MUSC
Medical University of South Carolina

AGENDA

(REGULAR AND CONSENT)

HOSPITAL AUTHORITY BOARD OF TRUSTEES

AND

UNIVERSITY BOARD OF TRUSTEES

December 9, 2022

MEDICAL UNIVERSITY HOSPITAL AUTHORITY (MUHA) BOARD OF TRUSTEES
REGULAR AGENDA
December 9, 2022
101 Colcock Hall

Members of the Board of Trustees

Dr. James Lemon, Chairman
Mr. Charles Schulze, Vice-Chairman
Ms. Terri R. Barnes
The Honorable James A. Battle, Jr.
Mr. William H. Bingham, Sr.
Dr. W. Melvin Brown III
Dr. Henry F. Butehorn III
Dr. C. Guy Castles III
Dr. Richard M. Christian, Jr.
Dr. Paul T. Davis
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Thomas L. Stephenson, Esq.
Dr. Bartlett J. Witherspoon, Jr.

Trustees Emeriti

Mr. Allan E. Stalvey Dr. Charles B. Thomas, Jr. Dr. James E. Wiseman, Jr.

Item 1. Call to Order ..... Dr. James Lemon
Chairman

Item 2. Roll Call ..... Katherine Haltiwanger
Board Secretary

Item 3. Date of Next Meeting – February 10, 2023 ..... Katherine Haltiwanger
Board Secretary

Item 4. Approval of Meeting Minutes ..... Dr. James Lemon
Chairman

Recommendations and Informational Report of the President: Dr. David Cole

Item 5. General Informational Report of the President ..... Dr. David Cole
President

Item 6. Other Business ..... Dr. David Cole
President

Authority Operations, Quality, and Finance Committee: Dr. Murrell Smith, Chair

Item 7. MUSC Health Status Report ..... Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 8. Request to Apply for Certificate for Need Applications .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Dr. Patrick Cawley, CEO, MUSC Health, will present for approval a request for the Medical University Hospital Authority to apply for Certificate of Need (CON) Applications for the following:

- MUSC Health Charleston Division – Construction of a replacement ambulatory clinical services building for Rutledge Tower on the northwest area of MUSC Medical Center Campus. The new replacement building will include ambulatory clinics, imaging center (X-Ray, US, CT, MRI), and ambulatory surgery with 3 additional operating rooms for a total of 12 operating rooms.

- MUSC Health Charleston Division – 2 additional endoscopy procedure rooms at MUSC Health West Ashley Medical Pavilion.

- MUSC Health Florence Division – 3 additional inpatient behavioral health Beds for the Pee Dee region.

Item 9. MUHA Financial Report.....Lisa Goodlett
Chief Financial Officer, MUSC Health

Item 10. Capital Reprioritization Request for Approval .....Lisa Goodlett
Chief Financial Officer, MUSC Health

Item 11. Approval of the Plan of Finance for Charleston Campus Ambulatory Medical Office Building .....Lisa Goodlett
Chief Financial Officer, MUSC Health

Lisa Goodlett, CFO, MUSC Health, will request approval to move forward with the financing plan for the new ambulatory medical office building for the Charleston Campus.

Item 12. MUSC Governmental Affairs Report ..... Mark Sweatman
Chief, Governmental Affairs

Item 13. MUSC Physicians Report .....Dr. Jonathan Edwards
President, MUSC Physicians

Item 14. Other Committee Business .....Dr. Murrell Smith
Committee Chair

<u>MUHA and MUSC Physical Facilities Committee: Bill Bingham, Chair</u>

Item 15. MUSC Lease Renewal for Approval.....Jessica Paul
Chief Real Estate Officer, MUSC Health

Item 16. MUSC Project Scope Changes for Approval:
College of Medicine Office and Academic Building ..... David Attard
Chief Facilities Officer, MUSC

Item 17. MUSC Established Project for Approval: President St., Ashley Rutledge, McClennan Banks, & Jonathan Lucas Parking Garages Maintenance Repairs, Phase 1 ..... David Attard
Chief Facilities Officer, MUSC

Item 18. Other Committee Business .....Bill Bingham
Committee Chair

MUHA and MUSC Audit Committee: Tom Stephenson, Chair

Item 19. KPMG Exit Conference .....Jennifer Hall
Senior Partner, KPMG

Item 20. Other Committee Business .....Tom Stephenson
Committee Chair

Other Business for the Board of Trustees

Item 21. Approval of Consent Agenda ..... Dr. James Lemon
Chairman

Item 22. Executive Session ..... Dr. James Lemon
Chairman

Upon proper motion and vote, the Board may convene a closed session pursuant to SC Code Ann. §30-4-70. Although the Board will not vote on any items discussed in closed session, the Board may return to public session to vote on items discussed.

Item 23. New Business for the Board of Trustees ..... Dr. James Lemon
Chairman

Item 24. Report from the Chairman ..... Dr. James Lemon
Chairman

MUSC Health - Board Package

MUHA - Medical University Hospital Authority

Interim Financial Statements

October 31, 2022

Note:

1) MUHA has recognized CARES stimulus funding related to COVID expenditures as non-operating revenue per GASB guidance.

2) In FY2018, the internal financial statement format was changed to a FASB basis report to appropriately match the income stream of state appropriations and expenses incurred in addition to a presentation format that matches HUD and the credit market expectations.

Medical University Hospital Authority - Consolidated

Statement of Revenues, Expenses, and Change in Net Position

For the 4 Month Period Ending - October 31, 2022

Modified FASB Basis (in thousands)

	Current Month				Fiscal Year To Date				
	Actual	Fixed Budget	Variance	Var %	Actual	Fixed Budget	Variance	Var %	YTD Prior Year
Operating Revenues									
Net Patient Service Revenue	$231,510	$224,172	$7,338	3.27%	$897,584	$888,098	$9,485	1.07%	$796,128
Prior Year Settlements	3,598	-	3,598	0.00%	7,196	-	7,196	0.00%	-
DSH	5,669	5,641	28	0.50%	21,641	22,565	(924)	-4.10%	21,658
Other Revenue	7,045	8,025	(980)	-12.21%	26,186	31,068	(4,882)	-15.71%	33,152
Retail Pharmacy Revenue	45,708	33,779	11,929	35.31%	170,572	134,027	36,545	27.27%	119,034
State Appropriations	2,381	2,381	-	0.00%	14,339	9,522	4,817	50.58%	9,196
Total Operating Revenues	$295,911	$273,997	$21,913	8.00%	$1,137,518	$1,085,280	$52,238	4.81%	$979,168
Operating Expenses									
Salaries Wages	$86,534	$85,515	$1,019	1.19%	$356,212	$332,521	$23,691	7.12%	$278,736
Benefits	26,294	29,519	(3,225)	-10.93%	114,234	114,722	(488)	-0.43%	95,388
Noncash Pension Expense	6,409	6,474	(65)	-1.01%	25,635	25,892	(257)	-0.99%	24,885
Noncash Other Post Employment Benefits	8,189	8,189	-	0.00%	32,754	32,754	-	0.00%	22,584
Purchased Services	45,933	40,821	5,111	12.52%	156,653	158,765	(2,111)	-1.33%	128,298
Physician Services	12,224	17,274	(5,050)	-29.24%	51,327	67,767	(16,440)	-24.26%	56,279
Pharmaceuticals	16,644	17,062	(418)	-2.45%	67,984	68,682	(699)	-1.02%	67,278
Retail Pharmaceuticals	20,736	16,607	4,129	24.87%	76,053	65,888	10,164	15.43%	55,917
Medical Supplies	41,320	39,607	1,713	4.33%	155,955	156,695	(740)	-0.47%	139,579
Other Supplies	4,337	4,693	(356)	-7.59%	18,569	17,424	1,145	6.57%	19,919
Utilities	2,897	2,741	156	5.69%	12,603	11,098	1,505	13.56%	10,765
Insurance	1,200	1,062	139	13.05%	4,687	4,239	448	10.57%	4,290
Leases	4,204	3,621	583	16.10%	16,940	14,487	2,453	16.93%	14,719
Other	3,974	4,299	(326)	-7.57%	14,392	16,698	(2,306)	-13.81%	12,282
Physician Clinic Expense	(890)	-	(890)	0.00%	-	-	-	0.00%	8,834
Total Operating Expenses	$280,003	$277,482	$2,521	0.91%	$1,103,998	$1,087,633	$16,366	1.50%	$939,753
EBIDA	$15,908	($3,485)	$19,393	-556.48%	$33,520	($2,352)	$35,872	-1524.96%	$39,415
Depreciation	$9,270	$10,155	($885)	-8.71%	$39,455	$40,619	($1,164)	-2.87%	$37,091
Interest	3,387	3,337	50	1.50%	13,181	13,423	($242)	-1.17%	12,955
Operating Income (Loss)	$3,251	($16,976)	$20,227	-119.15%	($19,116)	($56,394)	$37,278	-66.10%	($10,631)
Operating Margin	1.10%	-6.20%			-1.68%	-5.20%			-1.09%
NonOperating Revenue (Expenses)									
Gifts and Grants	$54	$1,161	($1,106)	-95.33%	$2,835	$4,643	($1,808)	-38.94%	$1,175
Noncash Pension OPEB Noemployer Contribution	-	-	-	0.00%	-	-	-	0.00%	2,157
Investment Income	(685)	(92)	(593)	645.07%	(4,584)	(368)	(4,216)	1146.28%	(1,251)
Loss on Disposal of Capital Assets	-	0	(0)	-100.00%	14	1	13	1321.32%	1
Covid Funding	-	-	-	0.00%	-	-	-	0.00%	469.79
Other NonOperating Revenues (Expenses)	-	-	-	0.00%	-	-	-	0.00%	(284)
Debt Issuance Costs	(10)	-	(10)	0.00%	(20)	-	(20)	0.00%	(168)
Total NonOperating Revenues (Expenses)	($641)	$1,069	($1,710)	-159.96%	($1,755)	$4,276	($6,031)	-141.04%	$2,099
Income (Loss) before NonOperating Payments to MUSC Affiliates	$2,610	($15,907)	$18,517	-116.41%	($20,871)	($52,118)	$31,247	-59.96%	($8,532)
Non Operating Payments to MUSC Affiliates	-	-	-	0.00%	-	-	-	0.00%	-
Change in Net Position	$2,610	($15,907)	$18,517	-116.41%	($20,871)	($52,118)	$31,247	-59.96%	($8,532)
Total Margin	0.88%	-5.81%			-1.83%	-4.80%			-0.87%
Operating Cash Flow Margin	8.95%	3.25%			6.77%	4.34%			7.54%

Medical University Hospital Authority – Consolidated

Notes to the Interim Financial Statements

Statement of Revenues, Expenses and Changes in Net Assets: YTD October 31, 2022 (Unaudited)

Actuals Compared to Fixed Budget

Revenue Explanation: October year-to-date net patient service revenues were favorable to budget by 1.1%, or $9.5M. Prior year settlements from third party payors totaled $7.2M year-to-date. Inpatient and outpatient surgeries were unfavorable to budget by 6.5% and 3.7%, respectively. Transplant procedures were unfavorable to budget by 6.4%. Case Mix Index was unfavorable $2.5M and Payor Mix shift was favorable $3.2M. Retail pharmacy revenues were favorable by $36.5M. Other Revenues were $4.8M unfavorable to budget.

Expense Explanation: The salary rate variance was unfavorable to budget by $23.7M due to clinical staff vacancies driving the utilization of premium and contract labor. Benefits were favorable to budget by $0.5M.

Purchased Services were favorable to budget $2.1M.

Physician Services were favorable to budget $16.4M due to timing of expenses associated with College of Medicine.

Pharmaceuticals, not explained by volume, were favorable to budget by $1.6M. Retail pharmacy revenues, net of expenses, were favorable to budget by $26.4M.

Medical and Other Supplies, not explained by volume, were $9.8M unfavorable to budget.

Utilities were unfavorable to budget by $1.5M due to increase in electric rates and fuel costs.

Insurance was unfavorable to budget by $0.5M.

Leases and Other were unfavorable to budget by $0.1M due to increase in equipment rentals.

Statements of Net Position

Medical University Hospital Authority - Consolidated

Statements of Net Position (in thousands)

October 31, 2022 and June 30, 2022

Assets and Deferred Outflows	As of 10/31/2022 (unaudited)	As of 6/30/2022 (unaudited)
Current Assets:		
Cash and Cash Equivalents	$ 320,863	$ 386,580
Cash Restricted for Capital Projects and Major Programs	102,062	74,373
Cash Restricted for COVID-19 Stimulus Funding	1,328	8,913
Investments Unrestricted	295,770	263,439
Investments Restricted for Capital Projects and Major Programs	-	35,163
Patient Accounts Receivable, Net of Allowance for Uncollectible Accounts of approximately $396,900 and $353,600	564,378	396,432
Due from Related Parties	-	7,878
Due from Third-Party Payors	6,031	6,416
Other Current Assets	209,175	230,621
Total Current Assets	$ 1,499,608	$ 1,409,815
Investments Held by Trustees Under Indenture Agreements	$ 69,629	$ 70,449
Investments in Joint Ventures and Partnerships	33,880	32,844
Other Non-Current Assets	2,927	6,479
Capital Assets, Net	1,169,137	1,175,595
Total Assets	$ 2,775,181	$ 2,695,182
Deferred Outflows	$ 857,100	$ 857,341
Total Assets and Deferred Outflows	$ 3,632,281	$ 3,552,523
Liabilities, Deferred Inflows and Net Position		
Current Liabilities:		
Current Installments of Long-Term Debt	$ 69,191	$ 35,442
Current Installments of Capital Lease Obligations	34,986	40,161
Current Installments of Notes Payable	8,833	1,169
Short-Term Debt	80,000	80,000
Advance Medicare Funding	26,260	76,980
Due to Related Parties	6,046	-
Due to Joint Ventures and Partnerships	803	2,705
Accounts Payable	216,987	188,010
Accrued Payroll, Withholdings and Benefits	171,897	148,448
Other Accrued Expenses	19,452	14,269
Unearned Revenue	47,725	-
Total Current Liabilities	$ 682,180	$ 587,184
Long-Term Debt	$ 699,066	$ 774,389
Capital Lease Obligations	210,300	207,375
Notes Payable	20,494	-
Net Pension Liability	1,053,215	1,027,557
Net OPEB Liability	1,360,541	1,327,515
Total Liabilities	$ 4,025,796	$ 3,924,020
Deferred Inflows	$ 225,160	$ 224,190
Total Liabilities and Deferred Inflows	$ 4,250,956	$ 4,148,210
Net Position:		
Net Investment in Capital Assets	$ 135,127	$ 128,890
Restricted:		
Under Indenture Agreements	69,629	70,449
Expendable for:		
Capital Projects	19,645	25,760
Major Programs	39,225	33,776
COVID-19 Stimulus Funding	1,328	8,913
Unrestricted (deficit)	(883,629)	(863,475)
Total Net Position	$ (618,675)	$ (595,687)
Total Liabilities, Deferred Inflows and Net Position	$ 3,632,281	$ 3,552,523

MEDICAL UNIVERSITY HOSPITAL AUTHORITY – Consolidated

Balance Sheet: As of 10/31/2022 (Unaudited) and 06/30/2022 (Unaudited) - (in thousands)

Cash and Cash Equivalents

Unrestricted cash and cash equivalents decreased by $65.7M from June 30, 2022. Significant FY2023 events decreasing cash include a $25M payment to reduce accrued accounts payable, $35M payroll processing ahead of schedule due to ERP implementation, and patient collections were $53M less than forecasted.

Bank Balance:	10/31/2022 Balance
Carrying Amount (cash and cash equivalents)	$ 320,863
Investment Unrestricted (cash and cash equivalents)	295,770
Total	$ 616,633

Investment Income comprises the following:	10/31/2022 Balance
Dividend and interest income	$ 2,425
Realized and unrealized loss on investments	(7,009)
	$ (4,584)

Net Accounts Receivable

Net patient accounts receivable increased $163.7M from June 30, 2022 due to slower collections from payors. October 2022 net accounts receivable days were 64 compared to June 30, 2022 at 50.

	10/31/2022 Balance	6/30/2022 Balance
Charleston Market	$ 333,820	$ 270,610
Florence Market	72,230	46,268
Midlands Market	81,933	36,148
MUSC Community Physicians	38,626	23,367
Lancaster Market	33,430	17,580
MUHA Rural Health Clinics	4,339	2,459
	$ 564,378	$ 396,432

MEDICAL UNIVERSITY HOSPITAL AUTHORITY – Consolidated

Balance Sheet: As of 10/31/2022 (Unaudited) and 06/30/2022 (Unaudited) - (in thousands)

Other Current Assets

The composition of other current assets is as follows:

	10/31/2022 Balance	6/30/2022 Balance
Inventory	$ 89,565	$ 86,728
Other Prepayments	78,154	70,348
Non-Patient Accounts Receivable	26,119	66,853
Lease Receivable	7,642	6,677
Health Insurance Prepayments	5,679	-
Workers' Compensation Prepayments	4,759	-
Dental Prepayments	131	-
Unemployment Prepayments	32	
Accrued Interest	22	19
Lease Prepaid Rent	(1)	(5)
	$ 212,102	$ 230,621

Medicare and Medicaid owes MUHA $6.0M, an decrease of $0.4M due to prior year Medicare cost adjustments.

Medicare/Medicaid Accounts Receivable	10/31/2022 Balance	6/30/2022 Balance
	$ 6,031	$ 6,416

The total net payable to MSV, MHI, Mainsail, Edgewater and MHP is reflected as a component of due from joint ventures and partnerships, net on the Statement of Net Position.

	10/31/2022 Balance	6/30/2022 Balance
MUSC Health Partners (MHP)	$ (186)	$ (385)
Edgewater Surgery Center	2,036	1,159
MUSC Health Initiatives (MHI)	241	207
Mainsail Health Partners	1,111	494
MUSC Strategic Ventures (MSV)	(4,005)	(4,181)
	$ (803)	$ (2,705)

MEDICAL UNIVERSITY HOSPITAL AUTHORITY – Consolidated

Balance Sheet: As of 10/31/2022 (Unaudited) and 06/30/2022 (Unaudited) - (in thousands)

Advanced Medicare Funding

The Authority received $182.8M in requested Accelerated Medicare Payments in September 2020. The payback provision amount of accelerated Medicare payment requests due within one year are recorded in the Statement of Net Position as Advanced Medicare funding, with a current portion due $26.3M as of October 31, 2022.

Accounts Payable

Accounts Payable increased by $29.0M from June 30, 2022.

Other Accrued Expenses

The composition of other accrued expenses is as follows:

	10/31/2022 Balance	6/30/2022 Balance
Accrued Interest	$ 5,228	$ 5,222
Amounts due to contractors	2,253	1,660
Other	11,972	7,387
	$ 19,453	$ 14,269

Unearned Revenue

Unearned revenue increased $47.7M from June 30, 2022 due to prior year settlement, state appropriations and DSH Revenue deferral.

	10/31/2022 Balance	6/30/2022 Balance
Cost Settlement	$ 28,785	$ -
Disproportionate Share Hospital (DSH)	11,338	-
MUSC Solutions	5,933	-
Telehealth	1,669	-
	$ 47,725	$ -

MEDICAL UNIVERSITY HOSPITAL AUTHORITY – Consolidated

Balance Sheet: As of 10/31/2022 (Unaudited) and 06/30/2022 (Unaudited) - (in thousands)

Long Term Debt

As of October 31, 2022, Current Installments of Long-Term Debt relates to HUD debt for Ashley River Tower (ART), Shawn Jenkins Children's Hospital (SJCH) and the Central Energy Plant (CEP). Current Installments of Notes Payable relate to the Sabin Street Energy Plant. A table of outstanding balances by major issuance is listed below:

Project (mo/yr issued)	10/31/2022 Balance	6/30/2022 Balance
SJCH (06/2019)	$ 289,442	$ 292,351
ART (12/2012)	214,898	220,589
Capital Leases (various - see below)	245,286	247,535
CHS Acquisition (03/2019)	117,072	118,285
Lifepoint Acquisition (07/2021)	78,814	79,510
Nexton and Consolidated Service Center (10/2018)	34,052	34,398
CEP (12/2013)	27,929	28,799
Imaging Equipment (01/2019)	17,887	17,887
Edgewater (03/2019)	6,054	6,117
Patient Monitors (07/2016)	5,552	6,617
1 Poston Road (10/2021)	5,118	5,278
Sabin Street (04/2013)	767	1,169
	$ 1,042,870	$ 1,058,535

As of October 31, 2022, capital leases relate to various pieces of equipment and properties. A table of outstanding balances by equipment description is listed below:

Project (month/year issued)	10/31/2022 Balance	6/30/2022 Balance
Charleston Property Lease	$ 100,784	$ 100,192
Summey Medical Pavilion (04/2019)	39,896	46,277
Charleston Equipment Lease	28,480	28,555
Equipment Financing Lease - Charleston (12/2021)	17,359	18,247
Equipment Financing Lease - Midlands (12/2021)	15,623	16,422
Equipment Financing Lease - Regional Health (12/2021)	12,000	12,000
RHN & Midlands Property Lease	11,671	8,112
Medical Malls (02/2019)	9,340	9,424
RHN & Midlands Equipment Lease	8,985	6,823
Cardiovascular Equipment (03/2020)	863	967
Ultrasound (03/2019)	184	234
Computer software (09/2019)	100	118
Midlands Property Lease (08/2021)	-	165
	$ 245,286	$ 247,535

MEDICAL UNIVERSITY HOSPITAL AUTHORITY – Consolidated

Balance Sheet: As of 10/31/2022 (Unaudited) and 06/30/2022 (Unaudited) - (in thousands)

Annual debt service costs for FY2022 totaled $156M. A table of debt service by major issuance is listed below, as well as by equipment description as it relates to capital leases:

Project (month/year issued)	Monthly Debt Service
Capital Leases (various - see below)	$ 34,986
Nexton and CSC (10/2018)	34,052
ART (12/2012)	17,410
SJCH (06/2019)	8,947
CHS Acquisition (03/2019)	3,757
Patient Monitors (07/2016)	3,285
Imaging Equipment (01/2019)	2,846
CEP (12/2013)	2,677
Lifepoint Acquisition (07/2021)	2,134
1 Poston Road (10/2021)	1,932
Sabin Street (04/2013)	770
Edgewater (03/2019)	194
	$ 112,990

Project (month/year issued)	Monthly Debt Service
Charleston Property Lease (various)	$ 11,169
Charleston Equipment Lease (various)	8,735
RHN & Midlands Property Lease (various)	3,774
RHN & Midlands Equipment Lease (various)	2,326
Equipment Financing Lease - Charleston (12/2021)	2,710
Equipment Financing Lease - Midlands (12/2021)	2,439
Equipment Financing Lease - Regional Health (12/2021)	1,873
Summey Medical Pavilion (04/2019)	1,213
Cardiovascular Equipment (03/2020)	249
Medical Malls (02/2019)	297
Ultrasound (03/2019)	147
Computer Software (09/2019)	54
	$ 34,986

Pension and Other Post Employment Benefit (OPEB) Liabilities

As of October 31, 2022, the net pension liability increased by $25.7M from June 30, 2022.

As of October 31, 2022, the net other post-employment benefit liability increased $33.0M from June 30, 2022.

Statements of Cash Flows

MEDICAL UNIVERSITY HOSPITAL AUTHORITY - Consolidated

Statements of Cash Flows - (in thousands)

October 31, 2022 and June 30, 2022

	As of 10/31/2022 (unaudited)	As of 6/30/2022 (unaudited)
Cash flows from operating activities:		
Receipts received from patients and third-party payors	$ 884,079	$ 2,813,096
Other cash receipts	66,294	101,186
Payments to suppliers and employees	(1,000,066)	(2,869,139)
Net cash provided (used) by operating activities	$ (49,692)	$ 45,142
Cash flows from noncapital financing activities:		
State appropriations	$ 14,251	$ 30,967
Proceeds from CARES Funding	45,720	87,938
Proceeds from noncapital grants and gifts	800	2,631
Proceeds from revenue anticipation notes	-	80,000
Nonoperating expenditures	-	(4,467)
Net cash provided (used) by noncapital financing activities	$ 60,771	$ 197,069
Cash flows from capital and related financing activities:		
Capital expenditures	$ (37,173)	$ (93,775)
Capital grants and gifts received	2,135	4,561
Proceeds from disposal of capital assets	14	2
Payments of principal on long-term debt	(13,881)	(123,786)
Proceeds from financing debt	-	143,146
Payments of bond issuance cost	(20)	(1,680)
Payments of mortgage insurance premium	557	(975)
Payments on lease obligations	(2,237)	(37,015)
Proceeds on equipment replacement obligations	476	901
Interest payments	(6,648)	(38,900)
Net cash provided (used) by capital and related financing activities	$ (56,776)	$ (147,521)
Cash flows from investing activities:		
Proceeds from sale and maturity of investments	$ 100,000	$ 242,922
Investment income received	2,441	3,286
Distributions from joint ventures and partnerships	-	1,498
Purchases of investments	(114,584)	(309,880)
Contributions to joint ventures and partnerships	-	(26,733)
Net cash provided (used) by investing activities	$ (12,143)	$ (88,907)
Net increase (decrease) in cash and cash equivalents	(57,841)	5,782
Cash and cash equivalents at beginning of year	484,799	479,017
Cash and cash equivalents at end of year	$ 426,958	$ 484,799

Crosswalk of Financial Accounting Standards Board (FASB) Income Statement Presentation to Government Accounting Standards Board (GASB)

Medical University Hospital Authority - Consolidated

Statement of Revenues, Expenses and Change in Net Position

For the 4 Month Period Ending - October 31, 2022

Modified FASB Basis (in thousands)

Crosswalk from FASB to GASB	FASB Fiscal Year To Date				GASB Fiscal Year To Date			
	Actual	Budget	Variance		Actual	Budget	Variance
Operating Revenues:				Operating Revenues:			
Net Patient Service Revenues	$ 897,584	$ 888,098	1.07%	Net Patient Service Revenues	$ 897,584	$ 888,098	1.07%
Prior Year Settlements	7,196	-	100%	Prior Year Settlements	7,196	-	0.00%
Other Revenues - DHS Revenue	21,641	22,565	-4.09%	Other Revenues - DSH Revenue	21,641	22,565	-4.09%
Retail Pharmacy Revenue	26,186	31,068	-15.71%	Retail Pharmacy Revenue	26,186	31,068	-15.71%
Other Revenues	170,572	134,027	27.27%	Other Revenues	170,572	134,027	27.27%
State Appropriations	***14,339***	***9,522***	***50.59%***				100.00%
Total Operating Revenues	$ 1,137,518	$ 1,085,280	4.81%	Total Operating Revenues	$ 1,123,180	$ 1,075,758	4.41%
Operating Expenses:				Operating Expenses:			
Salaries Wages	$ 356,212	$ 332,521	7.12%	Salaries Wages	$ 356,212	$ 332,521	7.12%
Benefits	114,234	114,722	-0.43%	Benefits	114,234	114,722	-0.43%
Noncash Pension Expense	25,635	25,892	-0.99%	Noncash Pension Expense	25,635	25,892	-0.99%
Noncash Other Post Employment Benefits	32,754	32,754	0.00%	Noncash Other Postemployment Benefits	32,754	32,754	0.00%
Purchased Services	156,653	158,765	-1.33%	Purchased Services	156,653	158,765	-1.33%
Physician Services	51,327	67,767	-24.26%	Physician Services	51,327	67,767	-24.26%
Pharmaceuticals	67,984	68,682	-1.02%	Pharmaceuticals	67,984	68,682	-1.02%
Retail Pharmaceuticals	76,053	65,888	15.43%	Retail Pharmaceuticals	76,053	65,888	15.43%
Medical Supplies	155,955	156,695	-0.47%	Medical Supplies	155,955	156,695	-0.47%
Other Supplies	18,569	17,424	6.57%	Other Supplies	18,569	17,424	6.57%
Utilities	12,603	11,098	13.56%	Utilities	12,603	11,098	13.56%
Insurance	4,687	4,239	10.57%	Insurance	4,687	4,239	10.57%
Leases	16,940	14,487	16.93%	Leases	16,940	14,487	16.93%
Other	14,392	16,698	-13.81%	Other	14,392	16,698	-13.81%
Total Operating Expenses	$ 1,103,998	$ 1,087,633	1.50%	Total Operating Expenses	$ 1,103,998	$ 1,087,631	1.50%
EBIDA	$ 33,520	$ (2,352)	-1525.17%	EBIDA	$ 19,182	$ (11,873)	-261.56%
Depreciation	$ 39,455	$ 40,619	-2.87%	Depreciation	$ 39,455	$ 40,619	-2.87%
Interest Expense	***$ 13,181***	***$ 13,423***	-1.80%				
Operating Income (Loss)	$ (19,116)	$ (56,394)	-66.10%	Operating Income (Loss)	$ (20,273)	$ (52,492)	-61.38%
Operating Margin	-1.68%	-5.20%	-67.66%	Operating Margin	-1.80%	-4.88%	-63.01%
NonOperating Revenues (Expenses):				**NonOperating Revenues (Expenses):**			
				State Appropriations	***$ 14,339***	***$ 9,522***	**50.59%**
Gifts and Grants	$ 2,835	$ 4,643	-38.94%	Gifts and Grants	2,835	4,643	-38.94%
Pension OPEB Nonemployer Contribution	-	-	100%	Pension OPEB Nonemployer Contribution	-	-	0.00%
Investment Income	(4,584)	(368)	1145.65%	Investment Income	(4,584)	(368)	1145.65%
				Interest Expense	***(13,181)***	***(13,423)***	**-1.80%**
Loss on Disposal of Capital Assets	14	1	-1300.00%	Loss on Disposal of Capital Assets	14	1	-1300.00%
Other NonOperating Expenses	-	-	-100.00%	Other NonOperating Expenses	-	-	0.00%
Debt Issuance Costs	(20)	-	-100.00%	Debt Issuance Costs	(20)	-	-100.00%
Total NonOperating Revenues (Expenses)	$ (1,755)	$ 4,276	-141.04%	Total NonOperating Revenues (Expenses)	$ (597)	$ 375	-259.20%
Income (Loss) Before NonOperating Payments to MUSC Entities	$ (20,871)	$ (52,118)	-59.95%	Income (Loss) Before NonOperating Payments to MUSC Entities	$ (20,871)	$ (52,118)	-59.95%
NonOperating Payments to MUSC Entities	-	-	-100.00%	NonOperating Payments to MUSC Entities	-	-	-100.00%
Change in Net Position	$ (20,871)	$ (52,118)	-59.95%	Change in Net Position	$ (20,871)	$ (52,118)	-59.95%
Total Margin	-1.83%	-4.80%		Total Margin	-1.85%	-4.84%	

FACILITIES - ACADEMIC
LEASE RENEWAL
FOR APPROVAL

DECEMBER 9, 2022

DESCRIPTION OF LEASE RENEWAL: This lease renewal is for 4,574 square feet of office space located at 56 Courtenay Drive, Charleston. The purpose of this lease renewal is to continue to provide office space for MUSC Engineering and Facilities. The cost per square foot is $19.24. The total monthly rental payment will be $7,333.33, resulting in an annual lease amount of $88,000.00.

This property is owned by the Medical University of South Carolina Foundation and leased in its entirety to the Medical University of South Carolina.

NEW LEASE AGREEMENT ____
RENEWAL LEASE AGREEMENT _X_

LANDLORD: The Medical University of South Carolina Foundation

LANDLORD CONTACT: Stuart Ames, Chief Executive Officer

TENANT NAME AND CONTACT: Medical University of South Carolina, Rick Anderson, Executive Vice President

SOURCE OF FUNDS: General Operating Funds

LEASE TERMS:

TERM: Five (5) years: [2/1/2023 – 1/31/2028]
TOTAL AMOUNT PER SQUARE FOOT: $19.24
TOTAL ANNUALIZED LEASE AMOUNT: $88,000.00

TOTAL TERM RENT AMOUNT: $440,000.00

EXTENDED TERM(S): 1 term, 5 years

OPERATING COSTS:

FULL SERVICE ____
NET __X__

FACILITIES
ACADEMIC/RESEARCH
PROJECT SCOPE CHANGES
FOR APPROVAL
December 9, 2022

PROJECT TITLE: MUSC College of Medicine Office & Academic Building

PROJECT NUMBER: H51-9855

TOTAL ORIGINAL ESTIMATED BUDGET: $172 million

FUNDS RE-DIRECTED: $18.5 million

SOURCE(S) OF FUNDS: $6.5 million FY22 State Capital Reserve Fund Appropriations
$7.1 million FY2023 University Capital Renewal Funds
$3.5 million (COM capital project reserves/other sources)
$1.4 million (CoHP capital project reserves/other sources)

SCOPE OF PROJECT: The College of Medicine (COM) Office and Academic Building project was approved by the MUSC Board of Trustees on December 10, 2021, for a total estimated budget of $172 million. The initial programming for the COM was estimated at 249,000 square feet. After approval and more detailed site and program planning meetings with the COM by the selected Architect and Engineering firm, the net usable square footage was reduced to approximately 200,000 square feet, with a revised pre-bid cost estimate of $153.5 million.

