	**355,838,691**	**118,820,708**	**123,763,783**	**4,943,075**	**F**
Total Revenues	**587,341,734**	**195,988,389**	**198,432,576**	**2,444,187**	**F**
EXPENDITURES					
Instruction	114,869,938	38,289,979	31,909,613	6,380,366	F
Instruction - Residents	45,932,032	15,310,677	16,025,050	(714,373)	U
Instruction - MUHA	18,853,707	6,284,569	6,284,569	-	F
Research	182,938,804	60,979,601	59,597,910	1,381,691	F
Public Service	46,676,189	15,558,730	24,319,399	(8,760,669)	U
Academic Support	48,810,640	16,270,213	15,102,062	1,168,151	F
Student Services	8,269,766	2,756,589	2,871,781	(115,192)	U
Institutional Support	68,448,398	22,816,133	19,257,315	3,558,818	F
Operation & Maintenance of Plant	65,106,403	21,702,134	23,218,972	(1,516,838)	U
Scholarships & Fellowships	2,387,602	795,867	828,224	(32,357)	U
Auxiliary Enterprises	11,399,494	3,799,831	3,219,030	580,801	F
Telemedicine - MUHA	12,400,000	4,133,333	2,800,000	1,333,333	F
Indirect Cost Remitted to State	140,000	46,667	150,707	(104,040)	U
Debt Services	6,839,339	2,279,780	2,279,780	-	F
Total Expenditures	**633,072,312**	**211,024,103**	**207,864,412**	**3,159,691**	**F**
OTHER ADDITIONS (DEDUCTIONS)					
Transfers from (to) UMA	65,148,206	21,716,069	17,009,425	(4,706,644)	U
Transfers from (to) Facilities Corporation	-	-	-	-	F
Transfers from (to) AHEC	(3,700)	(1,233)	(1,075)	158	F
Transfers from (to) CHS Development	(336,372)	(112,124)	(144,775)	(32,651)	U
Transfers from (to) Loan funds	-	-	(147)	(147)	U
Transfers from (to) Plant Funds	(23,521,006)	(7,840,335)	(7,847,002)	(6,667)	U
Refunds to Grantors	(9,373)	(3,124)	(53,718)	(50,594)	U
Transfers to Endowment Fund	(11,929)	(3,976)	-	3,976	F
Total Other Additions (Deductions)	**41,265,826**	**13,755,277**	**8,962,708**	**(4,792,569)**	**U**
NET INCREASE (DECREASE) in Fund Balance	**(4,464,752)**	**(1,280,437)**	**(469,128)**	**811,309**	**F**

Note: Budgeted tuition is prorated based on semesters; Other budgeted items prorated based on calendar months.

The Medical University of South Carolina
Direct Expenditures on Federal Grants and Contracts
(By Responsibility Center)
For the 4 Month Period Ending October 31, 2013

Administration	193,832
Centers of Excellence	2,089,872
College of Dental Medicine	1,106,773
College of Graduate Studies	419,733
College of Health Professions	643,196
College of Medicine	27,568,174
College of Nursing	939,349
College of Pharmacy	345,839
Library	507,580
	$33,814,346

NOTE: The federal direct expenditures shown above were incurred by the University. The federal grant and contract revenue earned to cover these direct expenditures. was $33,814,346 .

In addition to this federal grant and contract revenue, the University received $10,234,043 in federal monies to reimburse it for Facilites and Administration (F+A) costs incurred to administer the above federal grants and contracts. $10,083,336 of the F+A recoveries received is unrestricted which means the University can use it for any of its operating needs. The remaining $150,707 represents the F+A recoveries on non-research federal grants and contracts. This amount is required to be remitted to the State.

University direct federal expenditures	$33,814,346
Facilites and Administration costs	$10,234,043
Federal operating grants and contracts	$44,048,389

THE MEDICAL UNIVERSITY OF SOUTH CAROLINA
NOTES TO THE FINANCIAL STATEMENTS
October 31, 2013

Note 1. *Basis of Presentation*
This financial statement provides summarized information for The Medical University of South Carolina (MUSC) and its affiliated organizations in discrete columns on the same page. The purpose of this financial report is to provide information that will be helpful to those who must make decisions about MUSC.

Note 2. *State Appropriations*
State appropriations revenue is prorated evenly over the twelve month period for which the funds are to be spent.

Note 3. *Cash and Cash Equivalents - Restricted*
Cash and cash equivalents - restricted include bond proceeds, the debt service reserve accounts, and the debt service fund accounts.

Note 4. *Capital Assets, Net of Accumulated Depreciation*
The University's capital assets, net of accumulated depreciation consists of the following:

Construction in progress	$ 34,397,864
Land/Bldgs/Equipment/Accumulated depreciation	508,373,167
Capital Assets, Net of Accumulated Depreciation	$ 542,771,032

Note 5. *Construction in Progress*
Construction in progress consists of the following projects and expenditures to date and is included in Capital Assets, Net of Accumulated Depreciation on the Statement of Net Assets.

	Jun 30, 2013 Balance	Fiscal Year 2014 Added	Capitalized	Oct 31, 2013 Balance
Microbiology & Immunology Renovations in BSB	6,290,801	175,359	-	6,466,160
Air Handler Replacement in BSB	4,060,123	27,664	-	4,087,787
Dental Medicine Classroom Renovations in BSB	2,597,460	-	-	2,597,460
Neurosciences 3rd Floor Renovations in CSB	1,854,666	-	-	1,854,666
Psychiatric Institute Data Center System	1,855,848	64,112	-	1,919,960
Bioengineering Building	955,122	231,097		1,186,219
Thurmond Exhaust System	826,493	1,047,019		1,873,513
Exhaust & Emergency Power Impr in BSB	1,791,838	24,146	-	1,815,984
College of Nursing Floors 2-5	1,107,766	1,267,096	-	2,374,862
Deferred Maintenance - FY 2012	1,137,921	165,026	-	1,302,947
AHU-6 Replacement in CSB	1,073,959	-	-	1,073,959
Others less than $1,000,000 (ending balance)	6,700,184	1,144,163	-	7,844,347
Total construction in progress	$ 30,252,180	$ 4,145,684	$ -	$ 34,397,864