This request is for approval to modify the scope of the College of Medicine Building to include an expansion of the Mechanical Room building that currently provides chilled water supply (CWS) to the Basic Sciences Building (BSB) adjacent to the proposed location for the new COM building. In addition to serving the BSB and COM locations, this expansion will provide CWS to the College of Health Professionals (CHP) Academic Building project that was approved by the MUSC Board of Trustees on August 12, 2022. The Mechanical Room Expansion (MRE) will utilize the funding sources identified above. This request does not increase the overall $172 million authorization approved in December 2021 for the College of Medicine Building nor the $50 million authorization approved in August 2022 for the College of Health Professions Building. This project adjustment will construct a thirty (30) foot addition on the north side of the existing MRE Building. The project will install 2 new 1350-ton chillers, 2 new cooling towers, electrical switchgear, condenser water pumps, primary and secondary chill water pumps, and piping to supply the chill water needs for the new College of Health Professions and College of Medicine buildings. Underground chill water piping will connect the existing MRE system to the new buildings. The project would provide N+1 chill water redundancy for the entire MRE system which serves the Children's Research Institute, Basic Science Building, Drug Discovery Building, Bio-Engineering Building, Colcock Hall, Colbert Library, etc. in addition to the two new buildings. This project will also replace four (4) existing MRE cooling towers. These existing cooling towers are approximately 20 years old, deteriorated, near their end of useful life, and require replacement.

JUSTIFICATION: The initial scope for chilled water supply (CWS) for these two buildings was to provide penthouse specific chilled water plants for each building. This option is not optimal in design or efficiency for supporting maintenance costs to operate two new plants independently.

A secondary option evaluated was to install a larger, single new plant on the CHP building to supply chilled water to both buildings. This second option requires a very large penthouse that the City of Charleston Board

of Architectural Review (BAR) and Charleston Historic groups have expressed concern about a large penthouse on the CHP building. It is our opinion the most cost-effective and efficient long-term maintenance and operating option is to expand the existing Mechanical Room serving the BSB and other campus buildings.

This third option provides significant benefits: it is the most operationally efficient, allows for sizing the chillers more appropriately to serve both buildings, will provide CWS redundancy to the new buildings and the existing BSB by leveraging existing mechanical room CWS equipment, and will reduce the scope and size of the required penthouses serving both new buildings.

There are four major benefits to the expansion of the MRE building versus other chill water options for the new College of Health Professions and College of Medicine buildings:

1. MRE expansion allows Facilities to maintain/operate one chill water plant serving CHP and COM vs having to maintain/operate two by adding a second plant. A second plant would require additional maintenance personnel and increase operating costs.
2. The expansion allows MUSC to establish N+1 chill water capacity for the BSB building which supports most of the University's academic, research, and animal space. This will create a more resilient chill water system.
3. The installation of a second chill water plant at the College of Health Professions Building would require a significantly larger penthouse. Initial discussions with the Charleston historic societies pending submittal to the City of Charleston Board of Architectural Review (BAR) for conceptual (height, scale, mass) approval identified early concerns about the height and scale of the penthouse. The current design shows space for cooling towers & chillers to serve the College of Health Professions building.
4. MRE expansion also would allow a reduction of the penthouse size for the new College of Medicine Building. Any reduction to the size of the penthouse will help with BAR approval.

FACILITIES
ACADEMIC/RESEARCH
ESTABLISH PROJECT FOR APPROVAL
December 9, 2022

PROJECT TITLE:	President Street, Ashley Rutledge, McClennan Banks, & Jonathan Lucas Parking Garages Structural Maintenance Repairs, Phase 1
PROJECT NUMBER:	TBD
TOTAL ESTIMATED BUDGET:	$2,275,000.00
SOURCE(S) OF FUNDS:	Parking Revenue
SCOPE OF WORK:	This project will make miscellaneous concrete, steel, and waterproofing repairs in the President Street, Ashley Rutledge, McClennan Banks, and Jonathan Lucas Parking Garages to correct deficiencies identified in the 2019 Campus Wide Parking Garages Structural Review (updated 2022).
JUSTIFICATION:	Structural deficiencies must be corrected to maintain the long-term viability of the President Street, Ashley Rutledge, McClennan Banks, and Jonathan Lucas parking garages.

MEDICAL UNIVERSITY OF SOUTH CAROLINA (MUSC) BOARD OF TRUSTEES
REGULAR AGENDA
December 9, 2022
101 Colcock Hall

Members of the Board of Trustees

Dr. James Lemon, Chairman
Mr. Charles Schulze, Vice-Chairman
Ms. Terri R. Barnes
The Honorable James A. Battle, Jr.
Mr. William H. Bingham, Sr.
Dr. W. Melvin Brown III
Dr. Henry F. Butehorn III
Dr. C. Guy Castles III
Dr. Richard M. Christian, Jr.
Dr. Paul T. Davis
Dr. Donald R. Johnson II
Ms. Barbara Johnson-Williams
Dr. G. Murrell Smith, Sr.
Mr. Michael E. Stavrinakis
Thomas L. Stephenson, Esq.
Dr. Bartlett J. Witherspoon, Jr.

Trustees Emeriti

Mr. Allan E. Stalvey Dr. Charles B. Thomas, Jr. Dr. James E. Wiseman, Jr.

Item 1. Call to Order ..... Dr. James Lemon
Chairman

Item 2. Roll Call ..... Katherine Haltiwanger
Board Secretary

Item 3. Date of Next Meeting – February 10, 2023 ..... Katherine Haltiwanger
Board Secretary

Item 4. Approval of Meeting Minutes ..... Dr. James Lemon
Chairman

Recommendations and Informational Report of the President: Dr. David Cole

Item 5. General Informational Report of the President ..... Dr. David Cole
President

Item 6. Other Business ..... Dr. David Cole
President

Research and Institutional Advancement Committee: Terri Barnes, Chair

Item 7. Office of Research Update ..... Dr. Lori McMahon
Vice President for Research

Item 8. 2023-2024 Board of Visitors for Approval ..... Terri Barnes
Committee Chair

Item 9. Other Committee Business ..... Terri Barnes
Committee Chair

Education, Faculty & Student Affairs Committee: Barbara Johnson-Williams, Chair

Item 10. Annual Graduate Medical Education (GME) Update ..... Dr. Ben Clyburn
Associate Dean for Graduate Medical Education

Item 11. Provost Report ..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

Item 12. New Program Proposal: Master's in Public Health Generalist Online for Approval ..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

Item 13. 2023 Commencement Speaker and Honorary Degree Recipient for Approval ..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

Item 14. Other Committee Business ..... Barbara Johnson-Williams
Committee Chair

Finance and Administration Committee: Jim Battle, Chair

Item 15. MUSC Financial Report ..... Patrick Wamsley
Chief Financial Officer, MUSC

Item 16. MUSC Physicians Financial Report ..... Jonathan Boone
Interim Chief Financial Officer, MUSC Physicians

Item 17. Other Committee Business ..... Jim Battle
Committee Chair

Other Business for the Board of Trustees

Item 18. Approval of Consent Agenda ..... Dr. James Lemon
Chairman

Item 19. Executive Session ..... Dr. James Lemon
Chairman

Upon proper motion and vote, the Board may convene a closed session pursuant to SC Code Ann. §30-4-70. Although the Board will not vote on any items discussed in closed session, the Board may return to public session to vote on items discussed.

Item 20. New Business for the Board of Trustees ..... Dr. James Lemon
Chairman

Item 21. Report from the Chairman ..... Dr. James Lemon
Chairman

NEW PROGRAM PROPOSAL FORM

Name of Institution: Medical University of South Carolina

Name of Program (include degree designation and all concentrations, options, or tracks): MPH-Generalist

Program Designation:

☐ Associate's Degree
☒ Master's Degree
☐ Bachelor's Degree: 4 Year
☐ Specialist
☐ Bachelor's Degree: 5 Year
☐ Doctoral Degree: Research/Scholarship (e.g., Ph.D. and DMA)
☐ Doctoral Degree: Professional Practice (e.g., Ed.D., D.N.P., J.D., Pharm.D., and M.D.)

Consider the program for supplemental Palmetto Fellows and LIFE Scholarship awards?

☐ Yes
☒ No

Proposed Date of Implementation: Fall 2023

CIP Code: 51.2201

Delivery Site(s): 85750

Delivery Mode:

☐ Traditional/face-to-face
*select if less than 25% online

☒ Distance Education
☒ 100% online
☐ Blended/hybrid (50% or more online)
☐ Blended/hybrid (25-49% online)
☐ Other distance education (explain if selected)

Program Contact Information (name, title, telephone number, and email address):

Institutional Approvals and Dates of Approval (include department through Provost/Chief Academic Officer, President, and Board of Trustees approval):

DPHS Curriculum Committee/Faculty:	05/02/2022
Education Advisory Committee:	09/06/2022
Provost Council:	09/12/2022
MUSC Board of Trustees:	

Background Information

State the nature and purpose of the proposed program, including target audience, centrality to institutional mission, and relation to the strategic plan.

The Department of Public Health Sciences (DPHS) at the Medical University of South Carolina (MUSC) evolved from what used to be the Department of Biostatistics, Bioinformatics and Epidemiology, which was founded in 1968. Under the leadership of the Dean of the College of Medicine, in 2012, as part of the goals of a strategic plan DPHS was established and a public health program offering Master of Public Health degrees was added.

The MPH program at MUSC is approved by the CHE to offer the MPH degree in three areas (approved as three separate academic programs), namely, Health behavior and health promotion, Biostatistics, and Epidemiology. The first cohort of students began their respective programs in fall 2015. In December 2022 we will have a total of 91 MPH graduates from our program. In March 2022, our MPH program was fully accredited by the Council on Education for Public Health (CEPH).

Encouraged by our success, we are proposing to expand to offer a fourth MPH, an **online Generalist MPH degree**, which will be a **45-credit degree that can be completed in five semesters**. This program will address an unmet training need in South Carolina by providing an MPH degree that is targeted to those currently working in the public health field and clinicians in South Carolina and beyond. **MUSC confirms that the value of this program and its long-term viability are not adversely impacted by the COVID pandemic**.

Graduates from the MPH Generalist program will have general competency in the evaluation of status of health of diverse populations and in the development of rigorous plans and strategies to implement them to fulfill the primary objective of DPHS, namely to improve population health in and around the Lowcountry and across the state and globe. This program will strive to educate a diverse public health workforce, including working adults and students who may have difficulty with the logistics of attending a graduate degree program taught with inperson requirements, to be experts in innovative research, leadership and serve as advocates for improved and equitable population and community health across South Carolina and beyond. These goals align with MUSC's missions in disease prevention, patient and community wellness, and population health. The program will provide graduates marketable skills for careers in public health agencies, health departments, hospitals and other health care organizations, government regulatory agencies, not-for profit agencies, academic institutions, and industry.

MUSC is uniquely positioned to deliver this degree program, as it is **expected that a substantial portion of the students in this program will be current healthcare providers and those working in the public health field** interested in expanding their knowledge and skills in public health practice. It is also anticipated that with the approval of this online Generalist MPH degree, MUSC can request CHE approval for a host of “dual degree” programs, where our current healthcare students (in nursing, medicine, pharmacy, etc.) can work toward their professional practice degree and their public health degree concurrently.

In compliance with professional accreditation standards, the curriculum includes core courses (relevant for all MPH degrees) and elective courses in areas such as global health and chronic disease epidemiology. As of the date of preparation of this proposal, 31% of graduates from our current MPH program have been family medicine and pediatric clinicians at MUSC, and 34% of graduates have either become employed or continued their education at MUSC after graduation. This online MPH-Generalist degree will further afford current practicing clinicians

and public health practitioners the opportunity to receive training in public health to improve their impact.

Assessment of Need

Provide an assessment of the need for the program for the institution, the state, the region, and beyond, if applicable.

The proposed MPH Generalist degree will provide an in-depth education in the field of public health, giving students an opportunity to gain expertise within the following areas of core competency: evidence-based approaches to public health, public health and health care systems, planning and management to promote health, policy in public health, leadership, communication, interprofessional teams, and systems thinking. Having the generalist focus allows for concepts that are relevant to the field as a whole to be applied with management positions, policy development, or applied research. The MPH Generalist degree is the most widely offered online MPH degree in the United States, according to 2020 IPEDS data.

The proposed MPH Generalist will help fill a growing need for qualified public health professionals in the state and the nation, as shown in the following table. There is an expanding pool of working professionals at MUSC and across the globe who want to extend their education to include public health. Here at MUSC and in our state, there is a need for this new degree program to serve our own MUSC clinicians, public health practitioners and future students who may wish to earn a dual degree in response to the changing healthcare environment. This would give them a broad-based perspective about healthcare needs in the community.

MPH programs at medical schools typically enroll a significant number of students from health professionals employed at their institution (e.g., physicians, nurses, allied health providers), as they appreciate that the next era of health care will place greater emphasis on wellness and population health.

In fact, there is a growing number of medical professionals pursuing a Master of Public Health degree to further contribute to their practice, population health research, and epidemiological skills. Between 2010 and 2018, there was a 434% increase of MD-MPH graduates from 149 in 2010 to 796 in 2018.[c] With the shift of the health care system to emphasizing public health initiatives such as telemedicine, social determinants of health, access to health care, etc., there is an increased need of MD-MPH practitioners in the nation, other MPH-trained healthcare providers (e.g., nurse practitioners and physician assistants) and MPH-trained public health workers.

Transfer and Articulation

Identify any special articulation agreements for the proposed program. Provide the articulation agreement or Memorandum of Agreement/Understanding.

No articulation agreements exist for the proposed program.

Occupation	State		National	
	Number of Jobs	Employment Projection	Number of Jobs in 2020	Employment Projection
Mathematicians and Statisticians	240 (2020)[a]		44,800[a]	15,000 (33% increase 2020-2030)[a]
US: Medical Scientists, Except Epidemiologists	340 (2020)[a]		133,900[a]	22,600 (17% increase 2020-2030)[a]
Epidemiologists			7,800[a]	2,300 (30% increase 2020-2030)[a]
Health Education Specialists and Community Health Workers	960 (2020)[a]		125,200[a]	21,100 (17% increase 2020-2030)[a]
Environmental Scientists	340 (2020)[a]		87,100[a]	7,300 (8% increase 2020-2030)[a]

Supporting Evidence of Anticipated Employment Opportunities

Provide supporting evidence of anticipated employment opportunities for graduates. According to the U.S. Bureau of Labor Statistics, there is an expected increase for all public health positions listed in the table above. Mathematicians and Statisticians are predicted to have the greatest increase (33%) out of the careers in the table, with an additional 15,000 positions expected through 2030. The number of Medical Scientists positions is expected to increase 17% over ten years, with a projection of 156,500 positions by 2030. Epidemiologist positions throughout the United States in 2020 was 7,800 and that number is projected to increase by 30% through 2030. Health Education Specialists and Community Health Workers are expected to see a 17% increase, with a total of 146,300 estimated employment opportunities by 2030. Lastly, Environmental Scientists had an estimated 87,100 jobs in 2020, with that number expected to increase by 8% by 2030.

Description of the Program

Projected Enrollment			
Year	Spring Headcount	Summer Headcount	Fall Headcount
2023			25
2024-25	25 (24)	25 (24)	50 (49)
2025-26	50 (48)	25 (24)	50 (49)
2026-27	50 (48)	25 (24)	50 (49)
2027-28	50 (48)	25 (24)	50 (49)

*() indicates an estimated attrition of 1 student per cohort

Explain how the enrollment projections were calculated.

Currently, the three residential MPH degree programs at MUSC enroll a combined 20-24 new students every year. We believe that with the online delivery option, we can attract more students (because it will make enrollment by our current degree-seeking students possible, and our current healthcare providers at MUSC—working professionals—will be able to enroll in the program). Therefore, our projection for the online program is 25 new students per year. The only other online MPH program in South Carolina (at USC's Arnold School of Public Health) enrolls approximately 30 students per year, so we believe our enrollment projection is reasonable.

Besides the general institutional admission requirements, are there any separate or additional admission requirements for the proposed program? If yes, explain.

☒Yes

☐No

The MPH Generalist degree is designed for working professionals wanting to gain additional knowledge and skillsets to address current and future public health challenges.

To be eligible, applicants must:

1. Hold a bachelor's degree with at least 2 years of post-baccalaureate experience in a relevant health related field, or hold a doctoral degree in a health profession or academic are related to public health.

2. A minimum cumulative GPA of 3.0 on a 4.0 scale will be necessary to be competitive. The applicant will be required to provide official transcripts.

3. Applicants may have a background in public health, social sciences, basic sciences, or physical sciences including computing, mathematics, and engineering.

4. Three letters of recommendation from instructors or supervisors who have had close contact with the applicant during their undergraduate, graduate, clinical, or research training will be required.

5. Applicants will include a personal statement describing how the MPH degree will enhance their professional career as a public health practitioner, research interests, and future professional goals.

Curriculum

New Courses
List and provide course descriptions for new courses.

Topics in Public Health (3 credits)

This course will focus on topics such as budgeting, negotiating, and effective communications that are used for public health programs. Additionally, this course will prepare students for the Applied Practice Experience (APE or Internship) and the Integrated Learning Experience (ILE or

Capstone) during their final semester of the MPH Program. The APE is a 180-hour practicum which students complete to gain experience in the public health workforce. The ILE, is the culminating experience of the MPH Program, requires students to synthesize and integrate knowledge acquired in coursework and other learning experiences, and apply that knowledge to analyzing and addressing a public health practice and/or research challenge.

Applied Research Methods (3 credits)

The overall purpose of this course is to introduce students to the design and evaluation of research protocols in public health. Students will also learn methods for designing and writing measurable goals and objectives. Specifically, this course will cover concepts and provide skills required for research design, grant proposal development, quantitative and qualitative data analysis, and reporting results. The goal is to enable students to conduct original research and critically review published research, giving them the necessary tools to succeed as public health professionals.

Public Health Ethics & Leadership (3 credits)

The overall purpose of this course is to introduce students to a broad range of issues in public health ethics. Students will be provided an introduction to key frameworks and concepts relevant to public health ethics and describes the overlap and distinctions between public health and medical ethics. The course will also address ethical dilemmas across the following domains: 1) resource allocation and distributive justice; 2) conflicts between individual rights and the common good; and 3) research involving human subjects.

Program Planning, Development, and Evaluation (3 credits)

In this course, students will examine models and procedures for use in the systematic planning of public health interventions in a variety of settings (e.g., medical, community, schools). Students will obtain skills in conducting a needs assessment and using theory to guide the selection and development of public health intervention strategies. Students will also identify appropriate methods for selecting appropriate evaluation designs, data collection strategies and measures to conduct rigorous program evaluations.

Introduction to Global Health (3 credits)

The overall purpose of this course is to introduce students to critical global health issues and ways to address or solve them. The curriculum focuses on the following global health topics: infectious and chronic diseases, maternal/child health, immigrant and refugee health, the relationship between political and cultural processes and health, and factors contributing to disparate health outcomes in population groups. It provides essential methodological skills based on public health principles in a global setting and translate data to support policy.

Chronic Disease Epidemiology (3 credits)

This course designed for graduate students to provide a broad and comprehensive understanding of NCDs and their risk factors. The course will focus on the global and national determinants as well as distribution of NCD risk factors, prevention strategies to reduce the incidence and prevalence, and advancement of epidemiologic research for NCD prevention.

Total Credit Hours Required: **45 credit hours**

Curriculum by Year					
Course Name	**Credit Hours**	**Course Name**	**Credit Hours**	**Course Name**	**Credit Hours**
Year 1					
Fall		**Spring**		**Summer**	
Introduction to Public Health	2	Biostatistics Methods I	4	Applied Research Methods	3
Foundations of Epidemiology I	3	Principles of Environmental Health	3	Public Health Ethics & Leadership	3
Social and Behavioral Sciences	3	Introduction to Health Systems and Policy	3	Program Planning, Development, and Evaluation	3
Total Semester Hours	**8**	**Total Semester Hours**	**10**	**Total Semester Hours**	**9**
Year 2					
Fall		**Spring**		**Summer**	
Topics in Public Health	3	Applied Practice Experience	6		
Health Disparities Epidemiology	3	Integrative Learning Experience	3		
Elective	3				
Total Semester Hours	**9**	**Total Semester Hours**	**9**	Total Semester Hours	

Similar Programs in South Carolina offered by Public and Independent Institutions
Identify the similar programs offered and describe the similarities and differences for each program.

Program Name and Designation	Total Credit Hours	Institution	Similarities	Differences
MPH Health Promotion, Education, and Behavior	45 credits	University of South Carolina	Program is offered online	USC's online MPH in Health Promotion, Education, and Behavior is designed with a focus of health education providing training in leadership and advocacy, program development, and program evaluation. Our proposed MPH Generalist program will have focus of general public health competencies.

Faculty

Rank and Full- or Part-time	Courses Taught for the Program	Academic Degrees and Coursework Relevant to Courses Taught, Including Institution and Major	Other Qualifications and Relevant Professional Experience (e.g., licensures, certifications, years in industry, etc.)
Professor, Full-Time	Biostatistics Methods III & ILE Planning	PhD, Biostatistics, University of Southern California	
Professor, Full-Time	Health Behavior Theory	PhD, Social Work and Psychology, University of Michigan	This faculty member has over 30 years of public health experience with extensive public health research experience. The faculty member is currently is the Director of the Office of Community Outreach and Engagement, and Associate Director of Population Sciences and Cancer Disparities. This faculty has taught Health Behavior Theory within the current residential MPH programs since 2016.
Professor, Full-Time	Foundations of Epidemiology I	PhD, Epidemiology, University of North Carolina-Chapel Hill	
Associate, Full-Time	Epidemiology II & Field Epidemiology	PhD, Epidemiology, University of North Carolina-Chapel Hill	
Professor, Full-Time	Biostatistics Methods I	PhD, Biostatistics Medical University of South Carolina	
Assistant, Full-Time	Environmental Health Sciences	PhD, Geography & Environmental Sciences Monash University, Australia	
Assistant, Full-Time	Health Psychology	PhD, Psychology, University of Florida	This faculty member has over 10 years of experience, including a post-doctoral fellowship at Yale School of Medicine. This faculty member has taught Social and Behavioral Sciences within the current MPH program since 2020 and is an Associate Director for MUSC Health Tobacco Treatment and Associate Research Member with Hollings Cancer Center Cancer Control Program.
Associate, Full-Time	Health Behavior Intervention Planning	PhD, MPH, Health Behavior and Health Education, University of North Carolina-Chapel Hill	
Associate, Full-Time	Epidemiology II & Cancer Epidemiology	PhD, Epidemiology, Dartmouth College	
Assistant, Part-Time	Health Policy	PhD, Economics, University of Tennessee	This faculty member has over 20 years of experience as an economist related to public health policy, including years of experience working on the Joint Committee of Taxation with the US Congress. This faculty member has

			taught health policy within the current MPH program's curriculum since 2020.

Total FTE needed to support the proposed program:

Faculty: Need 3 additional faculty FTE
Staff: 3
Administration: 1

Faculty, Staff, and Administrative Personnel
Discuss the Faculty, Staff, and Administrative Personnel needs of the program.

Currently, we have 20 faculty for the residential MPH programs. We anticipate half (N=10) will be involved in teaching in the new online MPH. We will need to hire additional full-time or part-time teaching faculty to the equivalent of 3 FTE. The efforts of faculty will be dedicated to this program without need for additional compensation and so their employment costs are not included in the budget table.

We will hire one new staff member to serve as a second Program Coordinator I for the program. The individual will have both program administration experience and instructional design experience. This person will be tasked with designing courses in the LMS Brightspace, developing training materials, and working with faculty to develop online content. We will also hire a new IT specialist to oversee the IT infrastructure and provide IT support; this IT specialist will serve the online MPH program for 0.5 FTE.

Our current MPH Program Coordinator will manage recruitment and marketing of the online program as well as continue to provide internship coordination for our online students. The current Program Director will provide leadership and oversight of the day-to-day operations of the online program as well as supervision of staff. Same as with faculty, the efforts of the Program Director and current MPH Program Coordinator will be dedicated to this program without need for additional compensation and so their employment costs are not included in the budget table.

Resources

Library and Learning Resources
Explain how current library/learning collections, databases, resources, and services specific to the discipline, including those provided by PASCAL, can support the proposed program. Identify additional library resources needed.

The MUSC Libraries provide access to resources that support the University's tripartite mission of education, research, and clinical care. The Library serves as an instructional unit, a learning space, a database and knowledge center, academic computing support unit, and a leader in information planning. The Library's collections and resources are extensive and sufficient to support degrees awarded by the Department of Public Health Sciences. Pertinent online resources include nearly 50,000 electronic journals, over 350,000 electronic books, and 150 biomedical and health-related databases (e.g., Academic Search Premier, AccessMedicine, AnatomyTv, CINAHL, Cochrane Library, Lexicomp, NetAnatomy, PsycINFO, PubMed, SciFinder and UpToDate). A portal highlighting resources specific to public health is available on the *Public Health Resources Libguide* [https://musc.libguides.com/publichealth#loaded]. Access to the library's collections and resources is available 24/7/365 to students off campus and to distance learners through their MUSC NetID. In addition, the library's Interlibrary Loan (ILL) service enables MUSC students, faculty, and staff to borrow from other libraries materials

that are not currently owned by MUSC. Further, through membership in the Partnership among South Carolina Academic Libraries (PASCAL), MUSC users may borrow books from any South Carolina academic library either in-person or delivered via courier to MUSC.

The library employs 44 faculty and staff, including 16 librarians, to support faculty and students in all programs. All librarians hold master's degrees in Library and Information Science from programs accredited by the American Library Association. Our department has two identified liaison librarians assigned to support the MPH program, each holding a secondary Master's degree in Public Health and has a secondary faculty appointment within the department. In this role, they work with faculty to schedule library instruction sessions tailored to specific courses and assignments within the department, and creates a customized instruction plan based on particular information needs. They also offer private consultations to assist students with the use of the Library's resources. Students may request assistance via email, phone, or via web conferencing.

Student Support Services
Explain how current academic support services will support the proposed program. Identify new services needed and provide any estimated costs associated with these services.

This program does not require new university support services. The university-wide support services such as Counseling and Psychological Services (CAPS), Center for Academic Excellence, and the Writing Center will be offered for online students. Additionally, students will have the ability to engage in student support groups and organizations available through the Office of Student Engagement. We currently have the Public Health Society, which is a student-led organization within our department that provides community engagement, service, and professional development for all students within our department; our online students will also have the ability to be engaged with this support organization.

Physical Resources/Facilities
Identify the physical facilities needed to support the program and the institution's plan for meeting the requirements.

No new physical facilities are required to meet the proposed program's needs.

Equipment
Identify new instructional equipment needed for the proposed program.

No new equipment is needed to meet the proposed program's needs.

Impact on Existing Programs
Will the proposed program impact existing degree programs or services at the institution (e.g., course offerings or enrollment)? If yes, explain.

☒Yes

☐No

We anticipate with the approval of the online MPH degree, students will be attracted to traditional degree programs at MUSC (MD, DNP, PA, etc) because they will be able to study for a dual degree (e.g., MD-MPH) more readily, once such dual degree offerings are approved by the CHE. Thus, we expect an overall positive impact on existing programs should the online MPH be approved.

Financial Support

Sources of Financing for the Program by Year												
	1st		2nd		3rd		4th		5th		Grand Total	
Category	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**
Tuition Funding	583,875	583,875	973,125	973,125	973,125	973,125	973,125	973,125	973,125	973,125	4,445,235	4,445,235
Program-Specific Fees	73,125	73,125	114,375	114,375	114,375	114,375	114,375	114,375	114,375	114,375	527,845	527,845
Special State Appropriation												
Reallocation of Existing Funds												
Federal, Grant, or Other Funding												
Total	657,000	657,000	1,087,5000	1,087,5000	1,087,5000	1,087,500	1,087,500	1,087,500	1,087,500	1,087,500	5,007,000	5,007,000
Estimated Costs Associated with Implementing the Program by Year												
	1st		2nd		3rd		4th		5th		Grand Total	
Category	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**	**New**	**Total**
Program Administration and Faculty/Staff Salaries	508,586	508,586	597,206	597,206	552,587	552,587	569,164	569,164	586,239	586,239	2,813,782	2,813,782
Facilities, Equipment, Supplies, and Materials	14,170	14,170	14,595	14,595	15,033	15,033	15,484	15,484	15,948	15,948	75,230	75,230
Library Resources												
Other (specify)												
Total	522,756	522,756	611,802	611,802	567,620	567,620	584,648	584,648	602,188	602,188	2,889,013	2,889,013
Net Total (Sources of Financing	134,244	134,244	475,698	475,698	519,880	519,880	502,852	502,852	485,312	485,312	2,117,987	2,117,987

Minus Estimated Costs)												

Note: New costs - costs incurred solely as a result of implementing this program. Total costs - new costs; program's share of costs of existing resources used to support the program; and any other costs redirected to the program.

Budget Justification
Provide an explanation for all costs and sources of financing identified in the Financial Support table. Include an analysis of cost-effectiveness and return on investment and address any impacts to tuition, other programs, services, facilities, and the institution overall.

The tuition and fees for the Online MPH Generalist program have been modeled after similar programs currently at MUSC, including the active MPH residential program. The anticipated credit hour rate is $865 which is the same for both In-State and Out-of-State given this is an online program. The application ($95), matriculation ($485), exam and technical support ($260), and part-time ($861) fees are consistent with the current MPH residential program. The only additional fee specific to the online program is the semester fee ($695) which is applicable to all students enrolled each semester.

New faculty costs total the equivalent of 3.0 faculty FTE. These efforts will be delineated among required efforts for the development of the new courses, teaching of the online specific classes, and mentorship of the online student body. The new estimated staff personnel costs include salary and fringe for a new Program Coordinator I and 0.5 FTE of an IT specialist. These administrative roles are necessary to provide support to faculty and students given the entirety of the program will be online and instructional materials will need to be converted to accommodate the user platform. Additional new costs include recruitment expenses, particularly travel. It is expected the recruiter will need to attend college and career fair events across the country to promote and recruit for the online program. Personnel resources that will be reallocated as needed include effort of the current residential MPH program coordinator. It is anticipated that current faculty efforts will be reallocated to the online program for development and instruction of the courses along with mentoring efforts. Lastly, MUSC already has in place a platform that can be utilized for instruction; therefore, there will be no upfront cost for this.

To best serve students and the educational community, MUSC intends to hold tuition and fees flat at the initial stated rates throughout all years. After required taxes and fees are covered, if there is a positive margin it would be reinvested directly back into the program to expand offerings, hire additional teaching faculty, etc. It is anticipated there will be a 5% attrition rate across the cohorts.

Evaluation and Assessment

Program Objectives	**Student Learning Outcomes Aligned to Program Objectives**	**Methods of Assessment**
Outcome 1: The program performs well on dashboard indices of quality.		
1.1	Percentage of students who graduate within 150% of program length	Graduation data
1.2	Percent of students who obtain full-time employment in a relevant field OR who pursue full-time graduate education in a relevant field within one year of graduating.	The graduation survey is administered to each student at the end of the program prior to graduation. Each student is to report whether they have been hired or continuing education after graduation,

		including the location of job or graduate program.
Outcome 2: The program performs well on dashboard indices of satisfaction.		
2.1	Percent of graduating students who agreed that they would recommend the program to other prospective students.	The graduation survey is administered to each student at the end of the program prior to graduation. Each student is asked to report whether they would recommend the program to prospective students using the rating scale (strongly agree, agree, neutral, disagree, or strongly disagree)
2.2	Percent of graduating students who agreed that the program met their expectations.	The graduation survey is administered to each student at the end of the program prior to graduation. Each student is asked to report whether the program met their expectations using the rating scale (strongly agree, agree, neutral, disagree, or strongly disagree)
Outcome 3: The program fosters increased diversity in the profession.		
3.1	Percent of students in the incoming class from under-represented minorities.	Recruitment and admissions data
3.2	Percent of students who agree the program values diversity in people and ideas.	Using the graduation survey that is administered to each student at the end of the program prior to graduation, and the alumni survey which is administered 6-9 months post-graduation, students are asked to report whether the program values diversity in people and ideas using the rating scale (strongly agree, agree, neutral, disagree, or strongly disagree)
Outcome 4: Evidence of ability to apply public health knowledge to practice		
4.1	Percentage of students demonstrating mastery of	For the capstone, each student completes a final

	interdisciplinary/cross-cutting core competencies of the capstone grading rubric	paper and poster that demonstrates proficiency among the foundational and concentration specific competencies. The advisor uses a rubric to grade the paper and poster regarding the competencies addressed, oral and written presentation of the capstone project.
4.2	Percentage of students demonstrating mastery of interdisciplinary/cross-cutting core competencies of the internship grading rubric	For the internship, each student identifies an internship opportunity within a public health setting to apply public health knowledge to field practice experience. During the internship, each student is producing two products (i.e. strategic plan, needs assessment, educational material, data collection, data analysis, etc.) that is beneficial to the public health organization they are completing the internship. The internship addresses foundational and concentration specific competencies. The advisor of each student uses a rubric to grade the two deliverables.
Outcome 5: Apply principles of leadership, governance and management, which include creating a vision, empowering others, fostering collaboration and guiding decision making.		
5.1	Percentage of students who agree the program taught core competencies of public health ethics and leadership	A course evaluation is administered to each student at the end of each semester. Students are asked to report their confidence in understanding the public health ethics and leadership competencies.
5.2	Percentage of students demonstrating mastery of leadership skills through oral presentation.	For the capstone, each student completes a final poster that includes an oral presentation of capstone project, research background,

		methods, results, and public health competencies. The advisor uses a rubric to grade the poster presentation regarding the oral presentation of the capstone project.
Outcome 6: Perform effectively on interprofessional teams.		
6.1	Percentage of students who agree program taught core competencies of interprofessional team collaboration.	The final evaluation of the internship completed by each student as part of the internship assess students' knowledge of interprofessional competencies.
6.2	Percentage of students demonstrating mastery of skills of interprofessional team collaboration.	The grading rubric used by the advisor and internship preceptor for the internship evaluates student's ability to perform on interprofessional teams.

Explain how the proposed program, including all program objectives, will be evaluated, along with plans to track employment. Describe how assessment data will be used.

The MPH program regularly assess how well students learning needs are met with the use of grading rubrics and course evaluations. For the Capstone paper, a rubric is used by the advisor to evaluate all parts of the final capstone paper, including the introduction, learning objectives, methods, and results and discussion. For the poster oral presentation, two faculty judges from the student's concentration use a rubric during the presentation to evaluate the content and structure, the overall oral presentation, and the connectedness of the public health and concentration competencies. Similarly, for the Internship, each student's deliverables are graded using a rubric by the advisor and the internship preceptor to assess whether the deliverables (i.e. strategic plan, data collection, data analysis report, educational curriculum, etc.) produced during the internship met the learning objectives and public health competencies, the student's onsite performance (ability to work independently, reliable, attending meetings), and professionalism (effective communication, punctuality, professional attire). In addition to the grading rubric, the preceptor of each student completes an evaluation at the midpoint of the internship opportunity and at the end of the internship providing information regarding the student's ability throughout the course of the internship. At the conclusion of the internship, each student completes an overall evaluation of the internship opportunity to assess their overall experience with the internship.

To assess students' overall learning experience, course evaluations are administered to each student at the end of each semester. Additionally, a graduation survey is administered to each student prior to graduation to gather information regarding the student's learning experience in the overall program as well as future employment. Approximately 6-9 months post-graduation an Alumni Survey is administered to each graduate to assess their preparedness for the role they have with their employer.

Overall, as a program the MPH program continually assesses and evaluates program goals and how they relate to the advancement of the field of public health as well as student success. Assessment data from course evaluations, internship preceptor evaluations, graduation surveys, and Alumni Surveys are used to

improve the MPH program. For example, changes to courses or instructors, or provision of additional professional development opportunities for students.

As a secondary assessment, the MPH program assess how well faculty are teaching courses using the same course evaluations that are conducted at the end of each semester. The Assistant Academic Program Director compiles the results and disseminates them to each of the faculty members that were evaluated. The compiled report is discussed during MPH Program Committee meeting to devise a plan of action for any courses or faculty that need additional support or a corrective action plan.

Accreditation and Licensure/Certification

Will the institution seek program-specific accreditation (e.g., CAEP, ABET, NASM, etc.)? If yes, describe the institution's plans to seek accreditation, including the expected timeline.

☒Yes

☐No

The accrediting body for all schools and programs of public health is the Council on Education for Public Health. The current MPH program (as reflected by the three MPH degrees we offer) at MUSC received full accreditation status March 2022 for the residential program; thereby being eligible to submit a change request to include the online MPH degree. The process will include the submission of a 'Substantive Change' form to CEPH that outlines the purpose and goals of the online program, course list, faculty and staff resources, schedule of courses, and new competencies for the new courses added to the curriculum. The approval of this form is done on a rolling basis; therefore, we will submit our Substantive request after approval by the Commission on Higher Education.

Will the proposed program lead to licensure or certification? If yes, identify the licensure or certification.

☒Yes

☐No

Explain how the program will prepare students for this licensure or certification.

The Certified in Public Health (CPH) certification is the only credential of its kind for public health that demonstrates not only knowledge of key public health sciences, but also commitment to the field through continuing education. Becoming certified in public health solidifies the dedication to meeting and maintaining national standards, adhering to professional values, and following a core standard body of knowledge. Due to our accreditation status, all graduates of the MPH program are eligible to take the certification exam. The exam covers 10 domain areas which are covered in courses within our curriculum; these domains include: Evidence-based Approaches to Public Health, Communication, Leadership, Law and Ethics, Public Health Biology and Human Disease Risk, Collaboration and Partnership, Program Planning and Evaluation, Program Management, Policy in Public Health, and Health Equity and Social Justice.

While this certification is not a requirement, we will highly recommend it to our students and prepare them to be able to take it. The public health workforce is increasing job opportunities that are preferring or requiring applicants to have this certification, so as professional development, we want our students to take advantage of the opportunity to becoming certified.

If the program is an Educator Preparation Program, does the proposed certification area require national recognition from a Specialized Professional Association (SPA)? If yes, describe the institution's plans to seek national recognition, including the expected timeline.

☐ Yes

☒ No

THE MEDICAL UNIVERSITY OF SOUTH CAROLINA

Monthly Financial Reports

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For the Four (4) Month Period Ended October 31, 2022

The Medical University of South Carolina and Affiliated Organizations
Statement of Net Position
As of October 31, 2022

	University	Area Health Education Consortium	CHS Development Company
Assets & Deferred Outflows			
Cash and Cash Equivalents	$ 456,951,761	$ 11,629,510	$ -
Cash and Cash Equivalents - Restricted	28,818,968	-	702,363
State Appropriation Receivable	113,146,593	6,261,610	-
Student Tuition and Fees Receivable	3,552,864	-	-
Student Loan Receivable	11,766,406	-	-
Grants and Contracts Receivable	81,287,066	118,124	-
Capital Improvement Bond Proceeds Receivable	-	-	-
Lease Receivable	14,290,867	-	4,157,637
Other Receivables	3,959,620	-	-
Investments	-	-	1,506,116
Prepaid Items	14,185,802	-	186,948
Capital Assets, net of Accumulated Depreciation	442,927,533	-	-
Due from Hospital Authority	3,307,914	-	-
Due from Other Funds	116,312,541	-	-
Bond Issue Costs	-	-	-
Derivative Instruments Fair Value / Deferred Outflows	-	-	-
Deferred loss on Debt Refinancing	10,135	-	33,819
Deferred Outflows-Pensions	80,637,846	-	-
Deferred Outflows-OPEB	194,148,465		
Other Assets	-	-	-
Total Assets & Deferred Outflows	**$ 1,565,304,381**	**$ 18,009,244**	**$ 6,586,883**
Liabilities & Deferred Inflows			
Accounts Payable	$ 19,347,415	$ -	$ -
Accrued Payroll and Other Payroll Liabilities	45,614,594	-	-
Accrued Compensated Absences	31,431,216	181,586	-
Deferred Revenue	130,437,040	9,207,674	-
Retainages Payable	-	-	-
Long-Term Debt	93,666,077	-	5,450,000
Lease Liability	93,958,461		
Interest Payable	630,246	-	40,875
Deposits Held for Others	1,883,332	21,605	-
Due to Hospital Authority	-	-	-
Due to Other Funds	8,385,121	-	-
Federal Loan Program Liability	11,418,021	-	-
Derivative Instruments Fair Value / Deferred Inflows	-	-	-
Net Pension Liability	449,308,492	-	-
Net OPEB Liability	698,474,500		
Deferred Inflows-Leases	14,971,268		
Deferred Inflows-Pensions	96,579,440	-	-
Deferred Inflows-OPEB	42,996,146		
Other Liabilities	30,069,541	-	-
Total Liabilities & Deferred Inflows	**$ 1,769,170,910**	**$ 9,410,865**	**$ 5,490,875**
Net Position	**(203,866,529)**	**8,598,379**	**1,096,008**
Total Liabilities & Deferred Inflows and Net Position	**$ 1,565,304,381**	**$ 18,009,244**	**$ 6,586,883**

The Medical University of South Carolina
Budgeted Funds Comparison to Budget (Expenses Classified by Category)
For the period ending October 31, 2022

	Budget	Prorated Budget (Note)	Actual	Variance	
Revenues					
Federal Grants & Contracts	$ 143,729,464	$ 47,909,821	$ 53,363,633	$ 5,453,812	F
Federal Grants Indirect Cost Recoveries	41,203,063	13,734,354	14,081,884	347,530	F
State Grants & Contracts	8,921,887	2,973,962	2,789,989	(183,973)	U
Private Grants & Contracts	36,319,143	12,106,381	9,935,180	(2,171,201)	U
Private Grants Indirect Cost Recoveries	6,546,261	2,182,087	1,954,872	(227,215)	U
Total Grants & Contracts	**236,719,818**	**78,906,605**	**82,125,558**	**3,218,953**	**F**
State Appropriations	123,183,540	41,061,180	41,587,195	526,015	F
Tuition and Fees	115,504,693	38,501,564	37,183,465	(1,318,099)	U
Pass-Through Revenues	116,347,979	38,782,660	38,753,534	(29,126)	U
Gifts	26,406,705	8,802,235	4,543,486	(4,258,749)	U
Transfers from (to) MUSC Physicians	102,291,145	34,097,048	33,165,104	(931,944)	U
Sales and Services of Educational Departments	17,136,923	5,712,308	5,266,533	(445,775)	U
Sales and Services of Auxiliary Enterprises	14,285,172	4,761,724	4,256,456	(505,268)	U
Interest and Investment Income	3,041	1,014	(26,151)	(27,165)	U
Endowment Income	4,545,442	1,515,147	769,823	(745,324)	U
Miscellaneous	15,778,117	5,259,372	5,452,483	193,111	F
Miscellaneous - Residents	8,000,000	2,666,667	2,666,667	-	F
Authority Revenue	97,308,141	32,436,047	36,514,167	4,078,120	F
Authority Revenue - Residents	74,583,968	24,861,323	24,861,323	-	F
Intra-Institutional Sales	41,582,808	13,860,936	10,535,046	(3,325,890)	U
Total Other	**756,957,674**	**252,319,225**	**245,529,131**	**(6,790,094)**	**U**
Total Revenues	**993,677,492**	**331,225,830**	**327,654,689**	**(3,571,141)**	**U**
Expenditures					
Salaries	$ 366,599,538	$ 122,199,846	$ 120,180,500	$ 2,019,346	F
Miscellaneous Personnel Expenditures	5,197,950	1,732,650	-	1,732,650	F
Fringe Benefits	142,367,731	47,455,910	43,908,622	3,547,288	F
Total Personnel	**$ 514,165,219**	**$ 171,388,406**	**$ 164,089,122**	**$ 7,299,284**	**F**
Contractual Services	$ 180,625,308	$ 60,208,436	$ 58,804,722	$ 1,403,714	F
Pass-through Expenditures	116,347,979	38,782,660	38,753,534	29,126	F
Supplies	61,717,312	20,572,437	19,594,688	977,749	F
Fixed Charges	55,792,105	18,597,368	17,559,744	1,037,624	F
Equipment	9,760,068	3,253,356	2,726,038	527,318	F
Travel	3,981,829	1,327,276	1,045,178	282,098	F
Trainee / Scholarships	24,559,596	8,186,532	7,314,276	872,256	F
Other Expenses	6,105,086	2,035,029	239,480	1,795,549	F
Debt Service	9,680,387	3,226,796	3,396,463	(169,667)	U
Total Other	**$ 468,569,670**	**$ 156,189,890**	**$ 149,434,123**	**$ 6,755,767**	**F**
Total Expenditures	**$ 982,734,889**	**$ 327,578,296**	**$ 313,523,245**	**$ 14,055,051**	**F**
Other Additions (Deductions)					
Transfers from(to) Plant Funds	(42,293,869)	(14,097,956)	(18,172,493)	(4,074,537)	U
Other Transfers	33,413	11,138	(134,882)	(146,020)	U
Prior Year Fund Balance Usage	38,162,857	12,720,952	10,337,104	(2,383,848)	U
Total Other Additions (Deductions)	**$ (4,097,599)**	**$ (1,365,866)**	**$ (7,970,271)**	**$ (6,604,405)**	**U**
NET INCREASE (DECREASE) in Fund Balance	**$ 6,845,004**	**$ 2,281,668**	**$ 6,161,173**	**$ 3,879,505**	**F**
Non-Budgeted Items					
Net Unfunded Pension Expense			574,050		
Net Unfunded OPEB Expense			(12,313,571)		
Net Lease Activity - GASB 87			-		
Depreciation			(12,098,560)		
Endowment Gains/Losses			1,419,689		
Gain (Loss) on Disposition of Property			(10,277)		
Other Non-Budgeted Items			14,404,165		
SRECNP Bottom Line			**(1,863,330)**		

THE MEDICAL UNIVERSITY OF SOUTH CAROLINA
NOTES TO THE FINANCIAL STATEMENTS
October 31, 2022

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	$	50,460,359
Projects in progress		3,622,699
Land/Bldgs/Equipment/Accumulated depreciation		388,844,475
Capital Assets, Net of Accumulated Depreciation	$	442,927,533

Note 5. *Construction in Progress*
The itemized construction-in-progress will be updated in November.

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

State appropriations	$	90,783,343
Grants and contracts		19,564,354
Student tuition and fees		17,491,772
Other		2,597,571
Total Deferred Revenue	$	130,437,040

Note 7. *Long Term Liabilities and Leases*

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

Lease Liability	$ 93,958,460
Higher Ed Refunded Revenue bond payable	16,255,000
State Institution bonds payable	41,985,000
Energy Performance Note Payable	28,174,298
Premium on State Institution bonds payable	6,426,826
Premium on Refunding Revenue Bonds	814,818
Total Long Term Liabilities and Leases	$ 187,614,402

Note 8. *Summary of Net Position*

The University implemented GASB Statement No. 68, *Accounting and Financial Reporting for Pensions* in fiscal year 2015 and GASB Statement No. 75, *Accounting and Financial Reporting for Post Employment Benefits Other Than Pensions (OPEB)* in fiscal year 2018. These statements require participating employers to report their proportionate share of the plans' net pension liability and OPEB liabilities, pension and OPEB expense and deferred outflows and inflows. In fiscal year 2022, excluding the GASB 68 and GASB 75 impact, the University's unrestricted net position increased $39.6 million for a total of $200.2 million. In fiscal year 2021, excluding the GASB 68 and GASB 75 impact, the University's net position increased $2.3 million for a total of $160.6 million. In fiscal year 2020, excluding the GASB 68 and GASB 75 impact, the University's unrestricted net position decreased $7.1 million for at total of $158.3 million. In fiscal year 2019, excluding the GASB 68 and GASB 75 impact, the University's unrestricted net position increased $28.2 million for a total of $165.4 million.

	Per annual CAFR			
	FY2022	FY2021	FY2020	FY2019
Net investment in capital assets	$ 264,898,753	$ 256,273,784	$ 273,745,547	$ 290,960,785
Restricted				
Nonexpendable	94,737,549	93,450,804	92,884,333	91,997,286
Expendable	204,093,027	172,064,021	119,736,905	113,211,622
Unrestricted (exclusive of GASB 68 and 75 liabilities)	200,247,718	160,633,515	158,323,021	165,423,830
Unrestricted (including GASB 68 and 75 liabilities)	(961,299,272)	(908,652,076)	(868,396,874)	(841,631,771)
Total net position	$ (197,322,225)	$ (226,229,952)	$ (223,707,068)	$ (180,038,248)

Medical University of South Carolina

Summary of Current Debt Obligations

($$ in thousands)

	Original Issue	Purpose	Outstanding & Authorized as of 31-Oct-2022
State Institution Bonds (SIB)			
SIB 2011D	18,950	Deferred maintenance projects	-
SIB 2012B refunding	12,645	Refunding SIB 2001C, 2003D, & 2003J	1,645
SIB 2016D	30,095	Refunding SIB 2001C, 2003D, & 2003J	18,135
SIB 2021D	23,415	Refunding SIB 2011D & to fund construction of capital projects	22,205
	$ 146,150		
Current SIB Debt Authorized and Issued			$ 41,985
Notes Payable - JEDA	$ 32,985	Construction of College Health Health Profession facilities	$ 5,450
Refunding Revenue Bonds, Series 2017			
2017	$ 25,115	Refunding of Higher Ed Revenue Bonds	$ 16,255
Energy Performance Note Payable			
EPNP 02-27-19	$ 30,000	Energy Savings	$ 28,174

MUSC Affiliated Organizations
Statement of Revenues, Expenses and Changes in Net Position
For the Four (4) Month Period Ending October 31, 2022

	Area Health Education Consortium	CHS Development Company
Operating Revenues		
Student Tuition and Fees	$ -	$ -
Federal Grants and Contracts	328,986	-
State Grants and Contracts	1,016,849	-
Local Government Grants and Contracts	-	-
Nongovernmental Grants and Contracts	50,000	-
Sales and Services to Hospital Authority	-	-
Sales and Services of Educational and Other Activities	-	-
Sales and Services of Auxiliary Enterprises	-	-
Interest Income	-	75,140
Other Operating Revenues	-	-
Total Operating Revenues	**1,395,835**	**75,140**
Operating Expenses		
Compensation and Employee Benefits	762,042	-
Pension Benefits		
OPEB Expense		
Services and Supplies	796,306	-
Utilities	-	-
Scholarships and Fellowships	12,700	-
Refunds to Grantors	-	-
Interest Expense	-	45,042
Depreciation and Amortization	-	52,116
Total Operating Expenses	**1,571,048**	**97,158**
Operating Income (Loss)	**(175,213)**	**(22,018)**
Nonoperating Revenues (Expenses)		
State Appropriations	4,092,300	-
State Appropriations - MUHA	-	-
Gifts and Grants Received	-	-
Investment Income	-	-
Interest Expense	-	-
Gain (Loss) on Disposal of Capital Assets	-	-
Transfers From (To) Other State Agencies	-	-
Other Nonoperating Revenues (Expenses), net	-	-
Net Nonoperating Revenues (Expenses)	**4,092,300**	**-**
Income (Loss) Before Other Revenues, Expenses, Gains, Losses and Transfers	**3,917,087**	**(22,018)**
Capital Appropriations	-	-
Capital Grants and Gifts	-	-
Additions to Permanent Endowments	-	-
Transfers From (To) MUSC Physicians (UMA)	-	-
Transfers From (To) AHEC	319	-
Transfers From (To) CHS Development	-	3,436
Transfers From (To) Facilities Corporation	-	-
Increase (Decrease) In Net Position	**$ 3,917,406**	**$ (18,582)**

The MUSC Affiliated Organizations
Statement of Revenues, Expenses and Changes in Net Position
For the Three (3) Month Period Ending September 30, 2022

	Area Health Education Consortium	CHS Development Company
Operating Revenues		
Student Tuition and Fees	$ -	$ -
Federal Grants and Contracts	257,592	-
State Grants and Contracts	1,016,849	-
Local Government Grants and Contracts	-	-
Nongovernmental Grants and Contracts	50,000	-
Sales and Services to Hospital Authority	-	-
Sales and Services of Educational and Other Activities	-	-
Sales and Services of Auxiliary Enterprises	-	-
Interest Income	-	71,388
Other Operating Revenues	-	-
Total Operating Revenues	**1,324,441**	**71,388**
Operating Expenses		
Compensation and Employee Benefits	762,042	-
Pension Benefits		
OPEB Expense		
Services and Supplies	387,428	-
Utilities	-	-
Scholarships and Fellowships	12,700	-
Refunds to Grantors	-	-
Interest Expense	-	32,922
Depreciation and Amortization	-	39,087
Total Operating Expenses	**1,162,170**	**72,009**
Operating Income (Loss)	**162,271**	**(621)**
Nonoperating Revenues (Expenses)		
State Appropriations	3,069,225	-
State Appropriations - MUHA	-	-
Gifts and Grants Received	-	-
Investment Income	-	-
Interest Expense	-	-
Gain (Loss) on Disposal of Capital Assets	-	-
Transfers From (To) Other State Agencies	-	-
Other Nonoperating Revenues (Expenses), net	-	-
Net Nonoperating Revenues (Expenses)	**3,069,225**	**-**
Income (Loss) Before Other Revenues, Expenses, Gains, Losses and Transfers	**3,231,496**	**(621)**
Capital Appropriations	-	-
Capital Grants and Gifts	-	-
Additions to Permanent Endowments	-	-
Transfers From (To) MUSC Physicians (UMA)	-	-
Transfers From (To) AHEC	319	-
Transfers From (To) CHS Development	-	2,577
Transfers From (To) Facilities Corporation	-	-
Increase (Decrease) In Net Position	**$ 3,231,815**	**$ 1,956**

MUSC Physicians and Carolina Family Care

Interim Financial Statements For the four month period ending October 31, 2022

MUSC Physicians and Carolina Family Care, Inc.
(A Component Unit of MUSC)
Statement of Revenues, Expenses and Changes in Net Position
For the 4 Month Period Ending - October 31, 2022

	MUSC Physicians				Carolina Family Care, Inc.		Total		
	College of Medicine Actual	Corporate Actual	Ambulatory Care Actual	Other Actual	Carolina Family Care Primary Care Actual	Other Actual	Total Actual	Total Fixed Budget	Total Variance
Operating revenues:									
Net clinical service revenue	150,312,947	-	-	787,151	8,606,811	766,679	160,473,588	156,018,090	4,455,498
Supplemental medicaid	15,574,952	-	-	-	1,066,667	-	16,641,619	16,641,619	-
Other operating revenue	1,525,613	896,908	705	95,547	1,448,004	-	4,575,324	5,652,288	(1,076,964)
Intercompany transfers	(39,611,258)	11,196,587	27,416,863	997,808	-	-	-	-	-
Purchased services	36,192,668	260,193	(944,825)	1,249,150	135,626	1,986,933	39,343,900	40,137,530	(793,630)
Grant salary reimb. from MUSC	5,585,688	-	-	22,889	-	-	5,608,577	6,377,224	(768,647)
Total operating revenues	169,580,611	12,353,688	26,472,743	3,152,546	11,257,108	2,753,612	226,643,008	224,826,751	1,816,258
Operating expenses:									
Salaries, wages and benefits	122,764,654	11,210,533	10,606,636	2,519,145	7,641,783	1,873,333	156,718,989	153,461,792	(3,257,197)
MUSCP reimb. for education and research	33,985,406	-	-	-	-	-	33,985,406	33,985,406	-
Supplies	3,188,900	95,059	13,211,896	9,603	1,022,334	37,999	17,611,522	16,396,174	(1,215,348)
Contractual services	1,225,547	2,356,124	401,842	412,369	348,923	606,237	5,701,627	7,098,644	1,397,017
Facility cost and equipment	20,305	345,409	2,929,204	56,189	726,206	88,808	4,198,999	4,761,496	562,497
Professional liability insurance	2,668,083	10,873	1,410	167	134,147	18,864	2,833,543	3,033,065	199,522
Depreciation	-	49,845	1,224,190	170,216	104,007	-	1,870,814	2,151,612	280,798
Meals and travel	479,507	95,395	6,610	74,243	4,347	5,127	665,228	1,295,492	630,264
Other expenses	148,265	250,429	67,276	65,071	(9,180)	23,539	545,399	732,955	187,557
Faculty and staff recruitment	118,364	146,060	4,139	38,052	2,342	5,030	313,986	450,623	136,637
MUSCP corporate shared services	-	-	-	-	806,620	9,438	816,058	869,805	53,747
Total operating expenses	164,599,029	14,559,727	28,453,202	3,345,056	10,781,529	2,668,375	225,261,571	224,237,064	(1,024,507)
Operating income (loss)	4,981,581	(2,206,039)	(1,980,459)	(192,510)	475,579	85,238	1,381,437	589,687	791,751
Operating margin	2.9%	(17.9%)	(7.5%)	(6.1%)	4.2%	3.1%	0.6%	0.3%	
Nonoperating revenue (expenses):									
Investment income	398,875	1,457,041	-	(5,716,074)	31	162	(3,859,965)	2,083,708	(5,943,673)
Interest expense	-	(111,555)	-	(583,177)	-	(15,108)	(1,059,039)	(852,286)	(206,754)
Rental income	-	74,384	166,743	2,231,325	13,333	49	2,485,834	2,489,457	(3,623)
Rent expense	-	-	-	(494,011)	-	-	(494,011)	(494,011)	-
Gain (loss) on disposal of assets	-	(1,540)	-	-	-	-	(1,540)	-	(1,540)
Total Nonoperating revenue (expenses)	398,875	1,418,330	166,743	(4,561,938)	13,363	(14,897)	(2,928,721)	3,226,868	(6,155,590)
Change in net position	$ 5,380,456	$ (787,709)	$ (1,813,716)	$ (4,754,447)	$ 488,942	$ 70,341	$ (1,547,284)	$ 3,816,555	$ (5,363,839)
Net margin	3.2%	(6.4%)	(6.9%)	(150.8%)	4.3%	2.6%	(0.7%)	1.7%	

Notes:

MUSC Physicians Other includes other Colleges (Nursing CoHP, Dental), Presidents Fund, Rental Properties and Investment Accoun

Carolina Family Care, Inc. Other includes Grace Internal Medicine, Institutional Advancement, and MHA Participant Distributio

Medical University of South Carolina Physicians
Executive Summary
For the four-month period ending October 31, 2022

Charges:

- **YTD: 5% over budget and 8% over last year**
- Month of October: 1% under budget and 4% over last year
- Top 5 clinical departments: Infusion, Orthopedics, Anesthesiology, Radiology with Contracts, Radiation Oncology
- Bottom 5 clinical departments: Pathology & Lab Medicine, Otolaryngology, Ophthalmology, Urology, Medicine

Payments:

- **YTD: 1% over budget and 4% over last year**
- Month of October: 1% under budget and 7% over last year
- 36.4 Days in AR and $84 per wRVU

Income/(Loss):

- **$0.8M Operating Income; 0.4% Operating Margin**
    - $1.2M favorable variance to fixed budget
        - $5.1M favorable net clinical service revenue
        - ($2.5M) unfavorable other revenue categories: grant salary reimbursement, salary reimbursement, miscellaneous income - OurDay conversion
        - ($3.5M) unfavorable salaries, wages, and benefits – ($2.0M) for OurDay salary accrual and ($1.2M) College of Medicine staff salaries
        - ($1.1M) unfavorable vaccines and injectables – surplus/bulk ordering
        - $3.2M favorability in various expense categories: Purchased outside services, Meals and travel, Collection fees, Faculty cost and equipment

- **($2.1M) Net Loss; (1.0%) Net Margin**
    - ($5.0M) unfavorable variance to fixed budget
        - ($5.8M) unrealized/realized gain on investments

Balance Sheet:

- Days cash on hand: 246 days
- Current ratio: 7.1
- Net Position: $422.4M; decreased by $2.1M compared to June 2022

Pension:

- YTD expense: $16.7M; increased by 11.3% compared to YTD June 2022

MUSC Physicians

(A Component Unit of MUSC)

Statement of Revenues, Expenses and Changes in Net Position

For the 4 Month Period Ending - October 31, 2022

	Fiscal Year To Date				Prior Year To Date
	Actual	Fixed Budget	Variance	Var %	Actual
Operating revenues:					
Net clinical service revenue	$ 151,100,098	$ 145,999,259	$ 5,100,838	3%	$ 145,492,346
Supplemental medicaid	15,574,952	15,574,952	-	0%	19,765,798
Other operating revenue	3,277,320	4,048,863	(771,543)	(19%)	4,598,280
Purchased services	37,071,341	38,066,698	(995,357)	(3%)	33,944,923
Grant salary reimb. from MUSC	5,608,577	6,377,224	(768,647)	(12%)	4,838,654
Total operating revenues	212,632,288	210,066,997	2,565,291	1%	208,640,001
Operating expenses:					
Salaries, wages and benefits	147,203,873	143,730,768	(3,473,105)	(2%)	135,569,923
MUSCP reimb. for education and research	33,985,406	33,985,406	-	0%	30,271,299
Supplies	16,551,190	15,413,361	(1,137,829)	(7%)	14,026,111
Contractual services	4,746,467	6,057,514	1,311,047	22%	4,486,906
Facility cost and equipment	3,383,984	3,892,987	509,003	13%	3,100,240
Professional liability insurance	2,680,532	2,873,272	192,740	7%	2,601,567
Depreciation	1,766,806	2,033,045	266,239	13%	1,723,621
Meals and travel	655,754	1,285,520	629,766	49%	412,051
Other expenses	531,040	687,889	156,849	23%	580,633
Faculty and staff recruitment	306,615	445,191	138,577	31%	511,680
Donations - transfer to MUSCF	-	-	-	0%	100
Total operating expenses	211,811,667	210,404,953	(1,406,715)	(1%)	193,284,131
Operating income (loss)	820,620	(337,956)	1,158,576	343%	15,355,870
Operating margin	0.4%	(0.2%)			7.4%
Nonoperating revenue (expenses):					
Investment income	(3,860,158)	2,083,708	(5,943,866)	(285%)	2,275,005
Interest expense	(1,043,931)	(851,983)	(191,948)	(23%)	(1,004,001)
Rental income	2,472,452	2,478,488	(6,036)	(0%)	2,427,754
Rent expense	(494,011)	(494,011)	-	0%	(501,088)
Gain (loss) on disposal of assets	(1,540)	-	(1,540)	(100%)	-
Total nonoperating revenue (expenses)	(2,927,188)	3,216,202	(6,143,390)	(191%)	3,197,669
Change in net position	$ (2,106,567)	$ 2,878,246	$ (4,984,813)	(173%)	$ 18,553,540
Net margin	(1.0%)	1.4%			8.9%

Notes:

Other operating revenue ($0.8M) for OurDay implementation delay in billings

Purchased services: ($1M) College of Medicine underbudget - timing of hospital bill reconciliation

Salary, wages and benefits: approximately ($2M) for OurDay implementation change in accrual and ($1.2M) College of Medicine staff salaries

Supplies: Vaccines and injectibles ($1.2M) overbudget due to surplus ordering during September

Contractual services underbudget: Purchased outside services $738K, Collection fees $584K and Outside Physician Services $173K

Investment income includes unrealized/realized loss on investment of ($5.8M) and interest income of $1.9M

MUSC Physicians

(A Component Unit of the Medical University of South Carolina)

Statement of Net Position

ASSETS

	October 31, 2022	June 30, 2022	Variance
Current Assets:			
Cash and investments	$ 282,650,735	$ 336,177,799	$ (53,527,065)
Receivables:			
Patient services - net of allowances for contractual adjustments and bad debt of $184,944,257	55,451,276	49,788,996	5,662,280
Due from the Medical University of South Carolina	16,067,398	26,362,895	(10,295,497)
Due from the Medical University Hospital Authority	4,163,802	6,042,402	(1,878,600)
Due from the Medical University Foundation	691,969	747,471	(55,502)
Due from Carolina Family Care, Inc.	5,666,695	6,922,849	(1,256,154)
Note receivable from CFC/MHP	756,003	756,003	-
Investment / Advancements consolidated CFC	32,270,000	32,270,000	-
Due from Comprehensive Psychiatric Services	3,499	(2,659)	6,157
Due from MCP	868,653	478,651	390,001
Due from MUSC Health Alliance	481,196	416,422	64,774
Due from MSV	207,184	-	207,184
Lease receivable	2,946,249	2,946,249	-
Other current assets	19,636,676	5,477,686	14,158,990
Total Current Assets	421,861,333	468,384,765	(46,523,432)
Noncurrent assets:			
Capital assets:			
Land	17,034,537	17,034,537	-
Buildings	51,903,396	51,903,396	-
Furniture and equipment	31,465,951	31,172,656	293,295
Leasehold improvements	65,974,273	64,305,580	1,668,693
Rental buildings under capital lease	13,989,600	13,989,600	-
Computer software	14,207,950	14,207,950	-
Right of use assets	21,443,860	21,443,860	-
Accumulated depreciation and amortization	(102,538,407)	(99,497,004)	(3,041,403)
Lease receivable	5,037,665	5,866,028	(828,362)
Other assets	100,000	1,240,000	(1,140,000)
Investment in partnerships	6,595,269	6,595,269	-
Total noncurrent assets	125,214,094	128,261,871	(3,047,777)
Total Assets	547,075,427	596,646,636	(49,571,209)
Deferred outflows of resources:			
Deferred refunding cost	6,040,604	6,476,238	(435,634)
Deferred outflows-OPEB	780,785	780,785	-
Total deferred outflows	6,821,389	7,257,023	(435,634)
Total Assets and Deferred Outflows	$ 553,896,816	$ 603,903,659	$ (50,006,843)

Notes:

Cash and Investments: FY22 year-end incentive payments ($38.2M); FY23 Y incentive (salary + fringe) payments ($12.6M); Q3 Supplemental Medicaid $10.3M; Loss on investments ($5.8M)

Due from MUSC variance is due to receipt of $10.3M Q3 FY22 Supplemental Medicaid payments received in FY23

Other current assets variance is due to FY23 Supplemental Medicaid accrual $15.6M; ($1.1M) other income accruals: cash received in FY23 but recorded in FY22

Leasehold Improvements include ongoing projects: ERP (FY23 balance increase of $1.1M) and Nexton (FY23 balance increase of $0.5M)

Other Assets - (Noncurrent) decrease in collateral deposit for Swap. Swap valued at $0.9M

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

Statement of Net Position

LIABILITIES

	October 31, 2022	June 30, 2022	Variance
Current Liabilities:			
Accounts payable	$ 367,889	$ 7,239,840	$ 6,871,951
Accrued interest payable	141,098	142,165	1,066
Accrued payroll	15,055,093	42,569,084	27,513,990
Accrued payroll withholdings	5,789,008	10,291,887	4,502,879
Accrued pension contribution	936,861	1,886,233	949,372
Unapplied cash - patient services	8,117,120	6,777,393	(1,339,727)
Other accrued liabilities	9,376,532	5,297,863	(4,078,668)
Due to Medical University of South Carolina	683,561	409,401	(274,160)
Due to Medical University Hospital Authority	8,716,103	16,453,454	7,737,351
Accrued compensated absences	3,361,533	3,182,431	(179,102)
Lease liability	2,610,546	2,610,546	-
Bonds payable	4,160,000	4,160,000	-
Total current liabilities	59,315,344	101,020,296	41,704,952
Noncurrent Liabilities:			
Accrued compensated absences	2,763,815	2,763,815	-
Lease liability	11,868,978	12,576,285	707,307
Bonds payable	48,880,000	51,980,000	3,100,000
Deferred inflows-leases	7,913,214	8,747,699	834,484
Deferred inflows-OPEB	643,300	643,300	-
Net OPEB liability	1,019,759	1,019,759	-
Fair value of derivative instruments	(893,424)	660,108	1,553,533
Total noncurrent liabilities	72,195,642	78,390,966	6,195,324
Total liabilities	131,510,986	179,411,262	47,900,276
NET POSITION			
Invested in capital assets, net of related debt	79,754,058	79,754,058	-
Unrestricted (deficit)	342,631,772	344,738,339	2,106,567
Total Net Position	422,385,831	424,492,397	2,106,567
Total Liabilities, Inflows & Net Position	$ 553,896,816	$ 603,903,659	$ 50,006,843

Notes:

Accounts payable change in balance is due to the removal of FY22 AP accruals of $5.2M; change in credit card payable balance

Accrued payroll FY23 balance includes Y incentive (salary + fringe) accrual of ($6.4M); ($8.6M) for staff accrual; reversal of $41.1M FY22 year end accruals

Accrued payroll withholding balances FY23 & FY22 includes FICA employer withholding being deferred ($3.2M, which is 1/2 of original balance)

Other accrued liabilities change in balance due to FY23 ($2.4M) Infusion accrual and ($0.9M) R transfers accrual; ($0.6M) PLI accrual

Due to MUHA balance reduction due to $4.6M Epic Cash transfer, $1.5M IS Shared services and $1.2M East MRI

Rutledge Tower JEDA Bond Balance is approximately $48.8M.