Note 6. *Deferred Revenue*
The University's deferred revenue consists of the following:

State appropriations	$ 43,627,753
Grants and contracts	14,058,717
Student tuition and fees	14,989,053
Other	188,650
Total Deferred Revenue	$ 72,864,173

Note 7. *Long Term Liabilities*

The University's long term liabilities consist of the following:

Obligations under capital leases	$ 65,388,942
Higher Education Revenue bond payable	32,415,000
State Institution bonds payable	71,505,000
Premium on State Institution bonds payable	1,459,595
Energy performance note payable	3,214,751
Deferred loss on early retirement of bonds	(963,091)
Total Long Term Liabilities	$ 173,020,197

Note 8. *Comparison to Budget*

The Comparison to Budget statement (page 3) includes only activity in the current funds. The Statement of Revenues, Expenses, and Changes in Net Assets (page 2) includes current funds, loan funds, endowment and similar funds, and plant funds.

Net increase (decrease) in fund balance per Comparison to Budget statement		$ (469,128)
Plant funds:		
Capital grants and gifts - Federal	287,747	
Capital grants and gifts - State	-	
Capital grants and gifts - private	-	
Capital appropriations	356,509	
State appropriations (for MUHA)	-	
Donated property & other in-kind donations	5,475	
Interest and investment income	154,471	
Other operating revenue	-	
Other nonoperating revenue	-	
Expended in current fund-lease principal	977,469	
Expended in current fund-capital costs	918,716	
Transfers	10,126,782	
Expensed in plant fund-depreciation	(13,313,909)	
Expensed in plant fund-interest expense	(1,123,554)	
Expensed in plant fund-other	(88,875)	
Gain (loss) on disposition of property	(1,435,268)	(3,134,437)
Loan funds:		
Other income		
Interest and investment income	125,223	
Expenses	(63,696)	
Transfers	147	61,674
Endowment funds:		
New endowments	2,195,054	
Income draws to operating units	(892,146)	
Endowment income (Loss)	2,532,140	
Transfers	-	3,835,048
Other		
Net increase (decrease) in Net Assets per Statement of Revenues, Expenses, and Changes in Net Assets		$ 293,157

Medical University of South Carolina
Summary of Current Debt Obligations and Analysis of Available Bonded Debt Capacity

($$ in thousands)

	Original Issue	Authorized Not Issued	Purpose	Outstanding & Authorized as of 31-Oct-2013
State Institution Bonds (SIB)				
SIB 2003J	$ 12,000	$ -	Renovations of Thurmond/Gazes bldg. and subpower plant	$ 565
2005 Refunding	19,045	-	Advance refunding on SIB2000A	13,325
SI BAN 2012	30,000	-	College of Dental Medicine Building	28,000
SIB 2011D	18,950	-	Deferred maintenance projects	17,490
SIB 2012B refunding	12,645	-	Refunding SIB 2001C, 2003D, & 2003J	12,125
	$ 92,640	$ -		
Current SIB Debt Authorized and Issued				$ 71,505
Notes Payable - JEDA	$ 32,985	$ -	Construction of College Health Health Profession facilities	$ 19,290
Lease Revenue Bonds				
LRB 1995 A & B	$ 13,201	$ -	Thurmond Biomedical Center	$ 3,544
Higher Education Revenue Bonds				
2006	$ 38,000	$ -	Construction of Parking Garage	$ 32,415
Energy Performance Note Payable				
EPNP 11-26-08	$ 15,387	$ -	Energy Savings	$ 3,215

MUSC Physicians and MUSC Physicians Primary Care
(A Component Unit of the Medical University of South Carolina)

Statement of Revenues, Expenses and Changes in Net Position

	For the Four Months Ending 10/31/12	For the Four Months Ending 10/31/13
Operating Revenues		
Net clinical service revenue	88,243,542	94,740,819
Other operating revenue	1,077,831	1,843,426
Ambulatory care and MUHA revenue cycle support	2,075,653	1,788,119
Primary care support	1,066,667	1,066,667
Total operating revenues	92,463,693	99,439,031
Operating Expenses		
Departmental expenses	68,045,988	67,730,806
Corporate operating expenses	10,796,088	10,631,364
Ambulatory care and MUHA revenue cycle expenses	1,594,034	1,319,819
New Initiative expenses	2,987,000	348,838
Total expenses	83,423,110	80,030,827
Operating Income (Loss)	9,040,583	19,408,204
Nonoperating Revenues (Expenses)	2,800,020	1,791,216
Transfers from (to) Related Entities		
Nonmandatory contributions to the MUSC Foundation	(999,999)	(231,760)
Nonmandatory transfers to the MUSC	(18,948,428)	(17,009,425)
Change in Net Position Before Extraordinary Items	(8,107,824)	3,958,234
Extraordinary/Special Items	-	-
Transfers to Debt Service and Equity Deficits	531,274	(377,818)
Change in Net Position Before Expenses Related to the DHHS Supplemental Revenue	(7,576,550)	3,580,416
Expenses Related to the DHHS Supplemental Revenue	-	-
Change in Net Position	(7,576,550)	3,580,416

FACILITIES

ACADEMIC/RESEARCH/CLINICAL

POWER LINE EASEMENTS

FOR APPROVAL

December 13, 2013

PROJECT TITLE: SCE&G Power Line Easements along Bee and President Streets

PROJECT NUMBER: N/A

TOTAL ESTIMATED BUDGET: $3.00 credit

SOURCE(S) OF FUNDS: SCE&G

JUSTIFICATION: A total of three (3) easements, two along President and one on Bee Street, are being requested by SCE&G. The transmission line from their plant on Hagood to the Bee Street Substation will be rebuilt in order for SCE&G to increase capacity and service reliability to local customers throughout the community. This project includes the lowering of the transmission line on President Street which will reduce the obstructions for the helicopters landing on the President Street Parking Garage (PGII). Additionally, distribution facilities that are adjacent to the Garage will be placed underground.