Carolina Family Care, Inc.
Including Carolina Primary Care Physicians & MUSC Health Partners
Executive Summary
For the four-month period ending October 31, 2022

Charges-CFC:

- **YTD: 1% over budget and 14% over last year**
- Month of October: 2% over budget and 2% over last year

Payment-CFC:

- **YTD: 12% under budget and 9% over last year**
- Month of October: 17% under budget and 1% over last year
- 26.3 Days in AR and $99 per wRVU

Income/(Loss):

- **$0.6M Operating Income; 4.0% Operating Margin**
    - ($0.4M) unfavorable variance to fixed budget
        - ($645K) unfavorable net clinical service revenue
        - ($156K) unfavorable miscellaneous income
        - $216K favorable salaries at MUSCP Primary Care
            - $574K favorable physician salaries due to vacancies
            - ($355K) OurDay implementation – change in salary accrual
        - $200K favorable various expense categories
- **$0.6M Net Income; 4.0% Net Margin**
    - ($0.4M) unfavorable variance to fixed budget

Balance Sheet:

- Current ratio: 0.7
- Net Position: ($2.1M); increased by $0.6M compared to June 2022
- Assets increased by $1.0M compared to June 2022
    - ($1.2M) decrease in cash and cash equivalents (payments to UMA)
    - $0.6M increase in Due from MCP (MCP leadership employed by CPCP)
    - $0.5M increase in Due from MSV
    - $1.2M increase in Other current assets (Supplemental Medicaid accrual)
- Liabilities increased by $0.4M compared to June 2022
    - $0.7M decrease in accounts payable
    - ($1.6M) increase in Unapplied cash – patient services
    - $1.3M decrease in Due to UMA

Carolina Family Care, Inc.

(Including Carolina Primary Care Physicians and MUSC Health Partners)
Statement of Revenues, Expenses and Changes in Net Position
For the 4 Month Period Ending - October 31, 2022

	Fiscal Year To Date				Prior Year To Date
	Actual	Fixed Budget	Variance	Var %	Actual
Operating revenues:					
Net clinical service revenue	$ 9,373,490	$ 10,018,830	$ (645,340)	(6%)	$ 8,379,368
Supplemental medicaid	1,066,667	1,066,667	-	0%	1,066,667
Other operating revenue	1,448,004	1,603,425	(155,421)	(10%)	1,322,185
Purchased services	2,122,559	2,070,832	51,727	2%	1,083,187
Total operating revenues	14,010,720	14,759,754	(749,034)	(5%)	11,851,407
Operating expenses:					
Salaries, wages and benefits	9,515,116	9,731,024	215,908	2%	7,178,005
Supplies	1,060,332	982,813	(77,519)	(8%)	835,917
Contractual services	955,160	1,041,130	85,970	8%	714,371
Depreciation	104,007	118,567	14,559	12%	80,101
Facility cost and equipment	815,015	868,509	53,494	6%	713,221
Professional liability insurance	153,011	159,793	6,782	4%	157,040
Meals and travel	9,474	9,972	498	5%	5,310
Faculty and staff recruitment	7,372	5,432	(1,940)	(36%)	6,186
MUSCP corporate shared services	816,058	869,805	53,747	6%	741,730
Other expenses	14,358	45,067	30,708	68%	8,359
Total operating expenses	13,449,903	13,832,111	382,208	3%	10,440,241
Operating income (loss)	560,817	927,643	(366,826)	(40%)	1,411,166
Operating margin	4.0%	6.3%			11.9%
Nonoperating revenue (expenses):					
Investment income	193	-	193	100%	1,245
Interest expense	(15,108)	(303)	(14,806)	(4890%)	(852)
Rental income	13,382	10,969	2,413	22%	10,506
Total nonoperating revenue (expenses)	(1,533)	10,666	12,200	114%	10,899
Change in net position	$ 559,284	$ 938,309	$ (379,025)	(40%)	$ 1,422,064
Net margin	4.0%	6.4%			12.0%

Notes:

Net clinical service revenue: ($497K) CFC Primary Care underbudget and ($183K) Grace Internal Medicine underbudget

Other operating revenue: ($65K) PCMH underbudget, ($36K) New provider support underbudget, and ($27K) SC Ports Authority underbudget

Purchased services: $217K Modern Minds over budget (100% funded by MSV), ($197K) MCP Funded Leadership underbudget (100% funded by MCP)

Salaries and benefits: $574K CFC Primary Care faculty salaries underbudget (physician vacancies); ($355K) OurDay implementation: change in salary accrual method

Supplies: overbudget due to bulk/surplus ordering during September

Carolina Family Care, Inc.

Including Carolina Primary Care Physicians and MUSC Health Partners

Statement of Net Position

ASSETS

	October 31, 2022	June 30, 2022	Variance
Current Assets:			
Cash and cash equivalents	$ 2,963,601	$ 4,144,560	$ (1,180,959)
Receivables:			
Patient services - net of allowances for contractual adjustments and bad debt of $9,143,587	2,775,242	2,744,362	30,880
Due from the Medical University Hospital Authority	545,238	491,124	54,114
Due from MCP	1,147,893	593,319	554,574
Due from MUSC Health Alliance	652,044	524,839	127,204
Due from MSV	1,009,467	512,573	496,894
Lease receivable	20,127	20,127	-
Other current assets	1,541,121	333,534	1,207,587
Total Current Assets	10,654,733	9,364,439	1,290,294
Noncurrent assets:			
Capital assets:			
Furniture and equipment	1,608,959	1,608,959	-
Leasehold improvements	2,659,221	2,584,733	74,488
Computer software	46,563	46,563	-
Right of use assets	7,660,637	7,660,637	-
Accumulated depreciation and amortization	(4,221,977)	(3,825,545)	(396,432)
Lease receivable	60,752	65,725	(4,973)
Investment in partnerships	209,000	209,000	-
Total noncurrent assets	8,023,155	8,350,072	(326,917)
Total Assets	$ 18,677,889	$ 17,714,511	$ 963,377

Notes:

Other current assets variance due to Supplemental Medicaid accrual

Carolina Family Care, Inc.

Including Carolina Primary Care Physicians and MUSC Health Partners

Statement of Net Position

LIABILITIES

	October 31, 2022	June 30, 2022	Variance
Current Liabilities:			
Accounts payable	$ 614,189	$ 1,292,139	$ 677,949
Accrued interest payable	4,395	4,538	144
Accrued payroll	1,115,689	830,227	(285,463)
Accrued payroll withholdings	1,366,497	957,998	(408,499)
Unapplied cash - patient services	2,020,508	407,201	(1,613,307)
Other accrued liabilities	810,939	448,795	(362,144)
Due to Medical University of South Carolina	33,932	30,397	(3,536)
Due to Medical University Hospital Authority	263,421	309,135	45,714
Due to MUHA - RHN / RHN Settlement	823,625	823,625	-
Due to UMA	5,666,695	6,922,849	1,256,154
Note Payable to UMA	756,003	756,003	-
Note Payable to MSV	415,386	408,169	(7,217)
Accrued compensated absences	455,271	460,956	5,685
Lease liability	1,285,664	1,285,664	-
Total current liabilities	15,632,214	14,937,694	(694,520)
Noncurrent Liabilities:			
Accrued compensated absences	384,152	384,152	-
Lease liability	4,729,325	5,014,563	285,239
Deferred inflows-leases	79,546	84,734	5,188
Total noncurrent liabilities	5,193,023	5,483,449	290,427
Total liabilities	20,825,237	20,421,143	(404,093)
NET POSITION	(2,147,348)	(2,706,632)	(559,284)
Total Liabilities, Inflows & Net Position	$ 18,677,889	$ 17,714,511	$ (963,377)

Notes:

Accounts payable change in balance is due to the reversal of FY22 AP accruals of $341K

Accrued payroll FY23 includes $800K staff accrual; reversal of $654K in FY22 year end accruals

Accrued payroll withholding FY23 & FY22 balances includes FICA Employer Withholding being deferred ($762K, which is 1/2 of original balance)

Other accrued liabilities change in balance includes FY23 medical supply accrual of ($111K)

Carolina Family Care, Inc.

(Including Carolina Primary Care Physicians and MUSC Health Partners)
Statement of Revenues, Expenses and Changes in Net Position
For the 4 Month Period Ending - October 31, 2022

	Grace Internal Medicine	Other Entities	Carolina Family Care	CFC Total
	(1)	(2)	(3)	Sum of (1)-(3)
Operating revenues:				
Net clinical service revenue	471,887	294,792	8,606,811	9,373,490
Supplemental medicaid	-	-	1,066,667	1,066,667
Other operating revenue	-	-	1,448,004	1,448,004
Purchased services	-	1,986,933	135,626	2,122,559
Total operating revenues	471,887	2,281,725	11,257,108	14,010,720
Operating expenses:				
Salaries, wages and benefits	-	1,873,333	7,641,783	9,515,116
Supplies	-	37,999	1,022,334	1,060,332
Contractual services	415,860	190,377	348,923	955,160
Depreciation	-	-	104,007	104,007
Facility cost and equipment	34,717	54,091	726,206	815,015
Professional liability insurance	-	18,864	134,147	153,011
Meals and travel	-	5,127	4,347	9,474
Faculty and staff recruitment	-	5,030	2,342	7,372
MUSCP corporate shared services	9,438	-	806,620	816,058
Other expenses	-	23,539	(9,180)	14,358
Total operating expenses	460,015	2,208,360	10,781,529	13,449,903
Operating income (loss)	11,873	73,365	475,579	560,817
Operating margin	2.5%	3.2%	4.2%	4.0%
Nonoperating revenue (expenses):				
Investment income	-	162	31	193
Interest expense	-	(15,108)	-	(15,108)
Rental income	-	49	13,333	13,382
Total nonoperating revenue (expenses)	-	(14,897)	13,363	(1,533)
Change in net position	$ 11,873	$ 58,469	$ 488,942	$ 559,284
Net margin	2.5%	2.6%	4.3%	4.0%

Notes:

(1) Funding from MSV Line of credit in the amount of $0.4M has been received in FY21 and FY22; accumulated fund balance of ($457K)

(2) Other non-Primary Care entities:

- *$190K Group Health Insurance*
- *($158K) Mt Pleasant Community PM&R operating loss*
- *Other column also includes the following entities which are fully funded: Tidelands Multispecialty, Hampton Regional, Modern Minds, Charleston Cardiology, Centerspace, MCP Leadership, MHA Staffing and MUHA Midlands*

FY2022 MUSCP Due to/Due From
As of 10/31/22

	Outstanding Balance	Notes
1. MUSCP/MUHA		
MUSCP due from MUHA	$4,163,802	October recurring: $2.4M Epic Collections; $.6M Leadership costs; $.1M Ambulatory; $.3M Revenue Cycle
MUSCP due to MUHA	($8,716,103)	October recurring: $4.8M Epic Collections; $.7M IS costs; $1M Ambulatory; $.6M Billing agreements; .2M Telehealth RVU Transfer
Net Amount Due	($4,552,301)	
2. MUSCP/MUSC		
Net Amount Due	$15,383,837	Balance consists of $13.8M remaining FY22 STP accrual; $1.6M Grant salary reimbursement
3. CFC/MUHA		
CFC due from MUHA	$545,238	Balance consists of monthly recurring activity
CFC due to MUHA	($263,421)	Balance consists of monthly recurring activity
Net Amount Due	$281,817	Balance consists of monthly recurring activity
4. CFC/MUHA - RHN		
Total RHN accounts-Due from (to) MUHA	($823,625)	Net Advance from MUHA for RHN expenses:
5. CFC/MUSC		
Net Amount Due	($33,932)	Balance consists of monthly recurring activity
6. MHP/MUHA		
Net Amount Due	$0	
7. MHP/MUSC		
Net Amount Due	$0	
8. MSV		
Net Amount Due	$1,009,460	Modern Minds billing
9. MCP		
Net Amount Due	$2,016,545	Billing for MCP employees, Compliance services, Physician Recruitment services

FY2023 MUSCP Consolidated Approved Unbudgeted Expenses
As of 10/31/22

Unbudgeted Capital Projects		**Amount**
Concierge Medicine	$	800,000
Nexton Opthalmalogy		568,250
Park West Family Medicine Relocation		999,888
Total	**$**	**2,368,138**

Unbudgeted Operating Expenses		**Amount**
Concierge Medicine	$	100,000
Northwoods Peditratrics Expansion		186,000
Total	**$**	**286,000**

Total FY23 Approved Unbudgeted Expenses	**$**	**2,654,138**

MEDICAL UNIVERSITY HOSPITAL AUTHORITY (MUHA) BOARD OF TRUSTEES
CONSENT AGENDA
December 9, 2022
101 Colcock Hall

Authority Operations, Quality, and Finance Committee: Dr. Murrell Smith, Chair

Consent Agenda for Approval

Item 25. MUSC Health Black River Medical Center Board of Trustee Bylaws for Approval. .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 26. MUSC Health Black River Medical Center Medical Staff Bylaws for Approval. .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 27. RHN Unified Medical Staff Bylaws for Approval .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 28. RHN Unified Medical Staff Credentialing Policy Manual for Approval. .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 29. RHN Unified Medical Staff Rules and Regulations for Approval. .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 30. RHN Unified Fair Hearing Plan for Approval .....Dr. Patrick Cawley
Chief Executive Officer, MUSC Health

Item 31. Revised MUSC Health-Charleston Medical Staff Bylaws for Approval..... Dr. Carrie Herzke
Chief Medical Officer, MUHA

Item 32. Revised MUSC Health-Charleston Credentialing Policy Manual for Approval..... Dr. Carrie Herzke
Chief Medical Officer, MUHA

Item 33. Revised MUSC Health-Charleston Rules & Regulations for Approval..... Dr. Carrie Herzke
Chief Medical Officer, MUHA

Item 34. Appointments, Reappointments, and Delineation of Privileges..... Dr. Carrie Herzke
Chief Medical Officer, MUHA

Consent Agenda for Information

Item 35. MEC Minutes..... Dr. Carrie Herzke
Chief Medical Officer, MUHA

Item 36. Contracts and Agreements ..... Annette Drachman
General Counsel

MUHA and MUSC Physical Facilities Committee: Mr. Bill Bingham, Chair

Consent Agenda for Information

Item 37. MUSC FY2023 Active Projects >$250,000 ..... David Attard
Chief Facilities Officer, MUSC

Item 38. MUSC Facilities Contracts Awarded ..... David Attard
Chief Facilities Officer, MUSC

DRAFT 11/18/22

BOARD OF TRUSTEE BYLAWS

OF

MUSC HEALTH BLACK RIVER MEDICAL CENTER

D E F I N I T I O N S

1. "Allied Health Professional" (AHP) means an individual, other than a licensed physician or dentist, whose authority to perform specified patient care services is established by the Medical Staff based on his/her qualifications and whose functions are supervised by members of the Medical Staff. The qualifications, functions, responsibilities, and prerogatives of AHPs, including physician assistants, are defined in the Medical Staff Bylaws.

2. "Auxiliary Organization" means volunteers, auxiliaries, and other affiliated organizations composed of members of the local communities.

3. "Board" or "Board of Trustees" means the local governing authority appointed by MUHA exercising those prerogatives and authorities specified herein and subject to the limitations delineated herein.

4. "Executive Director" means the individual appointed by MUHA to provide for the overall on-site management of the Medical Center.

5. "Medical Center" means MUSC Health Black River Medical Center.

6. "Medical Staff" means the formal organization of practitioners who have been granted privileges by the MUHA Board to attend patients in the Medical Center.

7. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules and Regulations, Fair Hearing Plan, Credentials Manual, and such other policies as may be adopted by the Medical Staff subject to the recommendation of the Board and the approval of the MUHA Board.

8. "MUHA" means the Medical University Hospital Authority, an authority of the State of South Carolina, which owns and operates the Medical Center.

9. "MUHA Board" means the Board of Trustees of MUHA.

9. "National Practitioner Data Bank", means the entity established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting adverse actions and Medical Staff malpractice information.

10. "Practitioner" means a physician, psychologist, or dentist who has been granted clinical privileges at the Medical Center.

11. "Trustee" means a member of the Board of Trustees.

12. "Days" are defined as calendar days.

ARTICLE I
GENERAL SCOPE

Be it resolved by the Board of Trustees of MUSC Health Black River Medical Center that the bylaws set out below shall govern the transaction of the business and affairs of the Medical Center.

1.1 PURPOSE

The purposes, goals and objectives of the Board of Trustees of MUSC Health Black River Medical Center shall be to support MUHA and the Medical Center with their goals to:

1.1(a) Support, manage, and furnish facilities, personnel, and services; provide diagnosis, medical, surgical, and hospital care, outpatient care and other Medical Center and medically related services to sick, injured or disabled person; provide well-care programs as appropriate and feasible, without regard to race, color, sex, national origin, disability or other legally protected classification;

1.1(b) Provide appropriate facilities and necessary services to best serve the needs of patients;

1.1(c) Improve the standards of health care in the communities served by the Medical Center;

1.1(d) Establish and promote cost-effective health care delivery including timely adaptations to meet evolving Medicare and other regulations mandating data accumulation and cost control;

1.1(e) Encourage educational activities related to tendering care to the sick and injured or to the promotion of health, as may be justified by the facilities, personnel, funds, or other resources that are available;

1.1(f) Manage, or participate in, so far as Medical Center policy, circumstances, and available funds may permit, any activities designed to promote the general health of the communities it serves;

1.1(g) Guard against any activity in or on behalf of the Medical Center having, or tending to have, an undesirable effect upon the Medical Center or the services it renders;

1.1(h) Provide for overall institutional planning, with the participation of the Medical Staff, nursing department, and such other individuals as MUHA deems appropriate; and

1.1(i) Maintain a commitment to continued comprehensive quality assurance and quality improvement in all aspects of health care provided by the Medical Center in cooperation with the Medical Staff, Executive Director, and Medical Center personnel.

ARTICLE II
FISCAL YEAR

The Medical Center's fiscal year shall end Jun 30 and begin July 1, of each subsequent year.

ARTICLE III
MEMBERSHIP & MEETINGS OF THE BOARD OF TRUSTEES

All meetings of the Board of Trustees shall be held in conformance with the Freedom of Information Act as amended, S.C. Code Ann. § 30-4-10, et seq.

3.1 MEMBERSHIP & QUORUM

MUHA shall appoint the Board of Trustees (Board) which shall consist of nine (9) voting members. MUHA shall in any event select two (2) members each from the communities of Lake City and Kingstree and ensure that at least one (1) member of the Board shall be a member of the Medical Center's active Medical Staff chosen from a list of three (3) nominees submitted by the Medical Center's Active Medical Staff who must be a current member in good standing thereof. The Executive Director (who shall serve as Secretary to the Board), the Medical Center Chief of the Medical Staff, and the Chief Executive Officer of the Florence Division of MUSC Health or their respective designee will be ex-officio non-voting members of the Board.

A majority of voting members of the Board shall constitute a quorum at any regular or special meeting. After a quorum has been established, the subsequent withdrawal of Trustees present to fewer than the number required for a quorum shall not affect the validity of any action taken. A Trustee shall be deemed present at a meeting if he/she participated by conference telephone, speaker telephone, or other method by which all persons participating in the meeting can hear one another at the same time. If a quorum is not present at any meeting, those present may adjourn the meeting until such date and hour as a quorum may be had, and no further notice of the adjourned meeting shall be required.

With the exception of ex-officio members, Board members appointed at the initial meeting shall serve either a one (1) year term or two (2) year term as determined by MUHA. Upon the expiration of the terms established at the December 2024 Board meeting, all members shall serve for terms of two (2) years. Members may serve until their successors shall have been appointed or until their removal or resignation.

3.2 QUALIFICATIONS

Selection of Trustees shall be based on the individual's abilities and experience, without regard to race, color, sex, national origin, disability, or other legally protected classification (except as such disability may impair the Trustees' ability to discharge the responsibilities herein). Willingness to give as much time as is reasonably requested is critical. Experience in community activities and the arts of managing people, money, and property also are important considerations in the selection of Trustees.

3.3 REGULAR MEETINGS

The Board shall hold six (6) regular meetings per year at a time and place designated by the Chairman of the Board. December shall be designated as the month for the Medical Center's annual Board meeting.

3.4 SPECIAL MEETINGS

The Chairman or any member of the Board may call a special meeting on his/her own initiative and shall call a special meeting at the written request of two (2) members of the Board. The Chairman shall give written notice (delivered either personally, by mail, email, or telefax) of a special meeting to each member of the Board at least two (2) days before the date of the meeting, giving the time and place of the meeting. This notice shall state the business for which the special meeting has been called, and no business other than that stated in the notice shall be transacted. Meetings may be held at any time upon waiver of notice signed by all Board members. Attendance at any meeting without protest of lack of notice shall be deemed a waiver of notice.

3.5 CONFLICT OF INTEREST

The best interest of the communities and the Medical Center are served by Board members who are objective in the pursuit of their duties as Board members, and who exhibit that objectivity at all times. The decision-making process of the Board may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinion or decision. Therefore, it is considered to be in the best interest of the Medical Center for relationships of any Board member which may influence decisions related in any way to the Medical Center to be disclosed to all other members of the Board on a regular and contemporaneous basis.

No Board member shall use his/her position to obtain or accrue any benefit. All Board members shall at all times avoid even the appearance of influencing the actions of any employee of the Medical Center or MUHA, except through his/her vote, and the acknowledgment of that vote, as a Board member for or against opinions or actions to be stated or taken by or for the Board as a whole. Each Board member is expected to be familiar with, and abide by, the MUSC/MUHA Conflict of Interest Policy https://web.musc.edu/-/sm/enterprise/about/coi/f/musc-muha-coi-policy.ashx and the MUSC/MUHA Industry Relations Policy https://web.musc.edu/-/sm/enterprise/about/coi/f/bot-approved-industry-relations-policy.ashx ; failure to do so is grounds for termination as provided below.

Annually in accordance with a schedule adopted by MUHA' s Conflict of Interest Office ("COI Office") and in such form as the COI Office shall require, each Board member shall submit a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Board member and/or a member of the applicable community, which in any way and to any degree may impact on the finances or operations of MUHA, the Medical Center or its staff, or the Medical Center's relationship to the communities it serves. A new Board member shall file the written statement immediately upon being appointed to the Board. This disclosure requirement is to be construed broadly, and a Board member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is corporately and/or functionally related to the Medical Center.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the COI Office by the next regularly scheduled Board meeting.

The COI Office will maintain the Conflict of Interest statements and will disclose any relationship to the Board Chair which they, in their discretion, believe will create a conflict to Board members only as necessary and only as the need arises.

A Trustee shall abstain from voting on any issue in which the Trustee has an interest other than as a Trustee of the Medical Center.

A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the Board on majority vote.

3.6 VACANCIES

Vacancies on the Board shall be filled by MUHA after consideration of recommendations of the Board. Thereafter the Executive Director shall notify the Board of MUHA's selection to fill the vacancy. A Trustee appointed to fill a vacancy shall serve for the remainder of the term of his/her predecessor.

3.7 RESIGNATION OR REMOVAL OF TRUSTEE

A Trustee may resign at any time by tendering his/her resignation in writing to the Board. Any Trustee who has failed to attend two-thirds (2/3) of the regular meetings of the Board during the calendar year, except for good cause as determined by MUHA, may be removed from the Board. Resignation or removal of a Trustee also shall constitute resignation or removal as an officer or as a member of any committee of the Board. A Trustee may be removed at any time by MUHA, with or without cause.

3.8 COMPENSATION OF TRUSTEES & COMMITTEE MEMBERS

Trustees and members of all committees of the Board shall receive no compensation for any service rendered in their capacities as Board or committee members.

3.9 RESPONSIBILITIES

The Board shall provide recommendations to the MUHA Board with respect to the matters enumerated below, and related functions, subject to MUHA policies, these bylaws, and directives from the MUHA Board.

MUHA also reserves the right to intervene and participate in all matters entrusted to the Board and to amend or replace these bylaws as further provided in Article X herein.

3.9(a) Assuming responsibility for Medical Staff oversight and quality care evaluation as described in Section 7.2 and 8.1 of these bylaws.

3.9(b) Requiring a process designed to assure that all individuals who provide patient care services, but who are not subject to the Medical Staff privileges delineation process, are competent to provide such services, and receiving reports of quality assurance information regarding competency of care providers not subject to the privilege delineation process;

3.9(c) Overseeing quality of professional services as described in Article III and VIII of these Bylaws.

3.9(d) Establishing, maintaining, and supporting, through the Executive Director, the Medical Staff and its designated committees, a comprehensive, Medical Center-wide program for quality assessment and improvement; receiving reports or performance improvement information on a regular basis from the Medical Staff, and assuring that all aspects of the program are performed appropriately and that administrative assistance is available to the Medical Staff.

3.9(e) In consultation with the Medical Staff, MUHA and the Executive Director, formulating programs for efficient delivery of care, compliance with applicable law (including Medicare regulations and other applicable regulations) and development, review, and revision of policies and procedures;

3.9(f) Approving bylaws for Medical Center auxiliary organizations or for any other similar organizations;

3.9(g) Making recommendations to the Executive Director and MUHA regarding the kinds and quality of service to be made available at the Medical Center when appropriate;

3.9(h) Reviewing and consulting with the Executive Director Executive concerning the long-range plan for the Medical Center;

3.9(i) Overseeing of programs for continuing medical education for Medical Staff members and appropriate in-service education programs for Medical Center employees, for the purpose of improving clinical and employee performance;

3.9(j) Acting as liaison with MUHA, as well as the governing bodies and management of any health care delivery organizations that are related to the Medical Center, generally through the Executive Director, and being available for consultation with MUHA;

3.9(k) Assisting in the accreditation process, including participation in the summation conference. Assisting in maintaining compliance with current accreditation standards set by the Joint Commission, in conjunction with the Executive Director and the Medical Staff;

3.9(l) Assisting the Executive Director in establishing medical record policies respecting composition, retention, confidentiality and other aspects of record keeping. Maintaining confidentiality with respect to the records and affairs of the Medical Center**,** except as disclosure is authorized by MUHA or required by law;

3.9(m) Protecting the economic viability of the Medical Center, while ensuring that ethical principles guide the Medical Center's business practices;

3.9(n) Conducting an annual evaluation of its own activities and performance; and an annual evaluation of the Executive Director; and communicating same to the appropriate MUHA corporate officer;

3.9(o) Establishing mechanisms to assure that all patients with the same health care problem are receiving the same level of care in the Medical Center;

3.9(p) Designating particular individuals or departments responsible for evaluating and monitoring quality of care in particular patient services, and fostering communication between such individuals or departments through establishing timeframes for discussion of these issues. When the Medical Center provides a patient care service for which there is no designated department, establishing of an appropriate monitoring and evaluation process;

3.9(q) Performing any other functions designated listed in these bylaws but not specifically referred to in this Section;

3.9 (r) Ensuring that leaders of the Medical Staff have access to information and training in the areas where they need additional skills or expertise;

3.9(s) Ensuring that new or modified processes are well defined and that clinical practice guidelines are considered when such processes are promulgated; and

3.9(t) It will be the responsibility of each board member to participate in board development activities.

3.10 MINUTES OF MEETINGS

The Secretary or his/her designee shall keep regular minutes of Board proceedings and such minutes shall be placed in the minute book of the Board. The minutes shall be available to all members of the Board. Committees of the Board shall maintain separate minutes of their proceedings. All such minutes shall be confidential to the extent permitted by law.

3.11 PARLIAMENTARY PROCEEDINGS

All meetings will be conducted using parliamentary procedures. When there is doubt or dispute, reference will be made to the most recent edition of Roberts' Rules of Order.

ARTICLE IV
OFFICERS OF THE BOARD

4.1 OFFICERS

The officers of the Board shall be a Chairman, a Vice-Chairman and a Secretary. The Chairman and Vice-Chairman shall be appointed by MUHA at the regular December Board meeting after consideration of the recommendations of the Board. The Executive Director shall serve as Secretary for as long as he/she holds such position. The Chairperson shall hold office for one two-year term. The Vice Chair shall also hold office for one two-year term and shall assume the Chairperson role at anytime during the term if needed or at the completion of the Chairperson's term. The Chairperson and Vice Chairperson shall hold office until their successors are appointed.

4.2 CHAIRMAN'S DUTIES

The Chairman shall call and preside at all regular and special meetings and shall be, ex-officio, a member of all committees with voting privileges. He/she shall have such duties and responsibilities as shall be delegated to him/her by these bylaws and by MUHA, from time to time.

4.3 VICE-CHAIRMAN'S DUTIES

The Vice-Chairman shall act as Chairman in the absence of the Chairman. He/She shall perform such additional duties as may be assigned to him/her by the Chairman or the Board.

4.4 SECRETARY'S DUTIES

The duties of the Secretary shall be to:

4.4(a) Act as custodian of all records and reports of the Board and shall be responsible for the preparation and keeping of the minutes of all meetings of the Board;

4.4(b) Give proper notice of all Board meetings according to the provisions of these bylaws;

4.4(c) Assure that an answer is rendered to all official Board correspondence; and

4.4(d) Perform such other duties as ordinarily pertains to the office.

4.5 VACANCIES

A vacancy in any office because of death, resignation, or removal shall be filled by MUHA for the

unexpired term of such office in accordance with the provisions of Section 3.6 and 3.7.

4.6 RESIGNATION OR REMOVAL OF OFFICER

An officer may resign at any time by tendering his/her resignation in writing to the Chairman. The resignation will become effective immediately upon receipt. An officer may be removed at any time with or without cause by MUHA or by a vote of not less than two-thirds (2/3) of the whole number of Trustees at any meeting of the Board.

ARTICLE V
COMMITTEES OF THE BOARD OF TRUSTEES

5.1 APPOINTMENT OF COMMITTEES

The Chairman of the Board, after consultation with MUHA or its designee, may appoint and authorize any standing or special committees as he/she deems necessary, consistent with these bylaws. At a minimum, the standing committees shall include a Conflict Resolution Committee, whose functions shall be as outlined in Section 5.2, below. The Board shall have the authority to designate ad hoc committees as it deems necessary to address specific issues. At any time, such additional committee is designated, such committee shall consist of at least three (3) members of the Board including the Executive Director. In addition, if a quality of care issue is involved, at least one (1) member of the Medical Staff shall serve on such special committee.

5.2 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two (2) members of the Medical Staff who are selected by its Medical Staff Operations Committee (and may or may not be members of the Board), two (2) non-physician Board members who are selected by the Board Chair and the Chief Executive Officer of the Florence Division of MUSC Health. The Committee shall meet as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

5.3 TERM OF OFFICE

Each member of a committee shall continue in office until the next annual meeting of the Board and until his/her successor is appointed, unless the committee of which he/she is a member shall be sooner terminated by the Board or until the sooner of death, resignation, or removal of such member as a committee member or Trustee.

5.4 COMMITTEE MEETINGS & MINUTES

Meetings of any committee of the Board may be called by the Chairman of such committee by

giving notice of such meeting, setting forth its time and place and delivered personally or by mail, facsimile, email or telefax to the residence or place of business of each member at least two (2) days prior to such meeting. Unless otherwise provided in these bylaws, a majority of the members of any committee shall constitute a quorum for the transaction of business. After a quorum has been established at a committee meeting, the subsequent withdrawal of committee members present to fewer than the number required for a quorum shall not affect the validity of any action taken. The committee shall maintain written minutes that reflect business conducted by the committee. The minutes shall be available for review by the Board.

5.5 RESIGNATION OR REMOVAL OF COMMITTEE MEMBERS

A member of any committee of the Board may resign at any time by tendering his/her resignation in writing to the Chairman of the Board. Resignation as a Trustee shall also constitute resignation as a member of any committee of the Board. The Board by a majority vote may remove any member from a committee of the Board, with or without cause.

ARTICLE VI
EXECUTIVE DIRECTOR

6.1 APPOINTMENT OF EXECUTIVE DIRECTOR

The Executive Director shall be selected and employed by MUHA, after consultation with the Board, and shall be its direct executive representative in the management of the Medical Center. The Executive Director shall have the authority to, and be held responsible for, administering the Medical Center in all its activities and departments, subject only to such policies as may be adopted and such orders as may be issued by MUHA and the MUHA Board. He/she shall act as the authorized representative of the Board and MUHA Board if they have not formally designated some other person for that specific purpose. MUHA, through the Executive Director, shall be solely responsible for the selection of key management personnel for the operation of the Medical Center.

6.2 EXECUTIVE DIRECTOR PERFORMANCE

As provided in Section 3.9(n) above, the Board of Trustees shall provide to MUHA, an annual evaluation of the Executive Director's performance. The evaluation shall be submitted in such form as may be designated by MUHA.

ARTICLE VII
CREDENTIALED PRACTITIONERS

7.1 MEDICAL STAFF APPOINTMENTS AND CLINICAL PRIVILEGES

7.1(a) The Board shall initially recommend to the MUHA Board a Medical Staff, and shall see that the staff is organized into a responsible administrative unit and adopts such bylaws, rules, and regulations for government of their practice in the Medical Center as the MUHA Board deems to be the greatest benefit to the care of patients within the Medical Center. In the case of the individual patients, those appointed to the Medical Staff shall have full

authority and responsibility for the care of patients subject only to such limitations as the MUHA Board may formally impose and to the bylaws and rules and regulations for the Medical Staff as initially recommended by the Board and thereafter approved by the MUHA Board. The Medical Staff shall adhere to the highest ethical principles of the medical profession.

7.1(b) All applications for appointment to the Medical Staff shall be in writing and addressed to the Executive Director in such form as determined by the Medical Center and more specifically described in the Medical Staff bylaws. The application shall be complete and with required information relating to education, licensure, practice, previous hospital experience, professional liability coverage, and any history relative to licensure, malpractice experience, and/or Medical Center privileges.

7.1(c) At its next regular meeting after receipt of a completed application and a recommendation from the Medical Staff concerning an applicant for Medical Staff appointment, the MUHA Board shall act in the matter unless further investigation requires that action be postponed to a later meeting, as provided in the following paragraph.

In order to expedite the credentialing process, the MUHA Board may appoint a committee consisting of at least two (2) MUHA Board members to review the recommendations received from the Medical Staff. If the committee returns a positive decision concerning the practitioner's clinical privileges, the privileges shall be granted and the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the practitioner's clinical privileges, the matter shall be returned to the Medical Staff for further recommendation prior to final action by the MUHA Board.

The expedited process may not be used in the following circumstances:

(1) The applicant submits an incomplete application; or
(2) The Medical Staff makes a recommendation that is adverse or with limitation; or
(3) There is a current challenge or a previously successful challenge to licensure or registration; or
(4) The applicant has received an involuntary termination of Medical Staff membership at another organization; or
(5) The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or
(6) There has been a final judgment adverse to the applicant in a professional liability action.

The above circumstances shall require action by the full MUHA Board.

7.1(d) At any time in its consideration of such recommendation, the MUHA Board may, in its absolute discretion, defer final determination by referring the matter to a committee of its choice for further consideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the MUHA Board shall be made, and may include a directive that an additional meeting be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, the MUHA Board shall act in the matter.

7.1(e) Appointments to the Medical Staff shall not exceed two (2) years, renewable by the MUHA Board before the end of the appointment upon formal application.

7.1(f) The MUHA Board shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff and AHP membership status, clinical privileges and corrective action, and shall require that the Medical Staff adopt and forward to it specific written recommendations with appropriate supporting documentation that will allow the MUHA Board to take informed action. Such delegation, however, does not relieve the MUHA Board of its responsibilities in appointing members of the Medical Staff and overseeing the MEC in the appointment and delineation of functions, responsibilities and prerogatives of AHPs.

7.1(g) Final action on all such Medical Staff matters shall be taken after considering the Medical Staff recommendation, except that the MUHA Board shall act on its own initiative if the Medical Staff fails to adopt and submit recommendations within the time periods required by the Medical Staff Bylaws. MUHA Board action without a staff recommendation shall be based on the same kind of documented investigation and evaluation of current ability, judgment, and character as is required for Medical Staff recommendations.

7.1(h) The Executive Director shall make available to the applicant for staff membership a copy of the Medical Staff Bylaws, including the Medical Staff Rules and Regulations, Fair Hearing Plan, and Credential Manual. The applicant shall sign a statement on the application form declaring that he/she has received and reviewed those documents and that he/she specifically agrees:

(i) to obligate himself/herself, as an appointee to the Medical Staff, to provide continuous care and supervision as needed to all Medical Center patients for whom he/she has responsibility;

(ii) to abide by all such bylaws, policies, and directives of the Medical Center and its Medical Staff as shall be in force during the time he/she is appointed to the Medical Staff of the Medical Center; and

(iii) to accept committee assignments and such other duties and responsibilities as shall be assigned to him/her by the MUHA Board and the Medical Staff.

No appointment or reappointment shall take effect until such a statement has been signed by the individual concerned.

7.1(i) The terms and conditions of membership status and clinical privileges and the procedure to be followed in acting on same, shall be as specified in the Medical Staff Bylaws or as more specifically defined in the notice of individual appointment;

7.1(j) The MUHA Board shall make final decisions on all requests for corrective action, and shall otherwise participate in the corrective action process as described in the Medical Staff Bylaws.

7.1(k) No aspect of membership status nor specific clinical privileges shall be limited or denied to a practitioner on the basis of sex, race, creed, color, or national origin, or on the basis of any other criterion unrelated to quality patient care at the Medical Center, to professional qualifications, to the Medical Center's purposes, needs and capabilities, or to community needs. Members of the Medical Staff who also have Medical Center administrative responsibilities shall be required to meet the same requirements and qualifications for membership on the Medical Staff as do practitioners who do not have an administrative relationship to the Medical Center.

All administrative relationships with members of the Medical Staff and others who are not members of the Medical Staff shall be reduced to written agreement between the individual practitioner and the Medical Center. These administrative relationships may be terminated by the Executive Director following the same procedures utilized for other Medical Center employees, unless the written agreement provides another method of termination. Should the written agreements provision for termination conflict with the general procedures utilized for other employees, the written agreement shall control.

7.2 MEDICAL STAFF GOVERNANCE

The Board shall recommend to the MUHA Board bylaws and rules and regulations establishing the organization and government of the Medical Staff. The bylaws and rules and regulations shall be developed by the Medical Staff, but shall be effective only upon approval by the MUHA Board. The power of MUHA Board to adopt or amend Medical Staff Bylaws, and Rules and Regulations shall be conditioned upon the Medical Staff's failure to keep current, update or make necessary modifications to its bylaws in a manner that will allow for the maximum possible achievement of the purposes and objectives of the Medical Staff.

The MUHA Board retains the right to rescind any authority or procedures delegated to the Medical Staff, and to recommend amendment or replacement of the Medical Staff Bylaws as necessary for the operation of the Medical Center.

The Medical Staff shall review and revise all Medical Staff Rules and Regulations, and, as applicable, departmental policies and procedures, when warranted, provided that such review shall occur at least every two (2) years. The Medical Staff shall recommend changes in such policies and procedures for the Board’s review and recommendation for approval of the MUHA Board.

7.3 CATEGORIES OF STAFF MEMBERSHIP

The Medical Staff shall be organized into the categories as outlined in the Medical Staff Bylaws. The prerogatives and responsibilities of each staff category shall be outlined in the Medical Staff Bylaws.

7.4 ALLIED HEALTH PROFESSIONAL (AHP)

The MUHA Board may approve specific clinical privileges for individuals who are not part of the Medical Staff, but who may render patient care services within the Medical Center setting.

Each person afforded AHP status shall be assigned and made accountable to the appropriate clinical section of the Medical Staff, although such assignment will not constitute membership on the Medical Staff.

All applications for appointment to AHP status shall be in writing in such form as specified by the Medical Center. The application shall be processed in the same manner as Medical Staff applications.

The terms and conditions of AHP status, and of the exercise of clinical privileges, shall be as specified in the appropriate section of Medical Staff Bylaws or as more specifically defined in their scope of practice. AHPs shall not be entitled to the procedures set forth in the Fair Hearing Plan. They shall, however, be entitled to an appearance before a Medical Staff committee designated within the Medical Staff Bylaws, as well as a written appeal to the MUHA Board in the event of an adverse action.

ARTICLE VIII
MEDICAL CARE EVALUATION

8.1 BOARD RESPONSIBILITY FOR THE QUALITY OF PROFESSIONAL SERVICES

After considering the recommendations of the Medical Staff and the other health care professional providing patient care services, the Board may recommend to the MUHA Board specific review and evaluation activities to assess, preserve, and improve the overall quality and efficiency of patient care in the Medical Center. The Board, through the Executive Director, shall provide whatever administrative assistance is reasonably necessary to support and facilitate activities contributing to continuous quality assessment and improvement.

8.2 PROFESSIONAL ACCOUNTABILITY TO THE BOARDS

The Medical Staff and the other health care professional staffs providing patient care services shall conduct, and be accountable to the Board and the MUHA Board for conducting, activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Medical Center. These activities shall include these functions:

8.2(a) Providing effective mechanisms to monitor and evaluate the quality of patient care and the clinical performance of individuals with delineated clinical privileges within the Medical Center;

8.2(b) Ongoing review, evaluation, and monitoring of patient care practices through a systematic process of overall quality assessment and improvement;

8.2(c) Delineation of clinical privileges for Medical Staff members, commensurate with individual credentials and demonstrated ability and judgment, and assignment of patient care responsibilities to other health care professionals consistent with individual qualification and demonstrated ability;

8.2(d) Establishing a process designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to

the ages of the patients served:

(i) the ability to obtain information and interpret information in terms of the patients' needs;

(ii) a knowledge of cognitive, physical, and emotional growth and development in the particular age group treated; and

(iii) an understanding of the range of treatment needed by the patients.

8.2(e) Providing continuing professional education, shaped primarily by the needs identified through the review and evaluation activities;

8.2(f) Reviewing utilization of the Medical Center's resources to provide for their allocation to patients in need of them;

8.2(g) Reviewing the competency of care providers who are not subject to the Medical Staff privilege delineation process; and reporting to the Board and the MUHA Board findings with regard to such care providers;

8.2(h) Establishing a process to support the efficient flow of patients, such as a plan concerning the care of admitted patients who are in temporary bed locations; and

8.2(i) Such other measures as the MUHA Board may, after receiving and considering the advice of the Board and the Medical Staff, the other professional services, and the Executive Director, deem necessary for the preservation and improvement of the quality and efficiency of patient care.

8.4 DOCUMENTATION

The Board shall consider the findings and recommendations from its required review, evaluation, and monitoring activities and make recommendations to the MUHA Board, which shall be in writing, signed by the persons responsible for conducting the review activities, and supported and accompanied by documentation upon which the MUHA Board can take informed action.

ARTICLE IX
AUXILIARY ORGANIZATIONS

9.1 ORGANIZATION

The Board shall authorize and approve the formation of volunteers, auxiliaries, and other affiliated organizations composed of members of the local communities. For purposes of these bylaws, the term "auxiliary" shall be used in reference to such organizations.

9.2 PURPOSE

The general purpose of such auxiliaries shall be to render volunteer services in the form of comfort and welfare to Medical Center patients, and to conduct community service projects and related

activities enabling the accomplishment of these purposes.

9.3 RATIFICATION OF BYLAWS

An auxiliary shall adopt bylaws which shall be ratified and approved by the Board and MUHA. Such auxiliary's bylaws shall delineate its purposes and functions.

ARTICLE X
REVIEW, AMENDMENT & REPLACEMENT

These bylaws shall be reviewed by the Board and MUHA as needed, but at least every two (2) years and shall be dated to indicate the time of the last review.

These bylaws may be amended by affirmative vote of two-thirds (2/3) majority of the members of the Board, providing a full presentation of such proposed amendment shall have been published in the notice of meeting, and provided the amendments are approved in writing by the MUHA Board. The MUHA Board reserves the right to amend or replace these bylaws as necessary for the operation of the Medical Center in the event of a change in circumstances or emergency so dictating. The MUHA Board thereafter promptly will consult with the Board on permanent amendments to these bylaws (if any) necessary to meet the change of conditions, policy, or continuing emergency.

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ARTICLE XI
ADOPTION & EXECUTION

These bylaws shall not be effective until they have been approved by the MUHA Board. The signatures set forth below signify that the foregoing bylaws are the duly adopted Board of Trustees Bylaws of the Medical Center.

APPROVED:

MUSC HEALTH BLACK RIVER MEDICAL CENTER
BOARD OF TRUSTEES

By: _____ _____
Chairman of the Board Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for MUHA Date

MUSC HEALTH BLACK RIVER MEDICAL CENTER
MEDICAL STAFF BYLAWS

INDEX

MEDICAL STAFF BYLAWS

OF

MUSC HEALTH BLACK RIVER MEDICAL CENTERMUSC HEALTH BLACK RIVER MEDICAL CENTER

P R E A M B L E

WHEREAS, MUSC Health Black River Medical, hereinafter referred to as "Hospital" or "Hospital System", is operated by the Medical University Hospital Authority hereinafter referred to as "MUHA", a state authority organized and existing pursuant to statute at S.C. Code Ann. § 59-123-60 and is lawfully doing business in South Carolina; and

WHEREAS, no Practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another Hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care Hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board; and

WHEREAS, the cooperative efforts of the Medical Staff, Hospital administration, and the Board are necessary to fulfill these goals.

NOW, THEREFORE, the Practitioners practicing at MUSC Health Black River Medical Center hereby organize themselves into a Medical Staff conforming to these Bylaws.

D E F I N I T I O N S

1. "Active Staff" members shall be those physicians (D.O.'s and M.D.'s) licensed in the state of South Carolina that has the privilege of admitting patients, holding office and voting.

2. "Affiliated Health Professional" or “AHP” means a credentialed individual, other than a physician, dentist, or podiatrist, who is qualified to render direct or indirect medical or surgical care in collaboration with a physician who has been afforded privileges to provide such care in the Hospital. For such purposes as these Medical Staff Bylaws, “AHP” shall be deemed to refer only to advanced practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, Physician Assistants (“PA-C”), Advanced Practice Nurse Practitioners (“APRN”), Certified Registered Nurse Anesthetists (“CRNA”), Psychologists and other such professionals. For purposes of these Bylaws, “Allied Health Professional” shall not be deemed to include those non-credentialed individuals (“Clinical Assistants” pursuant to the Hospital policy) whose appointment and competencies are handled outside the Medical Staff process. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications, licensure, and approved written practice agreement for APRNs or written scope of practice guidelines for PA-Cs.

3. "Board" means the Board of Trustees of MUSC Health Black River Medical Center.

4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other applicable specialty boards.

5. “Campus” means each separately licensed Hospital within the Hospital System that has a unified and integrated Medical Staff.

6. "Chief Executive Officer" or “Executive Director” means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

7. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

8. "Clinical Privileges" means the Board's recognition of Practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services.

9. "MUHA" means Medical University Hospital Authority.

10. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

11. “Designee” means one selected by the Executive Director, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

12. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

13. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a Practitioner's clinical privileges are adversely affected by a determination based on the Practitioner's professional conduct or competence. The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix “A” hereto.

14. “Hospital” means MUSC Health Black River Medical Center

15. “Hospital System” means the Hospital and such other Hospital facilities that may be operated, acquired or removed by MUHA.

16. “Licensed Independent Practitioner” or “LIP” means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.

17. “Medical Executive Committee" or “MEC” means the Executive Committee of the Medical Staff.

18. "Medical Staff" means the formal organization of Practitioners who have been granted privileges by the Board to attend patients in the Hospital.

19. "Medical Staff Bylaws" or “Bylaws” means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

20. "Medical Staff Year" means October 1st through September 30th.

21. "Member" means a Practitioner who has been granted Medical Staff membership and clinical privileges pursuant to these Bylaws.

22. “Oral and Maxillofacial Surgeon” means an individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

23. “Peer Review Policy” means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Practitioners with delineated clinical privileges, evaluate the competence of Practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix “D” hereto.

24. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in South Carolina.

25. "Practitioner" means an appropriately licensed physician, dentist, or podiatrist, Affiliated Health Professional, including APRN, PA-C and CRNA, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice who has been granted clinical privileges at the Hospital.

26. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

27. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

28. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

29. “Unified and Integrated Medical Staff” means a single Medical Staff formed from a recommendation by the Board and acceptance by a majority vote of the members of the Medical Staffs at each Campus within the Hospital System.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of MUSC Health Black River Medical Center

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of Medical Staff membership may be fulfilled;

2.1(b) To foster cooperation with Hospital administration and the Board while allowing Medical Staff members to function with relative freedom in the evaluation, care and treatment of their patients;

2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay at the Hospital, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other performance improvement activities in accordance with the Hospital's performance improvement program;

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Practitioners authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each Practitioner's performance in the Hospital, and where applicable, collaboration with, supervision, review, evaluation and delineation of duties and prerogative of AHPs;

2.1(e) To work with the Board and Hospital administration to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

2.1(f) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;

2.1(g) To promulgate, maintain and enforce Bylaws and Rules and Regulations for the proper functioning of the Medical Staff;

2.1(h) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board and/or the Executive Director;

2.1(i) To participate in educational activities and scientific research with the Medical University of South Carolina and such other approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(j) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

2.1(k) To accomplish its goals through appropriate committees and departments.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Ensuring that Practitioners cooperate with each other in caring for patients in the Hospital;

2.2(b) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all Practitioners authorized to practice in the Hospital, by taking action to:

(1) Assist the Board and Executive Director and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

(3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital; and require documentation of individual participation in such programs by all individuals with clinical privileges;

(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of/collaboration with AHPs;

(6) Initiate and pursue corrective action with respect to Practitioners, when warranted;

(7) Develop, administer and enforce these Bylaws, the rules and regulations of the Medical Staff and other Hospital policies related to medical care;

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;

(9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Wellness Policy, which is incorporated herein and attached as Appendix “B” hereto.

2.2(c) Assisting the Board in maintaining the accreditation status of the Hospital;

2.2(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

2.2(e) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff**.**

2.4 UNIFIED AND INTEGRATED MEDICAL STAFF

2.4(a) The members of the active Medical Staff holding clinical privileges at each separate Campus may choose by a majority vote of the members eligible to vote, who are present and voting at a meeting at which a quorum is present, to participate in a unified and integrated Medical Staff structure. Written notice shall be provided stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days before the date of the meeting. Personal attendance at the meeting shall constitute a waiver of notice of such meeting.

2.4(b) The unified and integrated Medical Staff must be established in a manner that takes into account the unique circumstances and significant differences in patient populations and services offered at each Campus. The unified and integrated Medical Staff gives due consideration to the needs and concerns of its members, regardless of practice or location, and the Hospital System shall provide mechanisms to assure that issues localized to particular Campuses are duly considered and addressed.

2.4(c) The members of the Active Medical Staff holding clinical privileges at each Campus shall continually hold the right to determine whether to continue participation in the unified and integrated Medical Staff structure or to opt out of such structure, and to operate a Campus-specific separate and distinct Medical Staff for their respective Campus. A majority vote of the members of the Active Medical Staff holding clinical privileges at the separate and distinct Campus is also required to opt out of the unified and integrated Medical Staff structure. The members of the Active Medical Staff holding clinical privileges at a particular Campus shall obtain the signatures of ten percent (10%) of the Campus membership in order to call a vote to opt out. The vote to opt out shall take place at the annual MEC meeting. The Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days before the date of the meeting. Personal attendance at the meeting shall constitute a waiver of notice of such meeting.

2.4(d) All Practitioners shall be provided with a copy of these rights related to opting in and opting out of a unified Medical Staff at the time of initial appointment and reappointment.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent physicians, dentists, or podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the Practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she is a member of the Medical Staff with appropriate privileges, or has been granted temporary, one-case, locum tenens, or proctoring privileges as provided herein.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those physicians, dentists, or podiatrists legally licensed in South Carolina, who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide medically needed services within the Hospital;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of Medical Staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;

(4) Have professional liability insurance that meets the requirements of Section 14.2;

(5) Are graduates of an approved college holding appropriate degrees;

(6) Have successfully completed an approved internship program or the equivalent where applicable;

(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(8) Certify ongoing continuing medical education (CME) that fulfills current South Carolina state requirement for licensure

(9) Meet one of the following requirements, in addition to those listed above:

(i) Board certification; or

(ii) eligibility at the time of application for Board certification and become Board-certified within three (3) years of Practitioner completing a medical Residency or Fellowship program or six (6) years of Practitioner completing a surgical Residency or Fellowship program

(iii) demonstrate to the satisfaction of the MEC and the Board of competency and training equal or equivalent to that required for Board certification.

Any Medical Staff Member appointed prior to the effective date of this Section is not required to comply with the Board certification requirements of this Section, but must comply with any applicable Board certification criteria applicable to the Practitioner's Clinical Privileges in effect at the time of their initial appointment.

(9) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(10) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other Practitioners within the Hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, Medical Staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of race, color, sex, national origin, or disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past, and agrees that he/she will in the future; abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to Hospital medical review policies with regard to utilization;

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Practitioner Wellness and Behavior that Undermines a Culture of Safety policies, Appendices "B" and "C" hereto), and Rules & Regulations of the Medical Staff;

3.3(d) Discharge the Medical Staff, department, committee and Hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, election or otherwise;

3.3(e) Cooperate with other members of the Medical Staff, Hospital administration, the Board and employees of the Hospital;

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws;

3.3(h) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Hospital drug testing program;

3.3(i) Abide by the ethical principles of his/her profession and specialty;

3.3(j) Refuse to engage in improper inducements for patient referral;

3.3(k) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community;

3.3(l) Notify the Executive Director and Chief of Staff within seven (7) days if:

(1) His/Her professional licensure in any state is suspended or revoked, or of any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license;

(2) His/hers professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her; and any guilty pleas or convictions entered

(5) She/he has been excluded debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs, or is under investigation by any such program

(6) He/She has either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(7) There has been voluntary or involuntary limitation, reduction or loss of clinical privileges on any medical Staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above, shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

3.3(m) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.3 (n) Admission History

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician or other licensed Practitioner, including an APRN or PA-C, who has been credentialed and granted privileges to perform a history and physical examination) within twenty-four (24) hours of admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia. A written admission note shall be entered by the Attending Physician, APRN, or PA-C at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is written or dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia, the record shall be considered delinquent and the Chief of Staff or his/her designee or the Executive Directoror his designee may take appropriate steps to enforce compliance. If the history and physical is completed by a licensed Practitioner who is not a physician, oral and maxillofacial surgeon, APRN, or PA-C, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

At a minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient’s own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient’s symptoms; and (k) the plan

outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

A history and physical performed within thirty (30) days prior to Hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia.

History and Physical Documentation for Outpatient Procedures.
Outpatient procedures requiring history and physical documentation shall include the following:

- Outpatient Surgery procedures,
- Lithotripsy procedures,
- Cardiovascular procedures as defined in departmental policy,
- Radiographic procedures as defined in departmental policy, and
- All other invasive procedures and procedures requiring conscious sedation.

The individual Practitioner performing the procedure shall document history and physical information specific to the procedure prior to starting the outpatient surgery/procedure. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.4(b) Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting of Medical Staff privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its Medical Staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years.

3.4(d) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in Medical Staff category of a current Medical Staff member or the granting of additional privileges to a current Medical Staff

member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave is granted, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement. If the Medical Staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the Medical Staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the Executive Director or his/her designee for transmittal to the MEC. The Medical Staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of Medical Staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for Medical Staff membership subsequently received from a Medical Staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a Medical Staff member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning Medical Staff member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the Medical Staff member were a new applicant.

(3) Reinstatement will ordinarily be automatic if a leave of absence is for an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

(4) If a Medical Staff member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff shall include Active, Courtesy, Consulting and Honorary categories. Qualifications, prerogatives and responsibilities are outlined below. Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of Medical Staff membership.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of physicians, dentists, or podiatrists who:

(1) Meet the basic qualifications set forth in these Bylaws;

(2) Have an office and/or residence located within 30 miles of the Hospital in order to be continuously available for provision of care to his/her patients, **with the exception of the hospitalist,** as determined by the Board unless requesting membership without privileges or "refer and follow" privileges only; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least 30 patients in the Hospital in a calendar year. For purposes of determining whether a Practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist or other Practitioner. When a patient has more than one procedure or diagnostic test performed or interpreted by the same Practitioner during a single Hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation unless seeking membership without privileges or "refer and follow" privileges only, or unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

(2) To exercise only such delineated clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the Medical Staff organization and departments and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than _12_ hours after admission or sooner if warranted by the patient's condition;

(3) Actively participate*:

(i) in the performance improvement program and other patient care evaluation and monitoring activities required of the Medical Staff, and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;

(ii) in supervision of other appointees where appropriate;

(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations and as recommended by the MEC and , approved by the Board unless he/she holds membership without delineated privileges or "refer and follow" privileges only, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician; ***(Each Active Staff member must establish current competence in and maintain a sufficient breadth of clinical privileges in his/her specialty to meaningfully participate in emergency department unassigned call as required in the Rules & Regulations of the Medical Staff.)***

(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(v) in discharging such other Medical Staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

(5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the department and committees of which he/she is a member.

*Upon attaining the age of 65 and having served on the Active Medical Staff of a Hospital for a minimum of 20 years, including any years served on the active medical staff of any acute care hospital purchased, leased or otherwise acquired by MUHA, or having served a minimum of 30 years on the active medical staff of a hospital regardless of age, including any years served on the active medical staff of any acute care hospital purchased, leased or otherwise acquired by MUHA, an Active Staff member may elect to become a Senior Active Staff member. Senior Active Staff members shall retain all Active Staff privileges, but are not required to take compulsory emergency call or serve on committees except by mutual agreement of a majority of the Active Medical Staff and the Senior Active Staff member.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of physicians, dentists, or podiatrists, who:

(1) Meet the basic qualifications for Medical Staff membership set forth in these Bylaws;

(2) Have an office and/or residence located within _45_ miles of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the Medical Staff with privileges appropriate to the treatment provided unless requesting membership without delineated privileges or "refer and follow" privileges only;

(3) Do not admit or regularly participate in the care of more than _30_ patients in a calendar year (the limitation on patient contacts shall not apply to contracted emergency department physicians who reside outside the community); and

(4) Are members of the Active Staff of another Joint Commission accredited hospital where he/she actively participates in the performance improvement program, **with the exception of emergency room physicians who will participate in the Hospital Performance Improvement Program**.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital (excluding Emergency Room Physicians) within the limitations provided in Section 4.3(a) unless requesting membership without delineated privileges or "refer and follow" privileges only;

(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the Medical Staff and any Medical Staff or Hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, except that he/she shall be entitled to vote for Chairperson of any department, and shall vote at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service; and

(3) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff shall consist of a special category of physicians each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:

(i) consult on patients within his/her specialty to the extent he/she holds delineated clinical privileges to do so; and

(ii) attend all meetings of the Medical Staff and the applicable department that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

(3) Consulting Staff members with appropriate delineated clinical privileges may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Except where otherwise provided, Consulting Staff members shall not admit patients to the Hospital, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital.

4.4(c) Responsibilities

Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

4.5 HONORARY STAFF

4.5(a) Qualifications

The Honorary and Retired Staff shall consist of physicians, dentists, or podiatrists who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active Hospital services, but continue to demonstrate a genuine concern for the Hospital; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Honorary Staff members shall not be required to meet the qualifications set forth in Section 3.2(a) of these Bylaws.

4.5(b) Prerogatives

(1) Prerogatives of an Honorary Staff member shall be:

(i) attending by invitation any such Medical Staff meetings that he/she may wish to attend as a non-voting visitor.

(2) Honorary Staff members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital.

Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

4.6 MODIFICATION IN STAFF CATEGORIES AND CLINICAL PRIVILEGES

The MEC may recommend to the Board that a change in Medical Staff category of a current Medical Staff member be made in accordance with Article 4. In the event the Practitioner is not eligible for any other category, his/her Medical Staff membership shall automatically terminate. No such transfer or termination shall be subject to the provisions of the Fair Hearing Process.

ARTICLE V
AFFILIATED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

This article shall pertain only to Advanced Practice Affiliated Health Professionals ("AHPs"), that is, those who are credentialed pursuant to the Medical Staff process as outlined in the definition of "Affiliated Health Professional" herein. Clinical Assistants who are not Advanced Practice Allied Health Professionals and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. Affiliated Health Professionals may be employed by physicians on the Medical Staff; but whether or not so employed, must be engaged in practice under the direct supervision of or in collaboration with a Medical Staff physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations).

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under South Carolina state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and reviewed and approved by the Board.

5.2(a) AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

(3) Have professional liability insurance in the amount required by these Bylaws;

(4) Provide a needed service within the Hospital; and

(5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing, collaborating with, and/or supervising the AHP in the form of approved written scope of practice guidelines for PA-Cs or written practice agreement for APRNs, in accordance with the applicable scope of professional practice authorized by state law.