The project scope entails the removal and installation of four transmission structures, removal of overhead distribution conductors, and the installation of three switchgear cabinets, one transformer and one manhole.

MUSC will receive a $1.00 credit for each easement.

MEDICAL UNIVERSITY OF SOUTH CAROLINA

CONSENT AGENDA

Board of Trustees Meeting
Friday, December 13, 2013
101 Colcock Hall

Members of the Board of Trustees

Thomas L. Stephenson, Esquire, Chairman
Dr. James E. Wiseman, Jr., V-Chairman
The Honorable James A. Battle
Mr. William H. Bingham, Sr.
Mr. William B. Hewitt
Dr. Harold W. Jablon
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. Ragin C. Monteith
Mr. Charles W. Schulze
The Honorable Robin M. Tallon
Dr. Thomas C. Rowland, Jr.
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Dr. Charles B. Thomas, Jr.

Trustees Emeriti
Mrs. Margaret M. Addison
Dr. Cotesworth P. Fishburne, Jr.
Mrs. Claudia W. Peeples
Mr. Allan E. Stalvey

EDUCATION, FACULTY AND STUDENT AFFAIRS COMMITTEE
CHAIRMAN: DR. E. CONYERS O'BRYAN, JR.

(APPROVAL ITEMS)

Item 12. Conferring of Degrees.

Statement: Approval is requested to confer degrees upon those candidates who, pending successful completion of all requirements for their degrees by the conclusion of the fall semester, have the recommendation of their college dean and faculty.

Recommendation of Administration: That the conferring of degrees be approved.

Recommendation of Committee:

Board Action:

Item 13. Department Name Change.

Statement: At the request of the Dean of the College of Dental Medicine, administration presents the following department name change:

From: Department of Craniofacial Biology
To: Department of Oral Health Sciences

Recommendation of Administration: That this department name change be approved.

Recommendation of Committee:

Board Action:

Item 14. Revision to MUSC's Student Equal Opportunity Policy.

Statement: Administration presents for approval the following revision to MUSC's Student Equal Opportunity Policy:

Modification: To expand the nondiscrimination policy/language in *The Student Bulletin* to specifically include nondiscrimination based on "gender identity".

The language in the Student Bulletin, including the modification, would read as follows:

"The Medical University of South Carolina does not discriminate on the basis of race, color, creed, sex, age, national origin, disability, sexual orientation, gender identity, veteran status, or marital status in the administration of admission policies, educational policies, financial aid, or any other university activity."

Recommendation of Administration: That this revision to MUSC's Student Equal Opportunity Policy be approved.

Recommendation of Committee:

Board Action:

Item 15. Faculty Appointments.

Statement: At the request of the Dean of the College of Medicine, administration presents the following faculty appointments:

Richard K. Bogan, M.D., as Clinical Associate Professor in the Department of Psychiatry and Behavioral Sciences, effective October 1, 2013
Zipporah Krishnasami, M.D., as Clinical Associate Professor in the Department of Medicine, Division of Nephrology, effective December 1, 2013
Terrence E. Steyer, M.D., as Associate Professor with tenure, on the Clinician Educator track in the Department of Family Medicine, effective January 1, 2014

Dr. Steyer also will serve as Chair of the Department of Family Medicine.

John Edward Vena, Ph.D., as Professor on the Academic Clinician track in the Department of Public Health Sciences, effective January 1, 2014

Dr. Vena also will serve as Founding Chair of the Department of Public Health Sciences.

Recommendation of Administration: That these faculty appointments be approved.

Recommendation of Committee:

Board Action:

Item 16. Change in Faculty Status.

Statement: At the request of the Dean of the College of Medicine, administration presents for approval the following changes in faculty status:

Richard J. Friedman, M.D., from Clinical Professor to Professor on the Clinician Educator track, in the Department of Othopaedics, effective November 1, 2013
Raymond S. Greenberg, M.D., Ph.D., from Professor to Adjunct Professor, in the Department of Public Health Sciences, effective September 1, 2013

Recommendation of Administration: That these changes in faculty status be approved.

Recommendation of Committee:

Board Action:

Item 17. Endowed Professorships.

Statement: At the request of the Dean of the College of Medicine, administration presents the following requests for appointments and reappointments of endowed professorships, effective December 13, 2013:

Appointment of **Betsy K. Davis, D.M.D., M.S.**, as the Wendy and Keith Wellin Endowed Chair in Maxillofacial Prosthodontics and Dental Oncology
Reappointment of **John S. Ikonomidis, M.D.**, as the Horace G. Smithy Professor of Surgery
Reappointment of **Louis M. Luttrell, M.D.**, as the James A. Keating, Jr. Endowed Chair in Diabetes
Reappointment of **William P. Moran, M.D., M.S.**, as the McKnight Chair in Geriatrics
Reappointment of **Jihad S. Obeid, M.D.**, as the Endowed Chair for Biomedical Informatics Associated with Clinical Effectiveness and Patient Safety
Reappointment of **Melanie B. Thomas, M.D.**, as the Grace E. DeWolff Endowed Chair of Medical Oncology

Recommendation of Administration: That these appointments and reappointments of endowed professors be approved.

Recommendation of Committee:

Board Action:

FINANCE AND ADMINISTRATION COMMITTEE
CHAIRMAN: MR. CHARLES W. SCHULZE

(INFORMATION ITEM)

Item 21. Financial Status Report of the MUSC Foundation for Research Development.

Statement: A report will be provided on the financial status of the MUSC Foundation for Research Development.

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

Recommendation of Committee:

Board Action:

PHYSICAL FACILITIES COMMITTEE
CHAIRMAN: MR. WILLIAM H. BINGHAM, SR.

(INFORMATION ITEM)

Item 25. Facilities Contracts Awarded.

Statement: Facilities Contracts awarded will be presented to the Board of Trustees.

Recommendation of Administration: That this be received as information.