5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

5.3(a) To exercise independent professional judgment within the AHP's area of competence and applicable state practice, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;

5.3(b) To perform those medical acts, tasks, or functions as provided for in SC state law and as documented in the written practice agreements for APRNs or written scope of practice guidelines for PA-Cs under physician supervision/collaboration;

5.3(c) To participate directly, including writing orders to the extent permitted by law, in the management of patients in collaboration with and under the supervision or direction of an attending physician member of the Medical Staff; and

5.3(d) To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the Medical Staff and to discharge such other Medical Staff functions as may be required from time-to-time.

5.3(e) Attend/ Participate, without voting rights, on Medical Staff committees and Medical Staff meetings.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Practitioners. Each AHP shall be assigned to one (1) of the clinical departments and shall be granted clinical privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

5.4(b) Appointment of AHP's must be approved by the Board and may be terminated by the Board or the Executive Director. Adverse actions or recommendations affecting AHP privileges and their reduction or termination shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request an appearance before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity for an interview concerning the AHP's grievance. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

5.4(c) The AHP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and

the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

5.4(d) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising/collaborative attending physician Medical Staff member, unless another qualified attending physician indicates his/her willingness to supervise/collaborate with the AHP and complies with all requirements hereunder for undertaking such supervision/collaboration. In the event that an AHP's supervising/collaborating attending physician Medical Staff member's privileges are significantly reduced or restricted, the AHP must obtain supervision/collaboration agreement from another fully qualified and credentialed attending physician following relevant Board of Medical Examiners and/or Board of Nursing requirements for the change in supervising/collaborating physician, subject to review and approval of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

5.4(e) If the supervising/collaborating Practitioner employs or directly contracts with the AHP for services, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of and collaboration with the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising/collaborating Practitioner does not employ or directly contract with the AHP, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of and collaboration with the AHP by the Practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.5(c) Discharge any committee functions for which he/she is responsible;

5.5(d) Cooperate with members of the Medical Staff and AHPs, Hospital administration, the Board, and employees of the Hospital;

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.5(f) Participate in performance improvement activities and in continuing professional education;

5.5(g) Abide by the ethical principles of his/her profession and specialty; and

5.5(h) Notify the Executive Director and the Chief of Staff within seven (7) days if:

(1) His/hers professional license or certification in any state is suspended or revoked, or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license or certification;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or

(4) Any criminal charges, other than minor traffic violations, are brought/initiated against he/she; and any guilty pleas or convictions entered;

(5) He/she has been excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs, or is under investigation by any such program;

(6) He/she is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(7) There has been a voluntary or involuntary limitation, reduction or loss of clinical privileges on any medical staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above, shall result in immediate loss of Allied Health membership and clinical privileges, without right of fair hearing procedures.

5.5(i) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

5.5(j) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

5.5(k) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Allied Health membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Hospital drug testing program;

5.5(l) Refuse to engage in improper inducements for patient referral; and

5.5(m) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community.

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated committees and departments shall investigate and consider each application for appointment or reappointment to the Medical Staff and each request for modification of Medical Staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all Practitioners except pathologists and non-invasive radiologists), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. No application fee or Medical Staff dues shall be assessed. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(i) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(ii) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

(b) Administrative Remedies: A statement indicating that the applicant agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her Medical Staff membership, Medical Staff status, and/or clinical privileges;

(c) Criminal Charges: Any current criminal charges, except minor traffic violations, pending against the applicant and any past convictions or pleas. The Practitioner shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(d) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and any civil judgments or settlements related to the delivery of health care;

(e) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Medical Staff membership and exercising the privileges requested. In instances where there is doubt about an applicants'

ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board;

(f) Program Participation: Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion. In addition, the Practitioner shall have a continuing duty to notify the MEC through the Executive Director or his/her designee of the initiation of participation in any rehabilitation or impairment program. The Executive Director or his/her designee shall be responsible for notifying the MEC of all such actions;

(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment.

(h) Education: Detailed information concerning the applicant's education and training.

(i) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time.

(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 6.3(b) and (c);

(k) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:

(i) membership/fellowship in local, state or national professional organizations;

(ii) specialty board certifications;

(iii) license to practice any profession in any jurisdiction;

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists) Including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license);

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of such medical staff membership or clinical privileges after an investigation of his competence, professional conduct, or patient care activities has commenced or to avoid such investigation; and receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

(vi) the applicant management of patients which may have given rise to investigation by the state medical board and/or state nursing board, whichever is applicable; or

(vii) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid, including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete.

(l) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested Medical Staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;

(m) References: The names of at least three (3) Practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

(n) Request: Specific requests stating the Medical Staff category and specific clinical privileges for which the applicant wishes to be considered;

(o) Practice Affiliations: The name and address of all other Hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

(p) Photograph: A recent, wallet sized photograph of the applicant;

(q) Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years;

(r) Citizenship Status: Proof of United States citizenship or legal residency; and

(s) Professional Practice Review Data: For all new applicants, AHPs, and Practitioners requesting new or additional privileges, evidence of the applicant's, AHPs, or Practitioner's professional practice review, volumes and outcomes from organization(s) that current privilege the applicant.

(t) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required by this Hospital, which should be related to the physician's specialty and to the provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within forty-five (45) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within forty-five (45) days during any period of appointment or reappointment shall result in immediate loss of Medical Staff membership and clinical privileges at the decree of the MEC, without right of fair hearing procedures.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

An applicant wishing to be considered for appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her written request for an application form to the Executive Director or his/her designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff membership and clinical privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for Medical Staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application;

(5) Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights;

(6) Acknowledges that, if he/she is determined to have knowingly made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights;

(7) Pledges to provide continuous care for his/her patients treated in the Hospital; and

(8) Agrees to be bound by the statements described in Section 6.3(c).

6.3(c) <u>Statement of Release & Immunity from Liability</u>

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted; I acknowledge, consent and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges without fair hearing rights. I further acknowledge that if I am reasonably determined to have knowingly made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately relinquished my appointment and clinical privileges without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment or clinical privileges, including temporary privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other Hospital, Medical Staff, department, service or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means MUHA, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the Executive Director or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Medical Staff appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the Executive Director, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital. Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such Bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner or AHP providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) <u>Submission of Application & Verification of Information</u>

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the Executive Director or his/her designee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

(1) <u>Not Licensed</u>. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the applicant has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

(3) Exclusive Contract or Moratorium. The applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicant's specialty; or

(4) Inadequate Insurance. The practitioner does not meet the liability insurance coverage requirements of these Bylaws; or

(5) Ineligible for Medicare Provider Status. The practitioner has been excluded, suspended or debarred, or otherwise declared ineligible from any state or federal health care program or procurement program, or is currently the subject of a pending investigation by any such program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible; or

(6) No DEA number. The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists or non-invasive radiologists); or

(8) Continuous Care Requirement. For applicants to Active or Courtesy Staff, failure to maintain an office or residence within 30/45 miles of the Hospital.

(9) Application Incomplete. The applicant as failed to provide any information required by these Bylaws or requested on the application or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application; or

(9) Electronic Health Record Education/Training: The applicant has failed to complete education in accordance with a facility approved curriculum related to electronic clinical information systems, or fails to appropriately utilize the Electronic Health Record as outlined in more detail in the Electronic Health Record Policy of this Hospital.

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these Bylaws.

In the event that none of the above apply to the application, the Executive Director or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The Executive Director or his/her designee shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are

accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the applicable department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Hospital. Each Practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

6.3(f) Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation and other information available as may be relevant to consideration of the applicant's qualifications for the Medical Staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(g) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The MEC shall then forward to the Board a written report on the prescribed form concerning Medical Staff recommendations and, if appointment is recommended, Medical Staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

6.3(h) Effect of Medical Executive Committee Action

(1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any

additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Executive Director or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chairperson.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the Executive Director or his/her designee shall immediately inform the applicant by special notice which shall specify the reason or reasons for denial and the applicant then shall be entitled to the procedural rights as provided in the Fair Hearing Plan, or for AHPs the procedure outlined in 5.4(b). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan, or for AHPs the procedure outlined in 5.4(b).

6.3(i) Board Action

(1) Decision; Deadline. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

The Board may accept, reject or modify the MEC recommendation. The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to a final action by the Board.

The expedited process may not be used in the following circumstances:

(i) the applicant submits an incomplete application;
(ii) the MEC makes a recommendation that is adverse or with limitation;
(iii) there is a current challenge or a previously successful challenge to licensure or registration;
(iv) the applicant has received an involuntary termination of medical staff membership at another organization;
(v) the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or
(vi) there has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed, the Secretary of the Board shall reduce full Board's the decision to writing and shall set forth therein the

reasons for the decision. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board shall make every reasonable effort to render its decision within sixty (60) days following receipt of the MEC's recommendation.

(2) Favorable Action. In the event that the Board's decision is favorable to the applicant, such decision shall constitute final action on the application. The Executive Director or his/her designee shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board's action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b). The Executive Director or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Board's written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan, or for AHPs, the procedure outlined in 5.4(b).

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

6.3(j) Interview

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, the application materials.

6.3(l) Time Periods for Processing

Applications for Medical Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for

good cause, shall be processed within the time periods specified in this section. The Executive Director or his/her designee shall transmit a completed application to the credentials committee upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process.

6.3(m) Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny Medical Staff membership, Medical Staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the Hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the Hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the Hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the Hospital finds it possible to accept applications for Medical Staff positions for which the applicant is eligible, and the Hospital has no obligation to applicants with prior pending status, the Executive Director or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

6.3(n) Appointment Considerations

Each recommendation concerning the appointment of a Medical Staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant’s experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant’s proficiency in areas such as the following:

(1) **Patient Care** with the expectation that applicant provide patient care that is compassionate, appropriate and effective;

(2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

(3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patient’s families, members of the Medical Staff, Hospital Administration and employees, and others;

(5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of an applicant's present Medical Staff appointment, the Executive Director or his/her designee shall provide the applicant a reapplication form for use in considering reappointment. The Medical Staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the Executive Director or his/her designee. Returned reappointment forms shall include payment of biannual dues in such amount as established by the Active Medical Staff from time to time. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the Medical Staff member's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the Medical Staff member for the privileges sought on reappointment;

(2) License: Current licensure;

(3) Health Status: Current physical and mental health status only to the extent necessary to determine the applicant's ability to perform the functions of Medical Staff membership or to exercise the privileges requested;

(4) Program Participation: Information concerning the applicant's current and /or previous participation in any rehabilitation or impairment program, or termination of participation in such program without successful completion.

(5) Previous Affiliations: The name and address of any other health care organization or practice setting where the Medical Staff member provided clinical services during the preceding appointment period;

(6) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations during the preceding appointment period;

(7) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of such Medical Staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

(vi) the applicant's management of patients which may have been given rise to investigation by the state board; or

(vii) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid, including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete.

(8) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, or pursued to final judgment.

(9) Criminal Charges: Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period. This includes any arrests related to the use, misuse or abuse of drugs or alcohol including DUIs and DWIs;

(10) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period and any civil judgments or settlements related to the delivery of health care;

(11) Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years during the preceding appointment period;

(12) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at

any time. Each Practitioner must, at all times, keep the Executive Director informed of changes in his/her professional liability coverage;

(13) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by one (1) other Medical Staff member who is not a partner, employer, employee or relative of the applicant or two (2) Medical Staff members who are not partners, employers or employees, or relatives, and results from the performance improvement process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Applicants who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the applicant professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

Applicant who refer their patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing the above information in the form of quality profiles from other facilities where the applicant has actively practiced during the prior appointment period; quality profiles from managed care organizations with whom the applicant has been associated during the prior appointment period, or by submitting relevant medical record documentation from his/her office or other practice locations that demonstrates current competency for the privileges he/she is seeking applicants who refer their patients to a Hospitalist for inpatient treatment shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist must complete the Physician Reappointment Profile Hospitalist Addendum. The Hospitalist shall provide his/her evaluation of the applicant's care based upon consultation and interaction with the applicant with regard to the applicant Hospitalized patients. The Hospitalist shall provide his/her opinion as to the applicant's current competency based upon the condition of the Practitioner's patients upon admission or readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission;

(14) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c);

(15) Information on Ethics/Qualifications: Such other specific information about the Medical Staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital; and

(16) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) Practitioners (excluding partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others.

(17) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required

by this Hospital, which should be related to the physician's specialty and to the provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within seven (7) days during any period of appointment or reappointment shall result in immediate loss of medical Medical Staff membership and clinical privileges, without right of fair hearing procedures.

6.4(c) Verification of Information

The Executive Director or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the Medical Staff member's professional activities, performance and conduct in the Hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the Executive Director or his/her designee shall transmit the Reapplication Form and supporting materials to the Chairperson of the appropriate department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(o) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of Medical Staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other Practitioners and AHPs and with patients, results of the Hospital monitoring and evaluation process, including Practitioner and AHPs -specific information compared to aggregate information from Performance Improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category or clinical privileges, by submitting the request in writing to the Executive Director. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No Medical Staff member may seek modification of privileges or

Medical Staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A Practitioner, including an AHP, who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or Medical Staff member.

6.6(b) Requirements for Service

In approving any such Practitioners or AHPs for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital quality assessment and improvement program.

6.6 (c) Terminations

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6 shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. The Fair Hearing does not apply in this case.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Practitioner providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the Practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of Practitioner, and each Practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Practitioner's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for Medical Staff membership, each Practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a Medical Staff member for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the Practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For Practitioners who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b) (12) herein. In addition, those Practitioners seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank, if applicable. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a Medical Staff member or AHP.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.

7.2(d) Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of not less than six (6) months. The period of review may be renewed for additional periods up to the conclusion of the member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of focused review shall be incorporated into the Practitioner's evaluation for reappointment.

7.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges from dentists and oral surgeons shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists and oral surgeons shall be under the overall supervision of the Chief of Surgery, however, other dentists and/or oral surgeons shall participate in the review of the Practitioner through the performance improvement process. All dental patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

7.4(a) Temporary Privileges – Important Patient Care need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Chief of Staff and pending MEC review and Board approval. "New applicant" includes an individual applying for clinical privileges at the Hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

In these cases only, the Executive Director or his/her designee, upon recommendation of the Chief of Staff may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the Practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.4(b) Temporary Privileges – Important Patient Care Need – No Pending Application

Temporary privileges may be granted by the Executive Director upon recommendation of the Chief of Staff when there isan important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for Medical Staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately. Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the Medical Staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service within a calendar year. All practitioners providing coverage for other Practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute practitioner shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the practitioner and the dates during which the services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the Medical Staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the Practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, copies of the Practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the Practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases only, the Executive Director or his/her designee, upon recommendation of the President of

the Medical Staff, Chairperson of the Credentials Committee and Chairperson of the applicable department, may grant such privileges upon receipt of the required information.

7.4(d) Conditions

Temporary, one-case and locum tenens privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such applicant be admitted upon dual admission with a member of the Active Staff. Before temporary or locum tenens privileges are granted, the applicant must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.4(e) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Practitioner's qualifications or ability to exercise any or all of the privileges granted, the Executive Director may, after consultation with the Chief of Staff terminate any or all of such Practitioner's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute Practitioner.

7.4(f) Rights of the Practitioner

A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary or proctoring privileges or because of any termination or suspension of such privileges.

7.4(g) Term

No term of temporary or proctoring privileges shall exceed a total of one hundred and twenty (120) days.

7.5 EMERGENCY & DISASTER PRIVILEGES

For the purpose of this section, an “emergency” is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, delay in administering treatment immediately would add to that danger and no appropriately credentialed individual can be available in the time required to respond. A “disaster” for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available Medical Staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any practitioner, or Licensed Independent Practitioner, to the degree permitted by his/her license and regardless of Medical Staff status or clinical privileges, shall, as approved by the Executive Director or his/her designee or the Chief of Staff, be permitted to do, and be assisted by Hospital personnel in doing everything reasonable and necessary to save the life of a patient or to prevent imminent harm to the patient.

Disaster privileges may be granted by the Executive Director or Chief of Staff when, and for so long as, the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or Licensed Independent Practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current Medical Staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The Executive Director and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges. A member of the Medical Staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 TELEMEDICINE

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.6(b) Telemedicine Practitioners

Any Practitioner who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "Telemedicine Practitioner"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below for those circumstances in which the Telemedicine Practitioner's distant-site entity or distant-

site hospital is Joint Commission accredited and the Hospital places in the Practitioner's credentialing file a copy of written documentation confirming such accreditation.

In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the Telemedicine Practitioner's credentialing information from the distant-site entity or distant-hospital to credential and privilege the Telemedicine Practitioner ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

(1) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity's or distant-site hospital's physicians and practitioners providing telemedicine services;

(2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;

(3) The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation;

(4) The Telemedicine Practitioner is privileged at the distant-site entity or distant-site hospital providing the telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the Telemedicine Practitioner's privileges at the distant-site entity or distant-site hospital;

(5) The Telemedicine Practitioner holds a license issued or recognized by the state in which the Hospital is located; and

(6) The Hospital has evidence, or will collect evidence, of an internal review of the Telemedicine Practitioner's performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the Telemedicine Practitioner and all complaints the Hospital has received about the Telemedicine Practitioner) for use in the periodic appraisal of the Telemedicine Practitioner by the distant-site entity or distant-site hospital.

For the purposes of this Section 7.6, the term "distant-site entity" shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of practitioners providing telemedicine services. For the purposes of this Section 7.6, the term "distant-site hospital" shall mean a Medicare-participating hospital that provides telemedicine services.

If the Telemedicine Practitioner's site is also accredited by Joint Commission, and the Telemedicine Practitioner is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the Telemedicine Practitioner's credentialing information from that site may be relied upon to credential the Telemedicine Practitioner in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

7.7 MEMBERSHIP WITHOUT DELINEATED CLINICAL PRIVILEGES

7.7 (a) Membership Only

Practitioners who meet the basic qualifications set forth in Section 3.2(a) of these Medical Staff Bylaws and do not provide patient care in this Hospital may apply for Medical Staff membership without delineated clinical privileges. Practitioners who apply for Medical Staff membership only may apply for appointment in Active, Courtesy, Consulting or Honorary Staff.

7.7(b) Membership with "Refer & Follow" Privileges Only

Practitioners who do not wish to actively treat patients within the Hospital may seek "refer and follow" privileges only. These will permit the Practitioner to refer patients to the Hospital for outpatient testing and refer patients to Medical Staff members or Hospitalists for procedures or treatment within the facility. If the admitting/attending physician agrees, a Practitioner with "refer and follow" privileges may visit his/her patients in the Hospital, review patient medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall a Practitioner with "refer and follow" privileges participate in any treatment or procedure, make any entries in the medical record, or admit a patient to the Hospital. Practitioners who apply for "refer and follow" privileges only may apply for Active, Courtesy, Consulting or Honorary Staff category.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a Practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with Hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such Practitioner may be initiated by any officer of the Medical Staff, by the Chairperson of the Department of which the Practitioner is a member, by the Executive Director, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall promptly notify the Executive Director or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the Executive Director or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of Practitioner impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital's Practitioner Wellness Policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected Practitioner;

(3) Issuing a warning or a reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

(5) Recommending reduction, suspension or revocation of clinical privileges;

(6) Recommending reduction of Medical Staff category or limitation of any Medical Staff prerogatives; or

(7) Recommending suspension or revocation of Medical Staff membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d) (4), (5), (6), or (7) (where such action materially restricts a Practitioner's exercise of privileges) or any combination of such actions, shall entitle the Practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a Practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a Practitioner willfully disregards these Bylaws or other Hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then any two (2) of the following, that is, the Chief of Staff, the Executive Director, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the Executive Director or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Chief of Staff and the Executive Director in enforcing all suspensions and in caring for the suspended Practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) Procedural Rights

If the summary suspension is terminated or modified such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the Practitioner's clinical privileges, the Practitioner shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 ADMINISTRATIVE CORRECTIVE ACTION

8.3(a) Criteria for Initiation

Whenever a Practitioner violates Hospital policies, rules or regulations, exhibits behavior that undermines a culture of safety, or acts in a manner disruptive to Hospital operations, or in such a manner as to endanger the assets of the Hospital because of financially imprudent actions not justified by patient care considerations, administrative corrective action may be initiated pursuant to the Hospital Policy Regarding Behavior that Undermines a Culture of Safety. Such action shall be taken pursuant to this section, in conjunction with the above policy, rather than Section 8.1 or 8.2, only in those instances in which disruptive or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of Hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment.

8.3(b) Corrective Action by the MEC and/or Board

If collegial intervention and progressive discipline pursuant to the Policy Regarding Behavior that Undermines a Culture of Safety is not successful in remediating the issue, the MEC and/or Board may take action as provided herein. If the MEC addresses the issue, the procedure in Section 8.1 shall apply. If the MEC elects to refer the matter directly to the Board, or the Board takes action on its own initiative, the Board may commerce an investigation. The Executive Director shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprised of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary; the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.3 (c) Board Actions

Within sixty (60) days following receipt of the report, the Board shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Issuing a warning or a reprimand to which the Practitioner may write a rebuttal, if he/she so desires;

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking clinical privileges;

(5) Reducing Medical Staff category or limiting prerogatives; or

(6) Suspending or revoking Medical Staff membership.

8.3(d) Procedural Rights

Any action by the Board pursuant to Section 8.3(c)(4), (5) or (6), or (f)(3) (where such action materially restricts a Practitioner's exercise of privileges) or any combination of such actions, shall entitle the Practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The action will not become final until the Practitioner has either waived his/her right to a hearing or completed the hearing.

8.3(e) Other Action

If the Board's action is as provided in Section 8.3(c) (1) and (2), or (f) (3) (where such action does not materially restrict a Practitioner's exercise of privileges), such action shall become the final action of the Board, and the Practitioner shall not be entitled to the rights enumerated in the Fair Hearing Plan.

8.4 AUTOMATIC SUSPENSION

8.4(a) License

A Medical Staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in South Carolina is revoked, relinquished, suspended or restricted shall immediately and automatically be suspended from the Medical Staff and practicing in the Hospital.

8.4(b) Drug Enforcement Administration (DEA) Registration Number

Any Practitioner (except a pathologist) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended or relinquished shall immediately and automatically be suspended from the Medical Staff and practicing in the Hospital until such time as the registration is reinstated.

8.4(c) Medical Records

(1) Automatic suspension of a Practitioner or AHP's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the Practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Notwithstanding the provision of Section 8.4(c)(1), any Medical Staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.4(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.4(d) Malpractice Insurance Coverage

Any Practitioner unable to provide proof of current medical malpractice coverage in the amounts prescribed in these Bylaws will be automatically suspended until proof of such coverage is provided to the MEC and Executive Director.

8.4(e) Exclusions/Suspension from Medicare

Any Practitioner who is excluded, debarred, suspended, or otherwise declared ineligible from any state or federal government health care program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible) will be automatically suspended.

8.4(f) Automatic Suspension - Fair Hearing Plan Not Applicable

No Medical Staff member, whose privileges are automatically suspended under this Section 8.4, shall have the right of hearing or appeal as provided under Article IX of these Bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended Practitioner's patients.

8.4(g) Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the Executive Director in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The Executive Director or his/her designee shall periodically keep the Chief of Staff informed of the names of Medical Staff members who have been suspended or expelled under Section 8.4.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and corrective action.

8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the Practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the Practitioner's privileges. Any of the following shall have the right to impose supervision: Chief of Staff, the Executive Director, or the Board.

8.7 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and Hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 6.3(c) of these Bylaws.

8.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

8.9 FALSE INFORMATION ON APPLICATION

Any Practitioner who, after being granted appointment and/or clinical privileges, is determined to have knowingly made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No Practitioner or AHP who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.9 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the Practitioner or AHP, permit the Practitioner or AHP to appear before it and present information solely as to the issue of whether the Practitioner or AHP knowingly made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the Practitioner or AHP and render a decision as to whether the finding that he/she knowingly made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a Practitioner, it may in its discretion give the Practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a Practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the Practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING AHPS

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these Bylaws.

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the Medical Staff shall be:

(1) Chief of Staff;
(2) **Chief of Staff Elect/Vice Chief of Staff** and
(3) Immediate Past Chief of Staff.

10.1(b) Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the Chief of Staff and the two (2) most recent Past-Chiefs of Staff of the Medical Staff. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the Medical Staff and when otherwise necessary to fill vacancies. Only members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board, which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to or interfering with the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff. Reasons for removal may include, but shall not be limited to violation of these Bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

10.1(f) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

10.1(h) Duties of Elected Officers

(1) Chief of Staff. The Chief of Staff shall serve as the Chief Medical Officer and principal official of the Medical Staff. As such he/she will:

(i) appoint multi-disciplinary Medical Staff committees;

(ii) aid in coordinating the activities of the Hospital administration and of nursing and other non-physician patient care services with those of the Medical Staff;

(iii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;

(iv) in concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

(v) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Hospital administration committees;

(vi) report to the Board and the Executive Director concerning the opinions, policies, needs and grievances of the Medical Staff;

(vii) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

(viii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

(ix) serve as a voting member of the MEC and an ex-officio member of all other Medical Staff committees or functions;

(x) assist in coordinating the educational activities of the Medical Staff;

(xi) serve as liaison for the Medical Staff in its external professional and public relations;

(xii) confer with the Executive Director, CFO, CNO and Department or Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, Medical Staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

(xiii) assist the Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

(3) Immediate Past Chief of Staff shall be a member of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

10.1(i) Conflict of Interest of Medical Staff Members

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other Medical Staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its Medical Staff, or the Hospital's relationship to the community, including but not limited to each of the following:

(1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the Practitioner, including but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

(4) Business practices that may adversely affect the Hospital or community.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

In addition to the foregoing, a new Medical Staff leader (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board) shall file the written statement immediately upon being elected or appointed to his/her leadership position. Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Chairperson or his/her designee will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section 10.1(i) or failure to abstain from voting on an issue in which the Medical Staff member has an interest other than as a fiduciary of the Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI
CLINICAL DEPARTMENTS & SERVICES

11.1 DEPARTMENTS & SERVICES

11.1(a) There shall be clinical services of medicine, surgery and such other services as may be established by unanimous vote of the MEC or added by amendment procedures as described in Article XV of these Bylaws.

11.2 DEPARTMENT FUNCTIONS

The primary function of each department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall:

11.2(a) Require that patient care evaluations be performed and that appointees exercising privileges within the department be reviewed on an ongoing basis and upon application for reappointment;

11.2(b) Establish guidelines for the granting of clinical privileges within the department and submit the recommendations as required under these Bylaws regarding the specific clinical privileges for applicants and reapplicants for clinical privileges;

11.2(c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.2(d) Monitor on an ongoing basis the compliance of its department members with these Bylaws, and the rules and regulations, policies, procedures and other standards of the Hospital;

11.2(e) Monitor on an ongoing basis the compliance of its department members with applicable professional standards;

11.2(f) Coordinate the patient care provided by the department's members with nursing, administrative, and other non-Medical Staff services;

11.2(g) Foster an atmosphere of professional decorum within the department;

11.2(h) Review all deaths occurring in the Department and all unexpected patient care events and report findings to the MEC; and

11.2(i) Submit written reports or minutes of department meetings to the MEC on a regular basis concerning:
- (1) Findings of the department's review and evaluation activities, actions taken thereon, and the results thereof;
- (2) Recommendations for maintaining and improving the quality of care provided in the department and in the Hospital; and
- (3) Such other matters as may be requested from time to time by the MEC.

11.2(j) Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from department subcommittees regarding all pertinent recommendations and actions by the subcommittees.

ARTICLE XII
COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

12.1(c) All information pertaining to activities performed by the Medical Staff and its committees and departments shall be privileged and confidential to the full extent provided by law.

12.1(d) The Executive Director or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;
(2) The Chief of Staff Elect/Vice Chief of Staff;
(3) The Immediate Past Chief of Staff;
(4) Two (2) Physician Members at large to be elected by the Medical Staff;
(5) One (1) ex-officio/non-voting AHP Member at large
(6) Credentials Committee Chair
(7) The Executive Director, ex-officio, or his/her designee.

12.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include, at least the following:

(1) Receiving and acting upon department and committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, Medical Staff category and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Recommending action to the Executive Director on matters of a medico-administrative nature;

(7) Developing and implementing programs for continuing medical education for the Medical Staff;

(8) Developing and implementing programs to inform the Medical Staff about Practitioner health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;

(9) Assuring regular reporting of performance improvement and other Medical Staff issues to the MEC and to the Board and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate Medical Staff members;

(10) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(11) Assuring an annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted;

(12) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital;

(13) Requesting evaluation of Practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that an applicant to or Practitioner on the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for Practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;

(14) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(15) Developing and monitoring compliance with these Bylaws, the rules and regulations, policies and other Hospital standards; and

(16) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated.

12.2(c) Meetings

The MEC shall meet as needed, but at least monthly and maintain a permanent record of its proceedings and actions.

12.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the Chief of the Medical Staff, when a majority of the MEC can be convened.

12.2(e) Removal of MEC Members

The removal process (including the reasons for removal) for those members at large of the MEC who are elected by the Medical Staff shall be the same as described in Section 10.1(e) with respect to Medical Staff officers.

All other members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff who are ex officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e).

12.3 MEDICAL STAFF FUNCTIONS

12.3(a) Composition of Committees

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

12.3(b) Functions

The functions of the Medical Staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;

(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate reviews;

(3) Conduct or coordinate utilization review activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs, and supervise Hospital's professional library services;

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

(6) Investigate and control nosocomial infections and monitor the Hospital's infection control program;

(7) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(8) Direct Medical Staff organizational activities, including Medical Staff Bylaws, review and revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(9) Provide for appropriate physician involvement in and approval of the multi- disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

(10) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, a mechanism for addressing the health of all licensed individual Practitioners including a Practitioner Wellness Policy (attached hereto as Appendix "B" and incorporated herein by reference). The purpose of this mechanism is to provide education about Practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. The Practitioner Wellness Policy affords resources separate from the corrective action process to address Practitioner health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals.

(11) Provide leadership in activities related to patient safety;

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

(i) medical assessment and treatment of patients;

(ii) use of medications, use of blood and blood components;

(iii) use of operative and other procedure(s);

(iv) efficiency of clinical practice patterns; and

(v) significant departure from established patterns of clinical practice.

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;

(ii) coordination of care, treatment and services with other Practitioners and Hospital personnel, as relevant to the care of an individual patient;

(iii) accurate, timely and legible completion of patients' medical records including history and physicals;

(iv) patient satisfaction;

(v) sentinel events; and

(vi) patient safety.

(14) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a Practitioner's competence;

(15) Recommend to the Board policies and procedures which define the circumstances, trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Practitioner's performance and evaluation of a Practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord with the Hospital's Peer Review Policy, Appendix "D" to these Bylaws. The information relied upon to investigate a Practitioner's professional conduct and practice may include (among other items or information): internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, AHPs, assistants, nursing or Administrative personnel involved in the care of patients;

(16) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

(17) Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;

(18) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(19) Review, on a periodic basis, applications for reappointment including information regarding the competence of Medical Staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

(20) Investigate any breach of ethics that is reported to it;

(21) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and

(22) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

12.3(c) Meetings

These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

12.4 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two members of the Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two non-physician Board members who are selected by the Board Chair, and the Executive Director. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

12.5 CREDENTIALS COMMITTEE

12.5(a) Composition

The Credentials Committee shall be composed of three (3) representatives from the Active Medical Staff as appointed by the Chief of Staff. The Hospital's Executive Director shall attend on an ex-officio basis without vote.

12.5(b) Functions

The purpose of the Credentials Committee is to review information provided by applicants for appointment and/or reappointment to the Medical Staff and/or Affiliated Health Professionals, and for the granting or revising of clinical privileges. The Credentials Committee shall make recommendations regarding these and other related issues to the MEC for consideration.

12.5(c) Meetings

The Credentials Committee shall meet at least one time per year and on an as needed basis to allow proper functioning of the business of the Medical Staff.

ARTICLE XIII
MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be held in September, at a date, time and place determined by the MEC.