Recommendation of Committee:

Board Action:

Medical University of South Carolina
December 2013 Graduates

Bachelor of Science in Cardiovascular Perfusion

Anna Thomas Allen
Brooke Amber Barnes
Leslie Cerenzia
Cynthia S. Chasteen
Heather Meredith Childress
David Justin Guthrie
Lisa Ann Haltiwanger
Andrea Marie Iksic
Mary Alden Jackson
Grace Laird Johnston
Sheri Annette Jones
Seth Thomas Long
Ryan Andrew McLain
Jessica Jane Moroney
Megan Elizabeth Morris
Amber Dyan Mulak
Clarissa Maria Neely
Sarah Ann Nirewicz
Megan Grae Owens
Meghan Elizabeth Purves
Ashley Lawson Robinson
Jeffrey Joseph Smith
Dantri Renee Stark
Kristen Turner Tan
Anna TeVault
Andrea Lisa Vella-Camilleri
Brooke Anderson Williams
Kerry Mckeown Zeigler

Bachelor of Science in Nursing

Emmalyn Grace Baggett
Brian Richard Bartnett
Meghan Brittany Behlmer
Crystal Cassandra Bell
Matthew Walter Bogart
Sarah Elizabeth Brown
Desmond Tramell Capers
Rebecca Lane Carter
Zachary Davis Childress
Dominique Suzanne Cognetta
Kelly Elizabeth Creech
Lindsay Cherise Dangerfield
Gregg Swanson Davis
Jessica Megan Dell
Corey James Drake
Brittany Kristen Dunsford
Kara Charnelle Edmond
Emily Davenport Eling
Benito Espinoza Jr.
Everette Ashley Gallman
Holly Kathryn Hair
Sarah Lynn Hornsby
Kelley Marie Jewett
Cassie Ann Jones
Katie Marie Kundinger
Justyn Elizabeth Lamb
Katherine F. Langdon
Brooke Nicole Lehman
Abbey Maria Lowder
Julia Walker Mack
Thomas Daniel Martin Jr.
Steffany Marie Mattson
Kevin David McCarthy
Adam Lawrence Miller
Grace Mary Moran-Hanna
Ashley Morgan
Stephen Matthew Morris
Kelly Michelle Nagel
Kaitlyn Marie O'Gorman
Charlene Villanueva Ocampo
Michael Joseph Occhipinti
Robert Paul Osborne
Anne Griffin Patterson
Caroline Raines Pearce
Stephanie Lane Purser
Daniela Ramirez
Racheal Liz Rivera
Allison Marie Roble
Hollie Marie Schneck
Kelli Anne Schoen
Steven Michael Schultz
Braiden Leigh Sightler
Misty Rae Stauffer
Aly Lauren Stern
Shanice Daushaneik Strobhart
Megan Elizabeth Summers
Morgan Lewis Williams
Kyra Nicole Wilson

Libby Monica Yee

Master in Health Administration

Morgan Altman James
Brian Reynolds Jenkins
Jason Douglas Richichi

Master of Science in Physician Assistant Studies

Anthony Adarr Clare
Candace Keturah Lewis
Melissa Erin Whitson

Master of Science in Nursing

Devyn Christopher Feil
Sarah Megan Strong

Master of Science in Biomedical Sciences

Dion Anthony Foster, Jr.

Master of Science in Clinical Research

Nortorious Teaundra Coleman

Doctor of Health Administration

Merritt M. Brockman
Anthony Bernard Coleman
Justin Lamar Crockett
Daniel Edward Furlong
Larry Reese Kidd
Lauren F. Lent
Michael Dennis Moran
Anthony Charles Stanowski

Doctor of Nursing Practice

Evelyn Rebecca Holmes Coe
Sonya Kay Ehrhardt
Tishana Louise Gary
Delwin B. Jacoby
Elizabeth Ann Holloway Jensen
Bonne Tate Johnson
Denise Marie Kilway
Margaret Kingslea Moore
Sandra Sonia Munaco
Abigail Kaniaris Rishovd
Angela Yvonne Stanley
Susan Lee Zayac

Doctor of Philosophy - Rehabilitation Sciences

Victor Manuel Fresco

Doctor of Philosophy

Teresa Christina Wall Atz
Teresa Thornburg Carnevale
Hollie Kaye Caldwell
Kathryn Frances Cunningham
Jenny Rebecca Freeman
Shanmugam Panneer Selvam
Kimberly Ann Sell
Nicole Neva Marie Trager
Brent Allen Wilkerson

Medical University of South Carolina

College of Medicine

ABBREVIATED CURRICULUM VITAE

Date: August 23, 2013

Name: Bogan (**Last**) Richard (**First**) K. (**Middle**)

Citizenship and/or Visa Status:

Office Address: 1333 Taylor Street, Suite 6-B, Columbia, SC 29201 **Telephone:** 803-251-3093

Education: ***(Baccalaureate and above)***

Institution	Years attended	Degree/Date	Field of Study
Wofford College	1962 - 1966	B.S. / 1966	Chemistry
Medical University of South Carolina	1966 - 1970	M.D. / 1970	Medicine

Graduate Medical Training*: (Chronological)*

	Place	Dates
Internship		
	University of Alabama Hospital and Clinics; Internship – Medicine	1970-1971
Residencies or Postdoctoral:		
	University of Alabama Hospital and Clinics; Residency - Internal Medicine	1974-1975
	University of Alabama School of Medicine; Fellowship - Pulmonary Division	1976-1978

Board Certification:	American Board of Internal Medicine	**Date:** 1975
	American Board of Pulmonary Diseases	**Date:** 06/1978
	American Board of Sleep Medicine	**Date:** 04/1989
	American Board of Medicine, Sleep	**Date:** 11/2009
	American Board of Critical Care	**Date:** 11/1992 (expired)
Licensure:	Alabama, 5698	**Date:**
	Georgia, 14603	**Date:**
	South Carolina, 8796	**Date:**

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
Present	Assoc. Clin Professor	USC Medical School	

First Appointment to MUSC: Rank Clinical Associate Professor **Date:**

Medical University of South Carolina

College of Medicine

ABBREVIATED CURRICULUM VITAE

Date: October 1, 2013

Name: Krishnasami (**Last**) Zipporah (**First**) (**Middle**)

Citizenship and/or Visa Status: U.S.A.

Office Address: Charleston, SC 29425

Telephone: (843)

Education: ***(Baccalaureate and above)***

Institution	Years attended	Degree/Date	Field of Study
Boston University	1987-1991	B.S. / 1991	Biomedical Engineering
University of Alabama SOM	1992-1996	M.D. / 1996	Medicine

Graduate Medical Training*: (Chronological)*

	Place	Dates
Internship	Internal Medicine, University of Alabama at Birmingham	1996-1999

	Place	Dates
Residencies or Postdoctoral:	Internal Medicine, University of Alabama at Birmingham	1996-1999

Board Certification:	Internal Medicine	**Date:** 1999, Renewal 2011
	Nephrology	**Date:** 2001, Renewal 2011
		Date:
		Date:
Licensure:	Alabama 00021075	**Date:**
	Maryland D0057696 (Inactive)	**Date:**
		Date:
		Date:

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2003-2011	Assistant Professor	University of Alabama	Medicine
2011-pres.	Associate Professor	University of Alabama	Medicine

First Appointment to MUSC: Rank Clinical Associate Professor **Date:** 12/01/2013

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: Terrence E. Steyer, M.D. Date: 10/18/2013

Citizenship and/or Visa Status: U.S. Citizen

Office Address: UGA Health Sciences Campus
108 Spear Road - WD #207
Athens, GA, 30606

Telephone: (706) 713-2190

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1990	Allegheny College	B.S.	Mathematics
1994	Case Western Reserve University	M.D.	Medicine

Graduate Medical Training:*(Chronological)*

Residencies or Postdoctoral	Place	Dates
Family Medicine	Wake Forest University/Baptist Medical Center, Winston-Salem, NC	1995 - 1998
Robert Wood Johnson Clinical Scholar	University of Michigan School of Medicine, Ann Arbor, MI	1998 - 2000

Board Certification:

American Board of Family Medicine	Date: 1998
American Board of Family Medicine, Recertification	Date: 2004

Licensure:

North Carolina	Date: 1996-2010
Michigan	Date: 1998-2001
South Carolina	Date: 2000-2011
Georgia	Date: 2009-present

Faculty Appointments:

Years	Rank	Institution	Department
1998 - 2000	Lecturer	University of Michigan	Family Medicine & Internal Medicine
2000 - 2007	Assistant Professor	Medical University of South Carolina	Family Medicine
2007 - 2009	Associate Professor	Medical University of South Carolina	Family Medicine
2009 - Present	Associate Professor	Medical College of Georgia	Family Medicine

First Appointment to MUSC: Rank : Assistant Professor Date : 2000

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: John Edward Vena, Ph.D. Date: 10/18/2013

Citizenship and/or Visa Status: USA

Office Address: TBD Telephone: TBD

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1975	Saint Bonaventure University	B.S.	Biology
1976	State University of New York at Buffalo	M.S.	Natural Sciences (Epidemiology)
1980	State University of New York at Buffalo	Ph.D.	Epidemiology

Graduate Medical Training:*(Chronological)*

Board Certification:

Licensure:

Faculty Appointments:

Years	Rank	Institution	Department
1981 - 1987	Assistant Professor	University at Buffalo School of Medicine	Social and Preventive Medicine
1987 - 1994	Associate Professor	University at Buffalo School of Medicine	Social and Preventive Medicine
08/1994 - 08/2003	Professor	University at Buffalo School of Medicine	Social and Preventive Medicine
02/1995 - 08/2003	Research Professor	Roswell Park Cancer Institute	Experimental Pathology Division of Epidemiology
08/2003 - 07/2008	Professor	University of South Carolina School of Public Health	Epidemiology & Biostatistics
12/2003 - 08/2008	Associated Faculty	University of South Carolina	School of the Environment
08/2008 - Present	Professor	University of Georgia College of Public Health	Epidemiology & Biostatistics

First Appointment to MUSC: Rank : Professor Date : 2014

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: Betsy K. Davis, D.M.D., M.S. Date: 11/20/2013

Citizenship and/or Visa Status:

Office Address: 135 Rutledge Avenue, Room 1071, Charleston, SC, 29425 Telephone:

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1983	Wofford College, SC	B.S.	
1987	Medical College of South Carolina	D.M.D.	

Graduate Medical Training: *(Chronological)*

Residencies or Postdoctoral	Place	Dates
Resident	University of Iowa/Iowa City IA	1987 - 1989
Resident	M.D. Anderson Cancer Center/Houston, TX	1992 - 1993
Resident	UCLA Medical Center/Los Angeles CA	1993 - 1994

Board Certification:

Educationally Qualified, American Board of Prosthodontics

Fellow, American Academy of Maxillofacial Prosthetics

Licensure:

SC Dental Board Date: 1987-present

Faculty Appointments:

Years	Rank	Institution	Department
1989 - 1992	Assistant Professor	Ohio State University	College of Dentistry
1994 - 1995	Assistant Professor	Medical University of South Carolina	Prosthodontics (Primary)
1994 - 1995	Assistant Professor	Medical University of South Carolina	Otolaryngology - Head and Neck Surgery (Secondary)
1995 - 2001	Assistant Professor	Medical University of South Carolina	Prosthodontics
1995 - 2002	Assistant Professor	Medical University of South Carolina	Otolaryngology - Head and Neck Surgery
2001 - 2002	Assistant Professor	Medical University of South Carolina	Oral and Maxillofacial Surgery
2002 - Present	Associate Professor	Medical University of South Carolina	Otolaryngology - Head and Neck Surgery
2002 - Present	Associate Professor	Medical University of South Carolina	Oral and Maxillofacial Surgery
2006 - Present	Associate Member	Medical University of South Carolina	Graduate Studies
2006 - Present	Adjunct Professor	Clemson University	Bioengineering
2009 - Present	Associate Professor	Medical University of South Carolina	Craniofacial Biology
2009 - Present	Associate Professor	Medical University of South Carolina	College of Dental Medicine