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the Executive Director or his/her designee, the Chief of Staff and appropriate Service Chiefs;

(3) The election of officers and other officials of the Medical Staff when required by these Bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

13.2 REGULAR STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet quarterly with the last meeting each year to be designated as the Annual Staff Meeting. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular Medical Staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

13.2(c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the Chief of Staff or Committee Chairperson and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular

Medical Staff meeting has not otherwise been announced, the Chairperson of the MEC or his/her designee shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

The voting members of the Active Staff who are present at any Medical Staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) Committee Meetings

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except that the MEC and Performance Improvement Committee shall require fifty (50%) percent of members to constitute a quorum.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Members of the Medical Staff are encouraged to attend the regular and special meetings of the Medical Staff as well as the meetings of those departments and committees of which they are members.

13.7(b) Special Appearance; Cooperation with Medical Executive Committee

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the Practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the Practitioner. When such special notice is given, it shall include a statement of the issue involved and that the Practitioner's

appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the Practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV
GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each Medical Staff member or affiliate in the Hospital. Such rules and regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

14.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

14.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

14.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in Section 14.1(b) of this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 PROFESSIONAL LIABILITY INSURANCE

Each Practitioner granted clinical privileges in the Hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto; or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the Hospital and shall be on an occurrence basis or, if on a claim made basis, the Practitioner shall agree to obtain tail coverage covering his/her practice at the Hospital. Each Practitioner shall also inform the MEC and Executive Director of the details of such coverage annually. He/She shall also be responsible for advising the MEC and the Executive Director of any change in such professional liability coverage.

14.3 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the Executive Director or his/her designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.4 CONSTRUCTION OF TERMS & HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these Bylaws.

14.5 TRANSMITTAL OF REPORTS

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the Executive Director or his/her designee.

14.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.6(a) Reports to be Confidential

Information with respect to any Practitioner, including applicants, Medical Staff members or AHPs, submitted, collected or prepared by any representative of the Hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

14.6(b) Release from Liability

No representative of the Hospital, including its Board, Executive Director, administrative employees, Medical Staff or third party shall be liable to a Practitioner or AHP for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Board, Executive Director or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a Practitioner or AHP who is or has been an applicant to or member of the Medical Staff, or who has exercised clinical privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

14.6 (c) Actions in Good Faith

The representatives of the Hospital, including its Board, Executive Director, administrative employees and Medical Staff shall not be liable to a Practitioner or AHP for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

15.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and rules and regulations will be revised to reflect changes in regulatory requirements, corporate and Hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written notice, accompanied by the proposed Bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

15.2(b) Board

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular Medical Staff meeting (or at a special called meeting as provided in these Bylaws), and shall advise the Medical Staff of the basis for its action in this regard.

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the Executive Director, the Chairperson of the Board and approved by corporate legal counsel as to form; or

15.3(b) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, the Executive Director and the Chairperson of the Board approved by corporate legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these Bylaws in a timely manner.

MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____ _____
Chief of Staff Date

MUSC HEALTH BLACK RIVER MEDICAL CENTER BOARD:

By: _____ _____
Chairperson Date

MUSC HEALTH BLACK RIVER MEDICAL CENTER:

By: _____ _____
Executive Director Date

APPROVED AS TO FORM:

By: _____ _____
Legal Counsel for MUSC Health Date

Medical Staff Documents for the
MUSC Health Regional Healthcare Network Unified Medical Staff
December 9, 2022

Requesting Board approval:

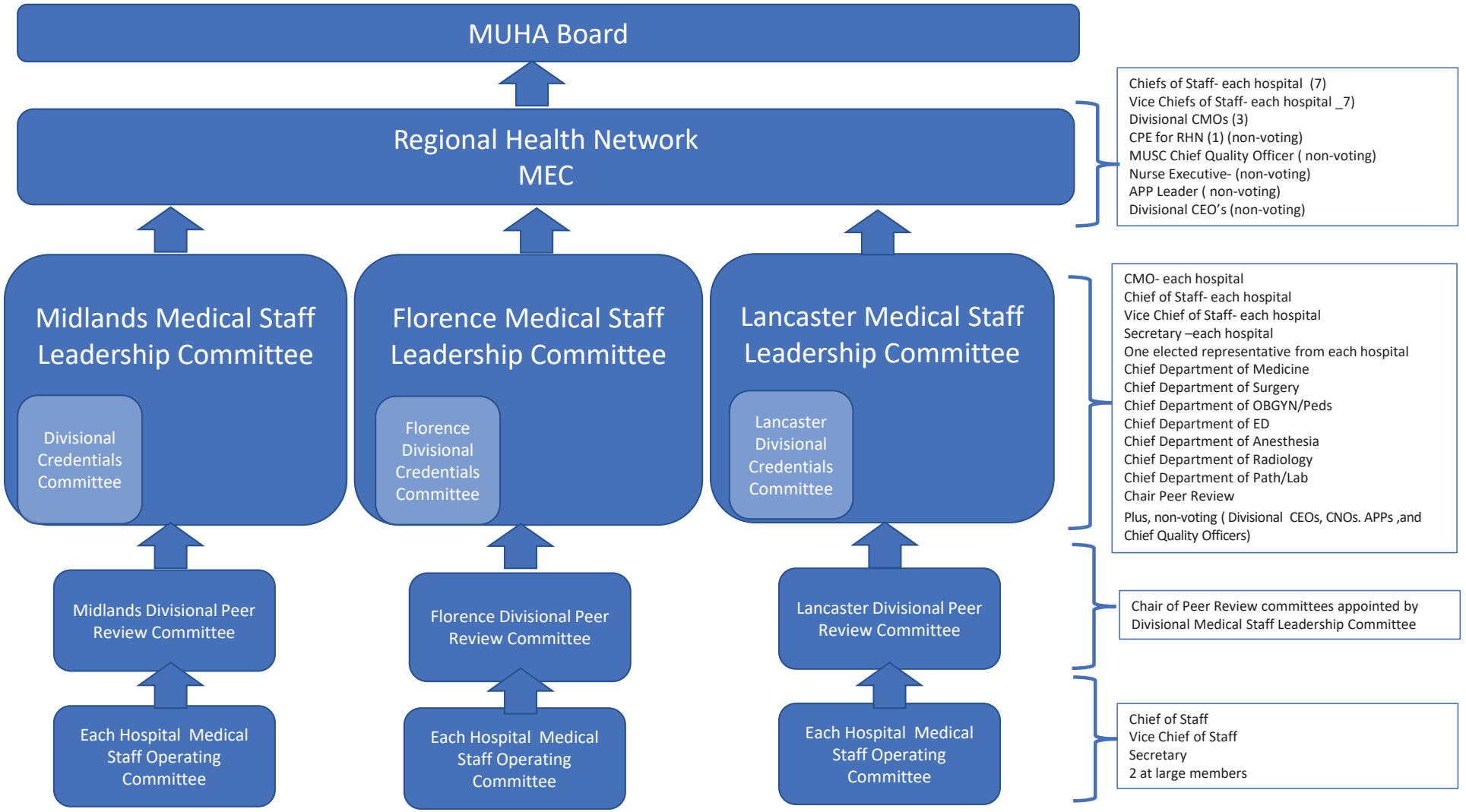
- Unified Bylaws
- Credentials Manual.
- Rules and Regulations
- Fair Hearing Plan

One common set of Bylaws, Credentials Manual, Rules and Regulations, and Fair Hearing Plan

- One MEC
- Centralized credentialing - streamlined and standardized requirements
- Standard delineations of privileges across hospitals when possible. Physicians can have privileges at more than one facility
- Identical policies for peer review, medical record delinquency, physician wellness, and professional conduct
- Increase efficiencies in approval processes when implementing policies, safety initiatives, and clinical protocols.
- More efficient sharing of knowledge and innovations among medical staff members
- Better physician on-call coverage for specialties
- Consistency with the move toward accountable care organizations and modern care delivery systems
- More efficient coordination of emergency preparedness and community health planning.

RHN Medical Staff Structure Chart is attached.

RHN Medical Staff Structure



MUSC HEALTH REGIONAL HEALTH NETWORK

UNIFIED MEDICAL STAFF BYLAWS

MUSC Health Florence Medical Center

MUSC Health Marion Medical Center

MUSC Health Black River Medical Center

MUSC Health Lancaster Medical Center

MUSC Health Chester Medical Center

MUSC Health Columbia Medical Center Downtown

MUSC Health Columbia Medical Center Northeast

MUSC Health Kershaw Medical Center

TABLE OF CONTENTS

DEFINITIONS

1. "Affiliated Health Professional" or "AHP" means a credentialed individual, other than a physician, dentist, or podiatrist, who is qualified to render direct or indirect medical or surgical care in collaboration with a physician who has been afforded Clinical Privileges to provide such care in the Medical Center. For such purposes of these Medical Staff Bylaws, "AHP" shall be deemed to refer only to advanced practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, physician assistants ("PA-C"), advanced practice registered nurses ("APRN"), certified registered nurse anesthetists ("CRNA"), and other such professionals. For purposes of these Bylaws, "Affiliated Health Professional" shall not be deemed to include those non-credentialed individuals ("Clinical Assistants" pursuant to applicable Medical Center policy) whose appointment and competencies are handled outside the Medical Staff process. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications, licensure, and approved written practice agreement for APRNs or written scope of practice guidelines for PA-Cs.

2. "Board" means the Board of Trustees of Medical University Hospital Authority.

3. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other applicable specialty boards.

4. "Chief Executive Officer" or "CEO" means the individual designated by the Board to provide for the overall management of the Medical Center or his/her designee.

5. "Chief Medical Officer" or "CMO" means the individual serving as the executive administrative medical leader of each Medical Center and/or Division or his/her designee.

6. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of this Medical Center or his/her designee.

7. "Clinical Privileges" means the Board's recognition of the Practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services..

8. "Credentials Policy Manual" means the procedure adopted by the Medical Staff to approve and extend a Practitioner's Clinical Privileges at each MUSC Health Medical Center. The Credentials Policy Manual is incorporated into these Bylaws and is contained in Appendix B hereto.

9. "Data Bank" means the National Practitioner Data Bank (or any state designee thereof) established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

10. "Department" means the major clinical departments at each Medical Center as further defined in Article VIII.

11. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

12. "Division" means a group of Medical Centers in a specific geographic area of the State of South Carolina. Divisions may be expanded by the addition of new Medical Centers within MUHA or may be decreased by the subtraction of Medical Centers that cease to be a part of MUHA.

13. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

14. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a Practitioner's Clinical Privileges are adversely affected by a determination based on the Practitioner's professional conduct or competence.

The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix A hereto.

15. "Medical Center" means any of the MUHA hospitals and their provider-based clinics that have opted in to these Unified Medical Staff Bylaws.

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

17. "Medical Staff" means the formal organization of practitioners who have been granted Clinical Privileges by the Board to attend patients in the Medical Center(s).

18. "Medical Staff Bylaws" or "Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations; Fair Hearing Plan and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

19. "Medical Staff Leadership Committee" or "MSLC" means the divisional Medical Staff committee further described in Section 9.03 of these Bylaws.

20. "Medical Staff Operating Committee" or "MSOC" means the Medical Center committee further described in Section 9.04 of these Bylaws.

21. "Medical Staff Rules & Regulations" or "Rules & Regulations" means the MUSC Health Medical Center Rules & Regulations duly adopted by the Medical Staff and approved by the Board.

22. "Medical Staff Year" means January 1 through December 31 of the same year.

23. "Member" means a practitioner who has been granted Medical Staff membership and Clinical Privileges pursuant to these Bylaws.

24. "Medical University Hospital Authority" or "MUHA" means the South Carolina state authority that owns and operates the Medical Centers, clinics, and other health-care related facilities.

25. "MUSC Health Regional Health Network" means all of the Medical Centers owned and operated by MUHA other than the MUSC Health University Medical Center in Charleston, South Carolina.

26. "Peer Review Policy" means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Practitioners with delineated Clinical Privileges, evaluate the competence of Practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix D hereto and can be referenced at https://musc.policytech.com/docview/?docid=7251.

27. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in South Carolina.

28. "Practitioner" means an appropriately licensed physician, dentist, podiatrist, Affiliated Health Professional, including APRN, PA-C and CRNA, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice who has been granted Clinical Privileges at the Medical Center(s).

29. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Medical Center and Medical Staff policies.

30. "Unified and Integrated Medical Staff" means a single Medical Staff formed from a recommendation by the Board and acceptance by a majority vote of the members of the Medical Staffs at each of the Medical Centers.

Article I. PURPOSE AND RESPONSIBILITIES

Section 1.01 PURPOSE

Provisions shall be made in these Bylaws or by resolution of the Medical Executive Committee, approved by the Board, either through assignment to Departments, to Medical Staff committees, to Medical Staff Officers or officials, or to interdisciplinary hospital committees, for the effective performance of the Medical Staff functions specified in this Section and described in Medical Staff Policies, and such other Medical Staff functions as the Medical Executive Committee or the Body shall reasonably require.

The purpose of the Unified and Integrated Medical Staff of MUSC Health Regional Health Network is to bring the professionals, who practice at the Medical Center(s) together into a self-governing cohesive body, to:

a. Provide oversight of quality of care, treatment, and services to patients of the Medical Centers.

b. To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation, and professional support) may be obtained and the obligations of staff membership may be fulfilled.

c. Determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership

d. Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilitiesfor non-member practitioners with independent privileges.

e. Review new and on-going privileges of Medical Staff members and Affiliated Health Professionals who, while not members of the Medical Staff, have Clinical Privileges.

f. Provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Medical Centers shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other Quality Assessment Performance Improvement (QAPI) activities in accordance with the Medical Centers' QAPI program.

g. Conduct peer review for Practitioners as defined and outlined in the Peer Review Policy.

h. Approve and amend Medical Staff Bylaws, credential requirements, and Rules and Regulations.

i. Provide a mechanism to create a uniform standard of care, treatment, and service.

j. Evaluate and assist in improving the work done by the staff and to provide education and offer advice to the CEOs of the Medical Centers.

Section 1.02 MEDICAL STAFF RESPONSIBILITIES

The organized Medical Staff is also responsible for:

a. Ongoing evaluation of the competency of Practitioners who are privileged.

b. Delineating the scope of Clinical 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 Clinical Privileges.

e. Selecting and removing Medical Staff officers.

f. Developing, adopting, reviewing, amending, monitoring, and enforcing compliance with these Bylaws, the Medical Staff(s) policies governing medical practices, and other Medical Staff policies necessary for the proper functioning of the Medical Staff and the integration and coordination of Medical Staff members with the functions of the Medical Center (s).

g. Communicating with and accounting to the Board for the quality of medical care provided to Medical Center's patients, assisting the Board by serving as a professional review body, and cooperating with the Board, Medical Center administration, and Medical Center staff to resolve conflicts regarding issues of mutual concern.

h. Accomplishing its goals through appropriate committees, departments, and services.

Section 1.03 MUSC HEALTH FACILITIES ARRANGEMENTS

MUHA owns and operates multiple health care facilities. The unified Medical Staff acknowledges that the difference in scope of services among these facilities may necessitate adoption of policies, and procedures applicable on a Medical Center-specific basis. However, wherever possible, the unified desire of the Medical Staff is to consolidate resources, to standardize policies andprocedures, to minimize unnecessary variance in operations to promote their maximum efficiency and effectiveness, and to facilitate a comparably high standard of care at all the Medical Centers, while at the same time accommodating the uniqueness of each Medical Center and its practice culture.

MUHA may enter arrangements with other MUSC Health affiliated clinical entities (e.g., other MUSC Health owned Medical Centers, surgery centers, or their successor entities.) for the purpose of sharing information relevant to the activities of the medical staff and individual medical staff members. Such arrangements may include, without limitation, sharing of credentialing and peer review information between MUSC Health affiliated clinical entities, and participation in joint committees among MUSC Health affiliated clinical entities to address credentialing, privileging, peer review, and performance improvement matters. In addition, the Medical Staff may rely on Medical Center Medical Staff or professional staff support resources to assist in the processing of applications for appointment, reappointment, and Clinical Privileges. The Medical Staff may collaborate with other MUSC Health affiliated clinical entities and the Board to develop coordinated, cooperative, or joint corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, notice of corrective actions imposed and/or recommended, and coordinated hearings and appeals.

Article II. BILL OF RIGHTS

Section 2.01 MEDICAL STAFF MEMBER RIGHTS

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 Clinical Privileges will cause the Department Chief 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 Chief as time permits. Members can petition the Medical Executive Committee for a specific agenda item or issue.

c. Right of Information - Activities of the various committees (except for peer review proceedings)may be reviewed by the Members in the Medical Staff office. The MEC will provide to the active membership all changes to the Bylaws, 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 andat 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 Clinical 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 MUSC Health Medical Centers Medical Staff 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 MUSC Health Medical Centers.

Section 3.02 QUALIFICATIONS FOR MEMBERSHIP

a. Only physicians with Doctor of Medicine (MD) Doctor of Osteopathy (DO) degrees, or equivalent foreign medical degree such as MBBS, or Dentists or Podiatrists (DPM) holding a current, valid academic license or 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 that any patient treated by them in the Medical Centers will receive 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 any MUSC Health Medical Centers 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. After the Effective Date of these Medical Staff Bylaws, any new applicant for MD, DO, MBBS, DPM or Dentist membership shall be eligible for or have obtained board certification and comply with individual board requirements in his/her respective medical or dental specialty board at the time of appointment. Any members of the Medical Staff prior to the Effective Date of these Bylaws shall not be required to meet this standard. 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, or longer if allowed for the applicant's specialty as detailed in the ABMS Member Boards Eligibility Periods and Transition Dates (rev July 2021) may be allowed an applicant from the time of completion of his/her residency or fellowship to obtain initial board certification, or, if an alternative pathway for board certification is allowed for the applicant's specialty, a grace period commensurate with the alternative pathway timeframe. Board recertification and maintenance certification should be in accordance with the criteria established by the applicable specialty and/or in accordance with the criteria established by the applicable specialty and/or subspecialty board. Satisfaction of all maintenance criteria will be assessed at reappointment. If no criteria applicable, recertification must be obtained within two (2) years following

any expiration of certification. Failure to achieve or maintain board certification within the time frames required herein may be grounds for revocation and/or denial of Medical Staff membership to be determined by the Medical Executive Committee and Board. In special cases, for recertification, 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 Chief in the department in which they are assigned, and the Department Chief has attested either in a written or oral format to the divisional Medical Staff Leadership Committee and the MEC for approval. Waiver of board certification requirement can be granted when no board specialty exists, and the Department Chief 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 Medical Staff Leadership Committee may choose to accept or reject such certification. In the event the certification is rejected, the Department Chief may petition the MEC for approval.

f. Maintain malpractice insurance as specified by the MEC, MUSC Health Medical Centers and Board.

g. Maintain Federal DEA and State DHEC license/certification where applicable.

Section 3.03 **NON-DISCRIMINATION**

The MUSC Health Medical Centers will not discriminate in granting staff appointment and/or Clinical Privileges on the basis of age, sex, race, creed, color, nationality, gender, sexualorientation, 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 MUHA Board.

b. The Board 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 theCredentials Policy Manual.

c. Appointments to the staff will be for no more than twenty-four (24) calendar months.

d. Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Board.

e. Only those practitioners assigned to the Active Medical Staff have general Medical Staff voting privileges.

f. 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 **CONTRACT SERVICES**

The Clinical Privileges of any Practitioner who has a contractual or employment relationship with an entity other than MUHA to provide professional services to patients shall be subject to those provisions contained in said contract regarding the termination of Medical Staff membership and Clinical Privileges upon the expiration, lapse,

cancellation, or termination of the contract. If no provisions for termination of membership or Clinical Privileges are contained in the contract, the affected Practitioners' membership and Clinical Privileges will be terminated at the time ofthe contract termination, lapse, expiration or cancellation date. The affected Practitioners shall have no right to a hearing regarding termination of Medical Staff membership or Clinical Privileges.

Section 3.06 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 Clinical 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 Chief, the Medical Staff organization will evaluate and make recommendations to the Board. Clinical 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 Clinical Privileges. For new procedures and at the time of reappointment, Members' requests for Clinical Privileges will be subject again to the procedures and associated details outlined in the Credentials Policy Manual.

b. Initial appointment and reappointment and Clinical Privileges shall be granted for a specific period not to exceed two (2) years upon final approval of the Governing Body.

c. The privilege to admit patients to a Medical Center shall be specifically delineated. Prescribing privileges shall be limited to the classes of drugs granted to the Applicant by the DEA and the Applicant's scope of practice and current competence.

d. When considering Clinical Privileges for a new practitioner, current data should be collected during the provisionaltime period for those Clinical Privileges selected by the Department Chief.

e. Prior to the granting of a Clinical Privilege, the Department Chief determines the resources needed for each requested Clinical Privilege 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 resources. The Department Chief will work with Medical Center(s) to ensure resources are available.

f. At the time of appointment and reappointment, each candidate applying for Clinical 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

g. 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 Clinical Privileges

h. Ongoing Professional Practice Evaluation (OPPE) is designed to continuously evaluate a Practitioner's professional performance. It allows potential problems to be identified and 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 Chief Medical Officers (CMOs), APP Best Practice Center and Chief Quality Officers. Information from ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing Clinical Privileges.

Section 3.07 TEMPORARY, DISASTER, AND EMERGENCY PRIVILEGES

a. Temporary Privileges - Important Patient Care Need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Department Chief and pending MEC review and Board approval. "New applicant" includes an individual applying for Clinical Privileges at the Medical Center for the first time and an individual currently holding Clinical Privileges who is requesting one or more additional Clinical Privileges. In these cases only, the CEO or his/her designee, upon recommendation of the Medical Center Chief of Staff may grant such Clinical Privileges upon establishment of current competence for the Clinical Privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the Practitioner has not been subject to involuntary termination of medical staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of Clinical Privileges at another facility. Such privileges may be granted for no more than one hundred twenty (120) days of service.

b. Temporary Privileges—Important Patient Care Need—No Pending Application

Temporary privileges may be granted by the CEO upon recommendation of the Medical Center Chief of Staff when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for Medical Staff membership or Clinical Privileges is pending. Upon receipt of a written request, an appropriately licensed person who is

serving as a substitute for a Member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service within a calendar year. All practitioners providing coverage for other practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted. Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute practitioner shall, where possible, advise the Medical Center at least thirty (30) days in advance of the identity of the practitioner and the dates during which the services will be utilized to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

c. Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such Practitioner be admitted upon dual admission with a member of the Active Staff.

d. Before temporary privileges are granted, the Practitioner must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, and Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

e. A Practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary privileges or because of any termination or suspension of such privileges.

f. Proctoring privileges- Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a Member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) days. The Data Bank query must be completed

prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases, only, the CEO or his/her designee, upon recommendation of the Chief Medical Officer or Chief of the Credentials Committee may grant such privileges upon receipt of the required information.

g. No term of temporary or proctoring privileges shall exceed a total of one hundred and twenty (120) days.

h. On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Practitioner's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Medical Center Chief of Staff terminate any or all of such Practitioner's temporary privileges.

i. Disaster Privileges - Disaster privileges may be granted by the Division CEO, or the Division Chief Medical Officer, according to Medical Center Policy C-035 Disaster Privileges for Licensed Independent Practitioners, when the Emergency Management Plan for the Medical Center(s) has been activated and when the Medical Center(s) cannot handle the needs of patients with just the available credentialed staff. The Department Chief 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 Chief is responsible for reviewing the continuation of disaster privileges within 72 hours of granting the disaster privileges.

j. 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.

    (i) In the case of an emergency any practitioner, to the degree permitted by his license and regardless of Medical 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 Chief.

    (ii) Under conditions of extreme patient risk, the Chief of the Medical Staff, the Division Chief Medical Officer, the appropriate Department Chief, Credentials Committee Chairperson, or the Division CEO (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 Medical 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 Chief or his/her designee to which he/she is assigned.

Section 3.08 **LEAVE OF ABSENCE**

Any Member may apply to the Medical Staff Leadership Committee for a leave of absence not to exceed one (1) year. Reinstatement of privileges may be requested from the Medical Staff Leadership 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 Chief or Medical Center Chief of Staff through the MSLC 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 (2) year re-appointment cycle.

Section 3.09 **RESPONSIBILITIES OF MEMBERSHIP**

Each Medical Staff Member will:

a. Provide timely, appropriate and continuous care/treatment/services for his/her patients and supervise the work of any AHP or trainee under his/her direction when appropriate.

b. Assist the MUSC Health Medical Center(s) in fulfilling its responsibilities by participating in the on-call coverage of the emergency room and other coverage as determined by the individual Medical Centers' MSOC.

c. Assist other Practitioners in the care of his/her patients when asked.

d. Act in an ethical and professional manner. Acceptance of membership and/or request for Clinical Privileges on the Medical Staff shall constitute the agreement that they will strictly abide by: all applicable laws and regulations of the United States and the State of South Carolina, the Principles of Medical Ethics of the American Medical Association, the Principles of Medical Ethics of the American Osteopathy Association, the Code of Ethics of the American Podiatric Medical Association, or the Code of Ethics of the American Dental Association and the Code of Conduct of MUSC Health.

e. Treat employees, patients, visitors, and other Practitioners 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 according to the MUSC Health Peer Review Policy.

h. Abide by the bylaws, rules and regulations, department rules, and other policies and procedures of MUHA. This includes participating in focused professional practice evaluation (FPPE), performance monitoring, performance improvement, and ongoing professional practice evaluation (OPPE) as required by the Medical Staff.

i. Abide by all standards from regulatory bodies. (i.e., The Joint Commission, DHEC and others)

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

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

Act.

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

m. Discharge such department and committee functions or office for which they are responsible by appointment or election.

n. Prepare and complete in a timely and legible manner the medical and other required records for all patients they admit or otherwise provides care to in a Medical Center.

Section 3.10 RESPONSIBILITIES OF MEMBERSHIP - ATTENDING PHYSICIANS

a. Hospitalized patients shall be seen by the attending physician or his/her designated credentialed provider at least daily and more frequently if their status warrants. Attendings will also see patients at the patient's request.

b. Hospitalized surgery patients or out-patients receiving moderate sedation or greater shall be seen by the attending physician at least once within the first 24 hours post-surgery. Outpatients may be seen by the attending surgeon during the recovery period.

Article IV. CATEGORIES OF THE MEDICAL STAFF

Section 4.01 ACTIVE CATEGORY

a. Qualifications – An appointee to this category must:

(i) Be involved on a regular basis in patient care delivery at the MUSC Health Medical Centers and annually provide the majority of his/her services/activities within the MUSC Health Medical Centers; or

(ii) Each divisional Chief Medical Officer shall be a Member of the active Medical Staff.

b. Prerogatives – An appointee to this category may:

(i) Exercise the Clinical Privileges granted without limitation, except as otherwise provided in the MedicalStaff Rules and Regulations, or by specific Clinical 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 appropriate MUSC Health 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-074 Resident Supervision.

(iv) Participate in the emergency room and other specialty coverage programs in their primary Medical Center or Division as set forth in each Medical Center's on-call policy as approved by the MSOC, each of which shall be incorporated herein by reference. The Active Staff member may be required to provide Emergency Department coverage at their primary Medical Center or Division and to accept assignment of patients that do not have an attending physician.

(v) Participate in focused professional practice evaluations to establish competency for Clinical Privileges requested as necessary.

d. Removal - Failure to satisfy the requirements for activity for the MUSC Health Medical Center(s), as deemed by the MSLC or the MEC during the appointment period will result in automatic transfer to Courtesy Category.

Section 4.02 COURTESY CATEGORY

a. Qualifications – An appointee to this category must:

(i) Participate in the clinical affairs of the MUSC Health Medical Centers

(ii) Be involved in the care or treatment of at least six (6) patients of the MUSC Health Medical Center(s) or clinics during his/her appointment period, or

(iii) Refer patients to other physicians or staff of the MUSC Health Medical Center (s) or those who order diagnostic or therapeutic services at the MUSC Health Medical Center (s).

(iv) Do not admit or regularly participate in the care of more than 25 patients in a calendar year. Should a Practitioner exceed the 25-patient encounter threshold, he/she shall automatically advance to Active Staff status for the remainder of the calendar year and must abide by the Prerogatives and responsibilities outlined in Section 4.01

(v) Physicians who meet the following criteria shall not be subject to the aforementioned 25 patient encounter limitation: (i) the physician provides a service that is not otherwise available at the Medical Center; and (ii) the physician's primary practice is located outside of the community.

(vi) The MSLC may waive the requirement to care for at least six (6) patients during an appointment period for physicians who are members in good standing with another MUSC Health affiliated Medical Center and who continue to meet the qualifications for appointment to the Courtesy Staff of MUSC Health. Additionally, this exception would only occur if physician specific quality and outcomes information has been provided by the affiliated Medical Center upon request. Such information shall be sufficient quality and quantity to allow a reappointment and privileging recommendation by the Credentials Committee.

b. Prerogatives

(i) An appointee to this category may exercise the Clinical Privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege exception.

(ii) Attend meetings of the Staff and Department to which he/she is appointed and any MUSC Health education programs.

(iii) Request admitting privileges.

c. Responsibilities

(i) Discharge the basic responsibilities specified in Section 3.09.

(ii) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for who he/she is providing service.

(iii) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

(iv) Participate in the emergency department on-call rotation as directed by the MEC and Board when there is an inadequate number of current Active Staff members to address an important patient coverage need, as determined by the MEC and Board. Any unassigned patient encounters incurred as a result of and while participating on the emergency department on-call rotation as assigned by the MEC and Board shall not count toward the patient encounter limitation described in Section 4.02 (a.iv).

d. Removal – Failure to satisfy the requirements for activity for the MUSC Health Medical Centers, as deemed by the MSLC, during the appointment period will result in automatic transfer to the Consulting category.

Section 4.03 CONSULTING CATEGORY

a. Qualifications: Consulting Staff shall consist of a special category of physicians, dentists, or podiatrists, each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.
b. Prerogatives of a Consulting Staff member shall be to consult on patients within his/her specialty to the extent he/she holds delineated Clinical Privileges to do so; and attend all meetings of the Medical Staff that he/she may wish to attend as a non-voting visitor.
c. Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.
d. Consulting Staff members must have fewer than fifteen (15) encounters in which they manage direct patient care.
e. For Consulting Staff members who have their primary practice outside the community, such members may provide or manage direct patient care, within the scope of their granted Clinical Privileges, in an unlimited number of cases, where there is, as determined by the Board in consultation with and on the recommendation of the Medical Executive Committee, an otherwise unfulfilled community need for the services to be provided by the particular Consulting Staff member.
    i. A determination by the Medical Executive Committee and/or Board that there is not an unfulfilled community need for the services of a particular Consulting Staff member shall not be subject to appeal nor entitle the member to any of the procedural rights under these Bylaws.
    ii. Consulting Staff members whose primary practice is located in the community, and who exceed the accepted number of encounters referenced above must transfer to Active Staff and meet all the requirements as outlined in Section 4.01
f. Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

Section 4.04 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 or administrativeappointments and no Clinical Privileges.

a. Such staff appointees are not eligible to admit patients to the MUSC Health Medical Centers, 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 Health Medical Centers 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 Health Medical Centers and reduction or termination in Clinical Privileges.

Section 4.05 RURAL HEALTH CLINIC (RHC) /AMBULATORY CATEGORY

a. Qualifications - The RHC staff shall consist of physicians, dentists, or podiatrists, who meet the basic qualifications for Medical Staff membership set forth in these Bylaws and who are currently providers in an MUSC Health Rural Health Care Clinic.

b. Prerogatives - The RHC member may refer his or her patients for admission to the Medical Center for care by another physician unless otherwise privileged. The referring physician may visit the patient and provide follow-up care, exercise such clinical privileges as are granted and may attend meetings of the Medical Staff and any Medical Staff or Medical Center education programs. Members of this category may not vote unless assigned to a standing committee and do not have call responsibility.

c. Responsibilities - The RHC Member shall discharge the basic responsibilities of membership and retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Rural Health Clinic for who he/she is providing service. The RHC staff participate in performance improvement and quality activities of the Medical Center sufficient to evaluate outcomes.

Section 4.06 NON-MEMBER CATEGORIES

a. House Staff/Residents -The House Staff consists of those practitioners, who by virtue of a contract, are in the post-graduate training program at the Medical University of South Carolina. House Staff are not eligible to hold a Medical Staff office and are not eligible to vote unless otherwise indicated in these Bylaws. Only practitioners who are graduates of an approved, recognized medical, osteopathic or dental school, who are legally licensed to practice in the State of South Carolina and who, continue to perform and develop appropriately in his/her training are qualified for assignment to the House Staff. The Chief of the House Staff member's department and the Associate DIO for the respective Division will be responsible for monitoring performance and will notify the MSLC of any change in status.

b. Professional Staff – Members of the Professional Staff are those AHPs who are not a licensed MD, DO or Dentist, and who, although not Members of the Medical Staff, are credentialed through the Medical Staff process as described in the Credentials Manual.

c. Telehealth Practitioners- Any Practitioner who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Medical Center through a telehealth procedure (the "Telehealth Physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws and associated Credentials Manual. The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telehealth, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards. An exception is outlined in the Credentials Manual below for those circumstances in which the Practitioner's distant-site entity or distant-site hospital is Joint Commission accredited and the Medical

Center places in the Practitioner's credentialing file a copy of written documentation confirming such accreditation.