First Appointment to MUSC: Rank : Assistant Professor Date : 1995

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: Louis Michael Luttrell, M.D., Ph.D. Date: 11/20/2013

Citizenship and/or Visa Status:

Office Address: Division of Endocrinology, Metabolism and Medical Genetics
Medical University of South Carolina 96 Jonathan Lucas Street, CSB Suite 816 Telephone: 843-792-2529
P.O. Box 250624 , Charleston, SC, 29425, USA

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1979	Pomona College	B.A.	Zoology
1988	University of Virginia, Charlottesville	Ph.D.	Pharmacology
1989	University of Virginia, Charlottesville	M.D.	Medicine

Graduate Medical Training:*(Chronological)*

Residencies or Postdoctoral	Place	Dates
Resident, Internal Medicine	Duke University Medical Center, Durham, NC	1989 - 1992
Fellow, Endocrinology	Duke University Medical Center, Durham, NC	1992 - 1995

Board Certification:

American Board of Internal Medicine	Date: 1993
American Board of Internal Medicine: Endocrinology and Metabolism	Date: 2001

Licensure:

North Carolina	Date: 1995
South Carolina	Date: 2003

Faculty Appointments:

Years	Rank	Institution	Department
1988 - 1989	Research Associate	University of Virginia, Charlottesville, VA	Department of Pharmacology
2003 - 2009	Professor	Medical University of South Carolina	Biochemistry and Molecular Biology
2003 - Present	Professor	Medical University of South Carolina	Medicine Division of Endocrinology
2005 - Present	Full Member	Medical University of South Carolina	Graduate Studies
2009 - 2011	Professor	Medical University of South Carolina	Basic Sciences Division of Biochemistry and Molecular Biology
2011 - Present	Professor	Medical University of South Carolina	Biochemistry and Molecular Biology

First Appointment to MUSC: Rank : Professor Date : 2003

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: William P. Moran, M.D., M.S. Date: 11/20/2013

Citizenship and/or Visa Status:

Office Address: Division of General Internal Medicine/Geriatrics 135 Rutledge Avenue Charleston, SC 29425 Telephone:

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1976	College of the Holy Cross	B.A.	Biology
1982	Georgetown University School of Medicine	M.D.	Medicine
1992	Wake Forest University	M.S.	Epidemiology

Graduate Medical Training:*(Chronological)*

Internship	Place	Dates
Internship-Internal Medicine	Georgetown University Hospital, Washington, DC	1982 - 1983

Residencies or Postdoctoral	Place	Dates
Residency-Internal Medicine	Georgetown University Hospital, Washington, DC	1983 - 1985
Fellowship in Geriatrics	Bowman Gray School of Medicine, Wake Forest University	1990 - 1992

Board Certification:

Diplomate, National Board Medical Examiners	Date: 1983
Diplomate, American Board of Internal Medicine	Date: 1985
Certificate of Added Qualificaton, Geriatric Medicine, American Board of Internal Medicine	Date: 1992-2002

Licensure:

Virginia (inactive)	Date: 1985
Massachusetts (inactive)	Date: 1986
North Carolina	Date: 1990
South Carolina	Date: 2005

Faculty Appointments:

Years	Rank	Institution	Department
1985 - 1986	Instructor	Georgetown University School of Medicine, Fairfax Hospital, Falls Church, VA	Medicine
1986 - 1990	Assistant Visiting Physician	Boston City Hospital, Boston, MA	Medicine
1992 - 1993	Instructor	Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, NC	Internal Medicine
1993 - 1997	Assistant Professor	Bowman Gray School of Medicine of Wake Forest University	Medicine
1994 - 2005	Associate	Wake Forest University	Public Health Sciences Division of Social Sciences and Public Health Policy
1998 - 2005	Associate Professor of Internal Medicine	Wake Forest University	Medicine Division of General Internal Medicine
2005 - Present	Professor	Medical University of South Carolina	Medicine Division of General Internal Medicine
2005	Professor with Tenure	Medical University of South Carolina	Medicine
2006 - Present	Full Member	Medical University of South Carolina	Graduate Studies

First Appointment to MUSC: Rank : Professor Date : 2005

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: Jihad S. Obeid, M.D. Date: 11/20/2013

Citizenship and/or Visa Status:

Office Address: 55 Bee St, Charleston, SC, 29425-2000 Telephone:

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1982	American University of Beirut	B.Sc.	Biology
1987	American University of Beirut	M.D.	Medicine

Graduate Medical Training:*(Chronological)*

Internship	Place	Dates
Internship	Duke University Medical Center, Durham, NC	07/1987 - 06/1988

Residencies or Postdoctoral	Place	Dates
Residency	Duke University Medical Center, Durham, NC	07/1988 - 06/1990
Pediatric Endocrinology Fellowship	Cornell University Medical College, New York, NY	07/1990 - 06/1993
Medical Informatics Fellowship	Harvard Medical School, Massachusetts Institute of Technology, Division of Health Sciences and Technology Brigham and Women's Hospital, Boston, MA	07/1993 - 06/1995

Board Certification:

The American Board of Pediatrics Number 47442 Date: 11/1991

Licensure:

License to Practice Medicine in The State of Massachusetts License Number 78364 Date: 08/1993

License to Practice Medicine and Surgery in The State of New York License Number 187717 Date: 11/1991

Faculty Appointments:

Years	Rank	Institution	Department
1995 - 1996	Research Associate	Brigham And Women's Hospital, Boston, MA	Medical Informatics
1996 - 2003	Assistant Professor	Weill Cornell Medical College, New York, NY	Pediatrics
2003 - 2008	Associate Research Professor	Weill Cornell Medical College, New York, NY	Pediatrics
2008 - 2009	Associate Professor	Medical University of South Carolina	Biostatistics and Epidemiology
2009 - Present	Associate Professor	Medical University of South Carolina	Health Sciences and Research
2009 - Present	Associate Professor	Medical University of South Carolina	Psychiatry and Behavioral Sciences

First Appointment to MUSC: Rank : Associate Professor Date : 2008

Medical University of South Carolina

College Of Medicine

ABBREVIATED CURRICULUM VITAE

Name: Melanie B. Thomas, M.D. Date: 11/20/2013

Citizenship and/or Visa Status:

Office Address: 86 Jonathan Lucas Street, Charleston, SC, 29425, USA Telephone: 843-792-4271

Education: *(Baccalaureate and above)*

Year Earned	Institution	Degree	Field of Study
1975	Boston University	B.A.	Biology
1982	Harvard University	M.S.	Engineering
1996	Boston University School of Medicine	M.D.	Medicine

Graduate Medical Training:*(Chronological)*

Internship	Place	Dates
Intern	Beth Israel-Deaconess Medical Center; Harvard Medical School	1996 - 1999

Residencies or Postdoctoral	Place	Dates
Resident	Beth Israel-Deaconess Medical Center; Harvard Medical School	1996 - 1999
Senior - Fellow, Medical Oncology	University of Texas; M. D. Anderson Cancer Center	1999 - 2000
Fellow	University of Texas; M. D. Anderson Cancer Center	1999 - 2002
Chief Fellow	LBJ Hospital Community Oncology Program	2001 - 2001

Board Certification:

Medical Oncology Date: 01/2005

Internal Medicine Date: 10/2001

Licensure:

Texas Date: 2001

South Carolina Date: 2008

Faculty Appointments:

Years	Rank	Institution	Department
1999 - 2002	Medical Oncology Fellow	The University of Texas	M. D. Anderson Cancer Center Division of Oncology
2002 - 2008	Assistant Professor	The University of Texas	M. D. Anderson Cancer Center Division of Oncology
2008 - Present	Associate Professor	Medical University of South Carolina	Medicine Division of Hematology-Oncology
2008 - Present	Grace E. DeWolff Chair	Medical University of South Carolina	Medicine Division of Medical Oncology
2008 - Present	Associate Director	MUSC	Medicine Division of Hematology/Oncology
2008 - Present	Associate Director of Clinical Investigations	Medical University of South Carolina - Hollings Cancer Center	

First Appointment to MUSC: Rank : Associate Professor Date : 2008

MUSC Foundation for Research Development
Statements of Financial Position

	9/30/2013	9/30/2012
Assets		
Cash and cash equivalents	$549,827	$871,217
Interest receivable	$1,745	$2,710
Accounts receivable, net	$305,537	$319,777
Accounts receivable - MUSC	$181,485	$323,547
Prepaid expenses	$9,552	$50,457
Investments	$323,861	$314,727
Property and equipment, net	$305	$1,474
Total Assets	$1,372,312	$1,883,910
Liabilities and Net Assets		
Liabilities		
Accounts payable	$180,223	$193,606
Accounts payable - MUSC	$311,620	$459,943
Due to UMA - accrued personnel expenses	$27,464	$19,618
Unearned revenue and deposits	$5,744	$85,380
Total Liabilities	$525,051	$758,547
Net Assets		
Total Net Assets	$847,261	$1,125,363
Total Liabilities and Net Assets	$1,372,312	$1,883,910

MUSC Foundation for Research Development
Income Statement

	Actual 9/30/2013	YTD Budget
Revenues		
Contracts, grants and awards	$262,500	$262,500
License fees and royalties, net of distributions	$13,896	$31,250
Investment income	$18,308	$2,500
Other revenues - program services	$525	$0
Total Revenues	**$295,229**	**$296,250**
Expenses		
Personnel	$105,525	$186,125
Patent prosecution costs, net of recovery	$91,417	$86,250
Professional fees	$29,082	$8,750
Other administrative expenses	$35,037	$40,125
Other expenses - program services	$3,776	$0
Total Expenses	**$264,837**	**$321,250**
NET SURPLUS/(DEFICIT) before transfer of residuals	**$30,392**	**($25,000)**
Residuals transferred to MUSC	**($181,185)**	**$0**
Surplus Funds from FY12 to be used in FY14	**$0**	**$25,000**
NET SURPLUS/(DEFICIT)	**($150,793)**	**$0**

FACILITIES

ACADEMIC

PROPERTY SALES

FOR INFORMATION

December 13, 2013

PROJECT TITLE: 166 and 168 Ashley Avenue Property Sales

PROJECT NUMBER: N/A

ESTIMATED SALE PRICE: $365,000 and $390,000

BUYER: MUSC Foundation

JUSTIFICATION: The Board approved these property sales back in December 2007, along with others located in the surrounding blocks of Ashley, Doughty and Rutledge Avenues, to be sold to the MUSC Foundation. The property values at that time were based on "pre-crash" market conditions. Since that time, all of the properties have been sold except for these two, as buyers were not interested. Since the market has now improved, we now have interest and plan to move forward with the sales, based on new appraisals done this past summer.

The properties remain to be in very poor condition and require substantial investments to bring them up to code. Estimated restoration costs exceed appraised values.

The property sale prices are based on June 2013 appraisals. The proceeds from these sales will be reinvested into capital assets and not used for operating expenses.

MEDICAL UNIVERSITY OF SOUTH CAROLINA
CONSTRUCTION CONTRACTS
DECEMBER 13, 2013

MUSC Indefinite Delivery Releases

Cullum Constructors $104,572.47

Modify existing general exhaust system in support of the Institute of Psychiatry Exhaust System Modification project.

Allen, H.R., Inc. $73,314.00

Add an integrated freon monitoring and exhaust system meeting ASHRAE 15 requirements to the 1st floor of the MRE Energy Facility attached to the Basic Science Building in support of the Bioengineering Building project.

Abate & Insulate, LLC $377.00

Remove asbestos-containing floor tile and mastic in support of the College of Nursing Floors 2-5 Renovation project.

Abate & Insulate, LLC $4,565.00

Remove and dispose of asbestos-containing pipe insulation in support of the Clinical Science Building Chilled Water project.

Abate & Insulate, LLC $4,410.00

Decontaminate the overhead deck in the Basic Science Building Auditorium in support of the Craniofacial Research Lab Renovation project.

Hill Construction Services of Charleston Inc. $11,477.00

Demolish existing and create new exit ramp in support of the Harborview Office Tower Expansion Joint Repair project.

Bonitz Contracting & Flooring Group $2,369.60

Install 60 square yards of carpet tile and 120 linear feet of cove base in support of the Thurmond 3rd Floor CT Surgery Renovation project.

Liberty Fire Protection, Inc. $5,497.87

Replace 38 fire sprinklers and relocate 20 fire sprinklers in support of the Clinical Sciences Building 7th Floor Orthopedic Surgery Office Renovation project.

Bonitz Contracting & Flooring Group $4,909.72

Install 90 square yards of carpet and 360 linear feet of cove base at 17 Ehrhardt at the request of the customer.

Huss, Inc. $28,826.00

Perform selective demolition and reconstruction in Room HO117, 1st Floor Hollings Cancer Center at the request of the customer.

MUSC General Construction Projects

Image Resource, LLC $5,298.34

Supply and install signage in support of the Microbiology Immunology project.

Hoffman & Hoffman Inc. $1,123.00

Provide hot water duct coils in support of the Clinical Science Building Reheat Floors 8 and 9 project.

International Public Works, LLC $495,994.00

Provide repairs and renovations in support of the Sebring Aimar House Interior Renovations project.

Thermal Resource Sales, Inc. $5,552.00

Provide fan coil units in support of the Clinical Science Building 7th Floor Orthopedic Surgery Office Renovation Phase I project.

Mr. Tint, Inc. $1,367.00

Install window film to block heat and save energy in Hollings Cancer Center at the request of the customer.

MUSC Indefinite Delivery Contracts

Bonitz Contracting & Flooring

Provide carpet and flooring installation and repair services campus-wide on an as-needed basis. Total services not to exceed $1,000,000 over a two year period. Releases not to exceed $250,000 each project.

BarMack Contracting Inc.

Provide carpet and flooring installation and repair services campus-wide on an as-needed basis. Total services not to exceed $1,000,000 over a two year period. Releases not to exceed $250,000 each project.

MEDICAL UNIVERSITY OF SOUTH CAROLINA
PROFESSIONAL SERVICES
FOR REPORTING
DECEMBER 13, 2013

MUSC Indefinite Delivery Releases

S&ME, Inc. $1,680.00

Provide lead-based paint abatement in support of the Rutledge Tower Garage Restriping project.

ECHO Engineering LLC $28,500.00

Provide mechanical engineering services in support of the Basic Science Building/Colbert Education Center Tunnel Steam and Chill Water Piping Replacement project.

RMF Engineering, Inc. $9,000.00

Provide mechanical engineering services in support of the College of Nursing Chiller Replacement project.

ADC Engineering, Inc. $15,800.00

Provide building envelope consulting services in support of the Fort Johnson House Repairs project.

MECA, Inc. $137,460.00

Provide mechanical engineering services in support of the Psychiatric Institute Data Center System Upgrade project.

S&ME, Inc. $1,220.00

Provide air monitoring in conjunction with clean-up of asbestos-containing spray-applied fireproofing in the overhead deck area of the first floor auditorium in the Basic Science Building Room 100 in support of the Craniofacial Research Lab Renovation project.

S&ME, Inc. $6,960.00

Provide asbestos air monitoring in Basic Science Rooms 228 and 229 in support of the Craniofacial Research Lab Renovation project.

S&ME, Inc. $4,050.00

Provide limited asbestos assessment of specific areas of the 3rd and 4th floor and roof of the Colbert Education Center in support of the Deferred Maintenance 2012 - Education Center HVAC Replacement project.

S&ME, Inc. $420.00

Provide asbestos bulk sampling analysis in support of the Deferred Maintenance 2012 - Quad E Air Handler Unit project.

MECA, Inc. $158,500.00

Provide mechanical engineering services in support of the 2013-14 Maintenance Needs - Clinical Science Building Air Handler Unit #2 and #3 project.

S&ME, Inc. $1,215.00

Provide asbestos bulk sampling and analysis in support of the Sebring Aimar House Interior Renovations project.

S&ME, Inc. $465.00

Provide asbestos bulk sampling and analysis in the College of Health Professions at the request of Engineering and Facilities.

S&ME, Inc. $300.00

Provide asbestos bulk sampling and analysis in Clinical Sciences Building Room 426B at the request of Occupational Safety.

Compass 5 Partners, LLC $5,500.00

Provide architectural and engineering design services to develop and prepare construction documents for the renovation of the Hollings Cancer Center Wig Shop as requested by the customer.

DesignStrategies LLC $6,850.00

Provide architectural services to analyze space requirements to relocate tenants currently occupying Harborview Office Tower at the request of Engineering and Facilities.

MUSC 230s

SKA Consulting $4,800.00

Provide waterproofing consulting services related to production window installation in support of the College of Nursing Floors 2-5 Renovation project.

SKA Consulting $3,300.00

Provide waterproofing consulting services related to a mock-up window installation in support of the College of Nursing Floors 2-5 Renovation project.

ADC Engineering, Inc. $3,780.00

Provide structural engineering services in support of the Harborview Office Tower Garage Expansion Joint project.

McMillan Pazdan Smith $4,000.00

Provide design services for the Orthopedic Surgery interior renovations to convert office H726 into PA/NP Office HE712 and Resident Locker Room HE723A at the request of the customer.

Other Contracts

Rosenblum & Associates $47,850.00

Provide design services in support of the Adult Emergency Room Expansion project.

Soil Consultants, Inc. $19,225.00

Provide special inspection and construction materials testing in support of the College of Nursing Floors 2 through 5 Renovation project.

SAFEbuilt Carolinas Inc. $10,525.00

Provide special inspection services in support of the Deferred Maintenance - Colbert Education Center Library 3rd and 4th Floor HVAC Replacement project.

IDC Contracts

SKA Consulting

Provide roofing and waterproofing consulting serivices under a small IDC contract on an as-needed basis. No project to exceed $50,000. Total small contracts not to exceed $150,000 in past two years.