Section 4.07 **MODIFICATION IN STAFF CATEGORIES AND CLINICAL PRIVILEGES**

a. The MSLC may recommend to the MEC, and then the MEC may recommend to the Board, that a change in staff category of a current Medical Staff Member be made in accordance with this Article 4. In the event the Practitioner is not eligible for any other category, his/her Medical Staff membership shall automatically terminate.

b. No such transfer or termination shall be subject to the provisions of the Fair Hearing Process.

Article V. OFFICERS OF MEDICAL CENTER MEDICAL STAFF

Section 5.01 OFFICERS OF THE MEDICAL STAFF

There shall be officers elected at each Medical Center within the MUSC Health Regional Health Network. The officers shall include:

a. Chief of Staff

b. Vice Chief of Staff

c. Secretary

Section 5.02 QUALIFICATIONS OF OFFICERS

Officers must be members of the Active Medical Staff at thetime 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 then current Chief of Staff at the meeting prior to biennial elections to nominate a Secretary or other officers if vacant.

a. The Nominating Committee shall present a list of names for consideration to the Medical Staff at its annual meeting or at a called 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. Officers at the time of the passing of these Bylaws shall serve until the first day of the immediate next calendar year when new officers are selected as outlined in Section 5.03.

Section 5.05 VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year, except the Chief of Staff, shall be filled by vote of the local Medical Center Medical Staff. If there is a vacancy in the office of Chief of Staff, the Vice Chief shall serve the remainder of the term.

Section 5.06 DUTIES OF OFFICERS

a. Chief of Staff -The Chief of Staff shall serve as the chief officer of the Medical Staff and will fulfill the following duties:

- Aid in coordinating the activities of the Medical Center administration and of nursing and other non-physician patient care services with those of the Medical Staff;

- be responsible to the MSLC for the quality and efficiency of clinical services and professional performance within the Medical Center and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff;
- work with the MEC, MSLC and/or Board in implementation of the MEC, MSLC, and/or Board's quality, performance, efficiency and other standards;
- in concert with the MSLC and Departments, support development and implementation of methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;
- participate in the selection or appointment of Medical Staff representatives to Medical Staff and Medical Center administration committees;
- report to the MSOC, MSLC, the Division CEO, and Division CMO concerning the opinions, policies, needs and grievances of the Medical Staff;
- be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;
- serve as chairperson of the MSOC;
- serve as liaison for the Medical Center Medical Staff in its external professional and public relations;
- confer with the Division CEO, CMO, COO, CFO, CNO and Department on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each Clinical Privilege requested by applicants to the Medical Staff and report on the same to the MSLC; and
- assist the Department Chiefs as to the types and amounts of data to be collected and compared in determining and informing the Medical Center Medical Staff of the professional practice of its Members.

b. Vice Chief of Staff - In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. He/she shall perform such further duties to assist the Chief of Staff as the Chief of Staff 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 serve as the local liaison for medical staff peer review activities. The Vice Chief of Staff will serve as the Chief of Staff-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 Vice Chief elect.

Section 5.07 **REMOVAL FROM OFFICE**

a. The Medical Staff and/or Board may remove any Medical Staff Officer for failure to fulfill his/her responsibilities, conduct detrimental to the interests of the MUSC Medical Centers and/or the Medical Staff, or a physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the office.
b. Removal from elected office shall not entitle the Practitioner to procedural rights.
c. 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 Medical Staff and be presented to the Medical Staff Leadership Committee. Upon presentation, the MSLC will schedule a general Medical Staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote.
d. Any Medical Staff Officer may resign at any time by giving written notice to the Medical Executive Committee.

ARTICLE VI. MEDICAL STAFF OFFICERS OF THE DIVISIONAL MEDICAL STAFF LEADERSHIP COMMITTEE

Section 6.01 OFFICERS

The Officers of each Divisional MSLC shall be:

a. Divisional Chief of Staff
b. Divisional Vice Chief of Staff
c. Divisional Secretary /Vice Chief elect

Section 6.02 QUALIFICATIONS OF DIVISIONAL 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. They must constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees and demonstrate an interest in maintaining quality patient care at the Medical Centers

Section 6.03 SELECTION OF DIVISIONAL OFFICERS

The MSLC members shall vote for MSLC Officers nominated from among the current MSLC members. MSLC Officers shall be elected every other year at a meeting of the MSLC (or via electronic voting if applicable) and shall be confirmed by the Governing Body.

Section 6.04 TERM OF OFFICE OF DIVISIONAL OFFICERS

All MSLC Officers shall take office on the first day of the calendar year and serve a term of two years.

Section 6.05 VACANCIES IN DIVISIONAL OFFICE

Vacancies in an office during an MSLC Officer's two (2) year term shall be filled by the vacancies in office during the Medical Staff year, except the Divisional Chief of Staff shall be filled by vote of the MSLC of the division. If there is a vacancy in the Office of the Divisional Chief of Staff, the Divisional Vice Chief shall serve the remainder of the term.

Section 6.06 DUTIES OF DIVISONAL OFFICERS

a. Chief of Staff -The Chief of Staff shall serve as the chief administrative officer of the MSLC and will fulfill the following duties for the MSLC:

   i. Aid in coordinating the activities of the Medical Center administration and of nursing and other non-physician patient care services with those of the Medical Staff;
   ii. With the local Medical Center Chiefs of Staff, be responsible to the MSLC for the quality and efficiency of clinical services and professional performance within the Division Medical Centers and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff;
   iii. Work with the MEC, MSLC and/or Board in implementation of the MEC, MSLC, and/or Board's quality, performance, efficiency and other standards;
   iv. In concert with the MSLC, MSOCs, and Departments, support development and implementation of methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation

studies;

v. Participate in the selection or appointment of Medical Staff representatives to Medical Staff and Medical Center administration committees;

vi. report to the MSLC, MEC, the Division CEO and Division CMO concerning the opinions, policies, needs and grievances of the Medical Staff;

vii. be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

viii. serve as chairperson of the MSLC;

ix. serve as liaison for the Medical Center Medical Staff in its external professional and public relations;

x. confer with the Division CEO, CFO, COO, CNO and Department on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each Clinical Privilege requested by applicants to the Medical Staff and report on the same to the MSLC; and

xi. assist the Department Chiefs as to the types and amounts of data to be collected and compared in determining and informing the Division Medical Staff of the professional practice of its Members.

b. Vice Chief of Staff- In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. He/she shall perform such further duties to assist the Chief of Staff as the Chief of Staff may, from time-to-time request, including the review and revision of Bylaws as necessary, supervision of the divisional Medical Centers' quality, patient safety, and resource utilization programs. The Vice Chief of Staff will serve as the Chief of Staff-Elect.

c. Secretary -The Secretary shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all MSLC meetings. The secretary serves as the Vice Chief elect.

Section 6.07 REMOVAL FROM OFFICE

a. The Medical Staff of the Division and/or the Board may remove any divisional MSLC officer for failure to fulfill his/her responsibilities, conduct detrimental to the interests of the MUSC Medical Centers within the Division and/or the Medical Staff, or a physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the office.

b. Removal from elected office shall not entitle the Practitioner to procedural rights.

c. Any Medical Staff member within the division has the right to initiate a recall election of a Divisional 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 Medical Staff Leadership Committee. Upon presentation, the MSLC will schedule a general Divisional Medical Staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote.

d. Any Divisional MSLC Officer may resign at any time by giving written notice to the Medical Executive Committee.

ARTICLE VII. MEDICAL STAFF OFFICERS OF THE UNIFIED MUSC HEALTH REGIONAL HEALTH CARE NETWORK

Section 7.01 MEDICAL STAFF OFFICERS OF THE UNIFIED MUSC HEALTH REGIONAL HEALTH CARE NETWORK

The officers of the MUSC Health Regional Health Care Network Medical Staff ("RHN Officers") shall be:

a. President
b. Vice President
c. Vice President Elect

Section 7.02 QUALIFICATIONS OF RHN OFFICERS

Officers must be Members of the Active Medical Staff of at least one (1) MUSC Health Medical Center at the time of nomination and election and must remain members in good standing during his/her terms of office. They must constructively participate in Medical Staff affairs, including active participation in peer review activities and on Medical Staff committees and demonstrate an interest in maintaining quality patient care at the Medical Centers.

Section 7.03 SELECTION OF RHN OFFICERS

The Medical Executive Committee shall vote for Medical Staff Officers nominated from among the current Medical Executive Committee members. Medical Staff Officers shall be elected every other year at a meeting of the Medical Executive Committee (or via electronic voting if applicable) and shall be confirmed by the Governing Body.

Section 7.04 TERM OF OFFICE OF RHN OFFICERS

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

Section 7.05 VACANCIES IN RHN OFFICERS

Vacancies in an office during a Medical Staff Officer's two (2) year term shall be filled by the Medical Executive Committee pursuant to the nomination and voting procedures in Sections 7.02 and 7.03 above. The individual filling the vacancy shall serve out the remaining term. If there is a vacancy in the office of President, the Vice President shall serve the remainder of the term.

Section 7.06 DUTIES OF RHN OFFICERS

a. President. The President shall serve as the organized Medical Staff's chief administrative officer and will fulfill those duties specified in these bylaws, and shall:
   i. act in coordination and cooperation with the Chief Medical Officers, the MSLCs and the Medical Executive Committee members in all matters of mutual concern within the Medical Centers;
   ii. call, preside at, and be responsible for the agenda of all Medical Executive Committee meetings;
   iii. serve as a voting member on the Medical Executive Committee;
   iv. be responsible for the enforcement of these Bylaws, medical staff policies, and associated policies; for implementation of sanctions where these Bylaws are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where remedial action has been requested against a Staff Member;
   v. present the views, policies, needs and grievances of the Medical Staff to the Board and to receive, and interpret the policies of the Board to the Medical Staff and report to the Board on quality

improvement review with respect to the Medical Staff's delegated responsibility to provide medical care;

vi. ensure that attendance is taken at and accurate and complete minutes are kept of all Medical Executive Committee meetings

b. Vice President shall:

i. be a voting member of the Medical Executive Committee.

ii. in the absence of the President assume all the duties and have the authority of the President.

iii. attend to and perform such other duties as ordinarily pertain to such office.

c. Vice President Elect -The Vice President ~~Elect shall~~Elect shall ensure that the recording, transcription, and communication processes produce accurate and complete minutes of all Medical Staff meetings.

Section 7.07 REMOVAL FROM RHN OFFICE

a. The Medical Staff and/or Board may remove any Medical Staff officer for failure to fulfill his/her responsibilities, conduct detrimental to the interests of the Medical Centers and/or the Medical Staff, or a physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the office.

b. Removal from elected office shall not entitle the Practitioner to procedural rights.

c. 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 Medical Executive Committee. Upon presentation, the MEC will schedule a general staff meeting to discuss the issue(s) and, if appropriate, entertain a no confidence vote.

d. Any Medical Staff Officer may resign at any time by giving written notice to the Medical Executive Committee.

Article VIII. DEPARTMENTS

Section 8.01 ORGANIZATION OF DEPARTMENTS

The Medical Staff at each division shall be organized into departments and/or sections, in a manner as to best assure:

a. The supervision of clinical practices within the Medical Center.
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, including peer review, objectively establish and monitor criteria for the effective utilization of Medical Center and practitioner 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 8.02 DIVISIONAL DEPARTMENTS

Each Division shall have the following Departments:

a. Department of Medicine
b. Department of Surgery
c. Department of Emergency Medicine
d. Department of Pediatrics
e. Department of Obstetrics/GYN
f. Department of Anesthesia
g. Department of Radiology
h. Department of Pathology/Laboratory
i. Department of Cardiology (Midlands Division only)

Section 8.03 QUALIFICATIONS AND SELECTION OF DEPARTMENT CHIEF

a. Each Department shall have a Chief, who shall be approved by the Board after election by the department members. Each Chief shall be a Member of the Active Category of the Medical Staff and be well qualified by training and experience and demonstrated competency for the position. The Chief must be certified in an appropriate specialty board or have comparable competence that has been affirmatively established through the credentialing process.
b. A Department Chief must be eligible for privileging within the Department and meet all credentials requirements within the Division.

c. The Department Chief must have the ability to work with and represent all Medical Centers in the Division and dedicate the time necessary to perform such duties.

d. Department Chiefs may be removed by affirmative vote of two-thirds (2/3) of the Department members as provided for removal of officers in Section 5.07.

Section 8.04 FUNCTIONS OF DEPARTMENT

Through the Department Chief 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 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 Clinical Privileges of practitioners within his/her department.

d. Develop and uniformly apply criteria for the on-going professional evaluation of all 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 Clinical 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 Health Medical Centers.

j. Monitor on a continuing basis, departmental activities and compliance with Medical Staff Bylaws and other accrediting bodies' standards.

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 Medical Center.

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 and quality care, treatment, and services.

p. Recommend sufficient qualified and competent staff to provide care within the Department and work with Clinical Services and MUSC Health Medical Centers leaders to determine the qualifications and competencies of non-licensed independent practitioners 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 Health Medical Centers administrative responsibilities assigned to departmental physicians.

s. Supervise the completion of the assigned responsibilities of departmental members who serve as MUSC Health Medical Centers Medical Directors.

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

u. Divisional Departments shall meet at least quarterly and may meet more often, as needed.

Section 8.05 **ASSIGNMENT TO DEPARTMENTS**

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

Article IX. COMMITTEES AND FUNCTIONS

Section 9.01 STRUCTURE OF COMMITTEES

a. There shall be a single MEC for all MUSC Health Medical Centers and provider-based clinics governed by these Bylaws. There shall be a Medical Staff Leadership Committee (MSLC) for each Division (Florence, Lancaster, Midlands). The MSLC will also serve as the Credentials Committee for each division. There shall be a divisional Peer Review Committee. There shall be a Medical Staff Operating Committee (MSOC) at each Medical Center within a Division.

b. Permanent medical staff committees may be established by the MEC. Committees may be established by the MSLCs for their respective locations. Temporary (ad hoc) committees may be established by the MEC, MSLCs, or by an individual department or service.

Section 9.02 MEDICAL EXECUTIVE COMMITTEE (MEC)

a. Composition: The members of the MEC include:

   i. Chief of Staff of each MUSC Health Medical Center – elected by each individual Medical Center Medical Staff

   ii. Vice Chief of Staff of each MUSC Health Medical Center – elected by each individual Medical Center Medical Staff

   iii. CMO'S as voting members with ability to abstain for conflicts

   iv. MUSC Chief Quality Officer (non-voting)

   v. Chief Physician Executive CPE for Regional Health Network (non-voting)

   vi. Nursing Representative (non-voting)

   vii. Divisional CEOs (or designee) as non-voting members

   viii. Advanced Practice Professional leader (non-voting)

b. Membership for all elected members and appointees will be for a two-year period starting on the first day of the calendar year.

c. Officers shall include a President, Vice President, and Vice President-Elect will be elected.

d. The MEC will be chaired by the President elected by the MEC.

e. All members unless specified will have voting rights.

f. If an emergent situation arises between meetings of the MEC that, requires a vote and approval by the MEC, the MEC President may by written, verbal, or printed notice request a virtual meeting, a vote, or both. The notice shall include a description/explanation of the matter that requires a vote and a mechanism for voting. This request for a vote shall be delivered, either personally or by mail, including electronic mail to each member of the MEC not less than three (3) days before the return deadline for voting. Members may submit their vote either in person or in writing via internal mail, email, fax, text, or as instructed (i.e.,

electronic survey) to either the office of the MEC President or as designated. A quorum for this voting would be the majority vote of returned ballots. A record of the official vote will be recorded and maintained by the MEC office and presented to the MEC at the next scheduled MEC meeting.

g. Duties-The duties of the MEC shall be to:

i. Ensure high quality cost-effective patient care across the continuum of the MUSC Health Medical Centers.

ii. Represent and to act on behalf of the Unified and Integrated Medical Staff

iii. Coordinate the activities and general policies of the Unified and Integrated Medical Staff

iv. Determine and monitor committee structure of the Unified and Integrated Medical Staff

v. Receive and act upon reports and recommendations from departments, committees, and officers of the Unified and Integrated Medical Staff.

vi. Implement Medical Staff policies not otherwise the responsibility of the Departments, Medical Centers, or Divisions.

vii. Provide a liaison between the Unified and Integrated Medical Staff and the Chief Executive of MUSC Health Medical Centers.

viii. Recommend action to the Chief Executive of the MUSC Health Medical Centers on medico-administrative matters.

ix. Make recommendations to the Board regarding: the Unified and Integrated Medical Staff structure, membership, delineated Clinical Privileges, appointments, and reappointments to the MedicalStaff, and performance improvement activities.

x. Ensure that no medical staff officer or department chief at the local, divisional or system level hold two offices during the same time period unless extenuating circumstances exist and the MEC approves.

xi. Ensure that the Unified and Integrated Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the MUSC Health Medical Centers

xii. Fulfill the Medical Staff organization's accountability to the Board for the medical care of patients in the MUSC Health Medical Centers.

xiii. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with Clinical Privileges.

xiv. Conduct such other functions as are necessary for effective operation of the Medical Staff.

xv. Report at each general staff meeting

xvi. Ensure that Medical Staff is involved in performance improvement and peer review activities and

xvii. Communicate decisions and discussions of the MEC to their respective, department, division, service line members or employees

h. The Medical Staff delegates the authority to the MEC the ability to act on its behalf in betweenorganized meetings of the medical staff. The Medical Staff delegates authority to the MEC to make amendments and submit directly to the Board 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. However, the MEC shall notify the Medical Staff of said changes prior to Board submission.

i. 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 Clinical Privileges, the processes or indications for recommending termination or suspension of a Medical Staff Member 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 Policy Manual of the Medical Staff, the Fair Hearing Plan, or other Medical staff policies.

j. The Medical Staff, after notification to the MEC and the Board, by 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.

k. The authority to amend these bylaws cannot be delegated.

l. 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. Meetings can be either in person or virtual. Special meetings of the MEC may be called at any time by the MEC Chief.

m. Removal from MEC - The Medical Staff and/or the Board may remove any member of the MEC for failure to fulfill his/her responsibilities, conduct detrimental to the interests of the MUSC Health Medical Centers and/or the Medical Staff, physical or mental infirmity to the degree that renders him incapable of fulfilling the duties of the MEC. 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 if the recall is for the majority or all the MEC members. Upon presentation, the MEC or Board 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 9.03 MEDICAL STAFF LEADERSHIP COMMITTEE

a. Each of the divisions within the Regional Health network will have a MLSC.

b. Composition- The MSLC is a leadership committee consisting of:
   i. Divisional Chief Medical Officer
   ii. Chief of Staff- each Medical Center

iii. Vice Chief of Staff- each Medical Center
iv. Secretary – each Medical Center
v. At Large members – one (1) per Medical Center
vi. Chief from the divisional department of Medicine
vii. Chief from the divisional department of Surgery
viii. Chief from the divisional department of OBGYN/Peds
ix. Chief from the divisional department of ED
x. Chief from the divisional department of Anesthesia
xi. Chief from the divisional department of Radiology
xii. Chief from the divisional department of Path/Lab
xiii. Chief from the Midlands divisional department of Cardiology
xiv. Chief of Peer Review from the division
xv. Non-voting (CEOs, CNOs, Chief Quality Officers, APPs) for the division
xvi. Ad hoc members as demand requires
xvii. The MSLC shall elect one of its members to serve as the MSLC Chief to preside over meetings at its first (1st) meeting of each new Medical Staff Year.

c. Duties-The duties of the MSLC are to provide the medical staff leadership forum and coordinating mechanism for relating medical staff functions to activities of individual Medical Centers, nursing, and administration within the division, as well as to act on any responsibilities delegated to MSLC by the MEC and/or the Board. This includes:

i. Receiving and act upon reports and recommendations from departments, committees, and officers of the Medical Staffs within the division.

ii. Serving as the Credentials Committee of the division.

iii. Making recommendations to the MEC regarding the Medical Staff structure, membership, delineated Clinical Privileges, appointments, and reappointments to the Medical Staff, and performance improvement activities and peer review activities within the division.

iv. Ensuring that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the MUSC Health Medical Centers within the division.

v. Fulfilling the Medical Staff organization's accountability to the Board for the medical care of patients within the division.

vi. Taking all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members within the division with Clinical Privileges.

vii. Conduct such other functions as are necessary for effective operation of the Medical Staff within the division.

viii. Communicate decisions and discussions of the MSLC to their respective, department, division, service line members or care team members.

ix. Implement Medical Staff policies for Departments, Medical Centers, or Divisions.

x. Provide a liaison between the Medical Staffs of a division and the MEC.

xi. The MSLC may appoint committees as needed

d. Meetings- The MSLC shall meet monthly or as often as necessary to accomplish their assigned functions. A record of these proceedings shall be kept.

e. Relevant reports shall be made to the MEC, relevant clinical Departments of the Medical Staff, nursing services, CEO, and relevant Medical Center departments within the division.

Section 9.04 MEDICAL STAFF OPERATING COMMITTEE (MSOC)

a. Each Medical Center within a Division will have a MSOC.

b. Members will be the local Chief of Staff, Vice Chief of Staff, and Secretary, as well as two elected members from the Medical Center medical staff.

c. Duties will include coordinating Medical Staff activities with the division MSLC.

d. The MSOC may meet as often as necessary as determined by the Chief of Staff.

Section 9.05 PEER REVIEW COMMITTEES

a. Each division will have a peer review committee appointed by the MSLC or Service Line/Department chiefs (or a designee) including:

i. Division Chief of Medicine

ii. Division Chief of Surgery

iii. Division Chief of Emergency Medicine

iv. Division Chief of Pediatrics

v. Division Chief of OB/GYN

vi. Division Chief of Cardiology (Midlands Division only)

vii. Additional At-Large Members as needed

viii. Division Chief Medical Officer (non-voting)

b. The Chief is appointed by Division Medical Staff Leadership Committee annually.

c. Just Culture onboarding is required.

d. The Peer Review Committee shall follow the procedures set forth in the Peer Review Policy.

e. 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.

Section 9.06 OTHER FUNCTIONS

a. 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 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 MSLC and the MEC, and in MEC reports to the Board. These functions can be carried out by a Medical

Staff Committee, a 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 Health Medical Centers infection control program.

vii. Plan for response to fire and other disasters.

viii. Direct Medical Staff organizational activities, including Medical Staff Bylaws, review and revision, Medical Staff officer andcommittee nominations, liaison with the Board and MUSC Health Medical Centers administration, and review and maintenance of MUSC Health Medical Centers accreditation

b. Committees- When committees have been assigned or sanctioned as Medical Staff Committees, the following will apply:

i. These committees shall serve as advisory committees to the MSOC.

ii. Each committee shall prepare minutes or a report of its meetings.

iii. Reports of the committees shall be presented to the MEC upon request.

iv. Any Medical Staff member serving on a committee including the chairperson may be removed by the Chief Medical Officer of the Division from the committee for failure to remain as a Member of the Medical Staff in good standing, for failure to attend meetings, for unsatisfactory performance of the duties assigned to the committee, or by action of the Medical ExecutiveCommittee.

Article X. HISTORY AND PHYSICAL REQUIREMENTS

Section 10.01 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.

Section 10.02 H&P REQUIREMENTS

A complete H&P (except in circumstances allowing a focused H&P) must include (as information isavailable):

a. chief complaint,
b. details of present illness (history),
c. past history (relevant - includes illnesses, injuries, and operations),
d. social history,
e. allergies and current medications,
f. family history,
g. review of systems pertinent to the diagnosis,
h. physical examination pertinent to the diagnosis,
i. pertinent normal and abnormal findings,
j. conclusion or a planned course of action.

Section 10.03 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 10.04 PRIMARY CARE CLINICS

H&Ps are required in all provider-based Medical Center clinics. On subsequent primary carevisits 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 10.05 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 10.06 UPDATING AN H&P

When using an H&P that was performed within 30 days prior to admission ora procedure, and that H&P is in the patient's medical record, a review of the H&P and a re-examination of the patient must take place as a part of the H&P update within 24 hours of admission for inpatients or prior to the procedure whichever comes first. Any changes in the patient's condition not consistent or otherwise reflected in the H&P must be documented. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia by a qualified physician or other licensed Practitioner who has been credentialed and granted Clinical Privileges to perform a history and physical examination. For all surgeries and other procedures requiring an H&P, this update may be completed in combination with the pre-anesthesia assessment.

Section 10.07 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 to assess the statusand 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 10.08 ATTENDING PHYSICIAN

The attending physician is responsible for thecomplete H&P.

a. Residents, appropriately privileged, may complete the H&P with the attending physician's countersignature.
b. AHPs, appropriately privileged, may complete the H&P without attending co-signature. This includes H&P's completed for in-patients, ED patients, and MUSC Health provider based clinic patients.
c. The attending physician may complete an additional attestation sheet to confirm or change the initialhistory and physical.
d. If changes are needed, the attestation must be completed by the attending within 48 hours of admissionor prior to any procedure requiring H&P's.

Article XI. MEDICAL STAFF MEETINGS

Section 11.01 REGULAR MEETINGS

a. The Medical Staff shall meet at least annually or more often, as needed. This meeting can either be in person or virtual or both. Appropriate action will be takenas indicated.

b. The annual Medical Staff Meeting shall be held during the last quarter of each calendar 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.

d. Matters that require a vote and approval by Medical Staff members as determined by the MEC or by regulation or law throughout the year may be presented to the Medical Staff members by written or printed notice. The notice will include a description/explanation of the matter that requires a vote and a mechanism for voting. This request for a vote 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 three (3) days before the return deadline for voting. Members may submit their vote either in person or in writing via internal mail, email, fax, text, or as instructed (i.e., electronic survey) to either the office ofthe Chief Medical Officer of each division or as designated. A quorum for this voting would be the majority vote of returned ballots. A record of the official vote will be recorded and maintained by the office of the MEC and presented to the MEC at the next scheduled MEC meeting.

Section 11.02 SPECIAL MEETINGS

The Chief of Staff of any Medical Staff, a Chief Medical Officer, the MSLC, 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, Courtesy, and Consulting 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 three (3) days 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 internal mail addressed to each Medical Staff Member at his/her address as it appears on the records of the Medical Center. 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 11.03 QUORUM

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

Section 11.04 **ATTENDANCE REQUIREMENTS**

a. Although attendance at the annual meeting is encouraged, Medical Staff members are not required to attend general Medical 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 Chief.

c. Members of the MEC, MSLC and Credentials Committee are required to attend fifty percent (50%) of the committee meetings, either in person or virtually, during each year unless otherwise excused.

Section 11.05 **PARTICIPATION BY EXECUTIVE DIRECTOR OF THE MUSC HEALTH MEDICAL CENTERS**

The CEO of the MUSC Health Medical Centers or his/her designee may attend any Committee, Department, or Section meeting of the Medical Staff.

Section11.06 **ROBERT'S RULES OF ORDER**

The latest edition of Robert's Rules of Order shall prevail at all meetings of the General Medical Staff, MEC, and Department Meetings unless waived by the Chief or one of the Co-Chairs.

Section 11.07 **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. Notices can be delivered by internal mail, email, text, or in person. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 11.08 **ACTION OF COMMITTEE/DEPARTMENT**

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

Section 11.09 **MINUTES**

Minutes of each regular and special meetings of a Committee or Department shall beprepared 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 MSLC and MEC. The minutes from other committee meetings shall be signed by the presiding officer and copies thereof submitted to the appropriate departments.

Article XII. TERMINATION, REDUCTION, AND SUSPENSION OF PRIVILEGES

Section 12.01 SUSPENSION

In the event that an individual Practitioner's action may pose a danger to patients, other Medical Staff members, or the Medical Center or its personnel, then either the Medical Center Chief of Staff, Chief Medical Officer or the Chief of the clinical Department of 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 thatcaused 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 affected following theprovision of this Article of the Medical Staff Bylaws.

c. Immediately upon the imposition of a suspension, the appropriate Department Chief assigns to another Medical Staff member the responsibility for care of any Medical Center 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 of the Fair Hearing Plan shall apply

Section 12.02 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 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. 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 Medical Staff Membership and Clinical 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.

d. Lapse of Malpractice Coverage - If the MEC and Board have established a requirement forliability 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.

e. Governmental Sanction or Ban - Imposition of governmental sanction or ban as outlined by Medicare and the DHHS -Office of the Inspector General is cause for immediate loss of all Clinical Privileges.

f. Felony Conviction - conviction of a felony offense is cause for immediate loss of all Clinical Privileges.

g. Loss of Faculty Appointment - Loss of faculty appointment with cause shall result in immediate revocation of Clinical Privileges and appointment to the Medical Staff.

h. Failure to Meet Application Requirements - Failure to comply with deadlines or other application requirements will result in loss of appointment and Clinical Privileges as outlined in the Credentials Policy Manual.

Article XIII. CONFLICT MANAGEMENT AND RESOLUTION

Section 13.01 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 oramendment of bylaws, rules and regulations, or medical staff policies and when MUSC Health Medical Centers Policy A- 115 Conflict Management does not apply, the voting members of the Medical Staff by a two-thirds (2/3) vote may appoint aConflict Management Team consisting of six (6) Active members of the Medical 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 for action.

Section 13.02 MEC AND BOARD

If a conflict arises between the MEC and the Board regarding a matter pertaining to the quality or safety of care or to the adoption or amendment of MedicalStaff Bylaws, Rules and Regulations, or Medical Staff Policies and when MUSC Health Medical Centers Policy A-115 Conflict Management does not apply, the Chief Executive of the MUSC Health Medical Centers may convene an ad-hoc committee of MUSC Health Medical Centers, Board and Medical Staff leadership to manage or resolve the conflict. This committeeshall meet as early as possible and within thirty (30) days of its appointment shall report its work and report to the MEC and the Board its recommendations for resolution or management of the conflict.

Article XIV. OFFICIAL MEDICAL STAFF DOCUMENTS/ MISCELLANEOUS

Section 14.01 OFFICIAL GOVERNING 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, the Peer Review Policy and other Medical Staff policies pursuant to these bylaws. Adoption and amendment of these documents shall be as provided below.

Section 14.02 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 approvedby 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 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- Adoption of and/or 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. The Bylaws may be adopted, amended or revised after submission of the proposed Bylaws or amendment at least seven (7) calendar days in advance of 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, the Bylaws or an amendment or revisions shall require a majority vote of the voting 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.

b. The MEC 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 MEC, which can appoint an ad hoc Bylaws Committee as detailed in Section 7.02(b). Findings shall be reported at a regular meeting of the Medical Staff or at a special meeting called for such purposeor by email to Active Medical Staff members. Any recommended changes shall be amended in accordance with these Bylaws.

Section 14.03 UNIFIED BYLAWS

a. Initial Unification - Each Medical Center's previously separate medical staff members have voted by majority, in accordance with the Medical Center's previous medical staff bylaws, to approve these Bylaws and accept the Unified Medical Staff structure provided herein.

b. The Medical Executive Committee shall consider each Medical Center's unique circumstances and any significant differences in patient populations and services offered at each Medical Center. The Medical

Executive Committee shall establish and implement policies and procedures to make certain the needs and concerns expressed by Medical Staff Members of each Medical Center are given due consideration and shall ensure that mechanisms are in place to make certain that issues localized to a particular Medical Center are duly considered and addressed.

c. Each Medical Center has the right to opt out of the Unified Medical Staff by a majority vote of the Staff Members with active Clinical Privileges at the applicable Medical Center who are eligible to vote on the adoption and amendment of Medical Staff Bylaws.

d. Medical Centers may not hold opt out votes more than once every two (2) years, except for voting on the introduction of the Unified Bylaws, which may be reconsidered for vote during the twelve (12) months following the initial vote.

Section 14.04 RULES AND REGULATIONS AND OTHER RELATED DOCUMENTS

The MEC will provide to the Board a set of Medical Staff Rules and Regulations, a Credentials Policy Manual, a Peer Review Policy, 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, the Peer Review Policy 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. 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 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 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 regardingthe 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 for action.

e. The Rules and Regulations of the Medical Staff, the Credentials Manual, the Fair Hearing Plan, the Peer Review Policy, and other policies of the Medical Staff are intended to provide the associated details necessary to implement theseBylaws of the MUSC Medical Staff.

Section 14.05 RULE CHALLENGE

Any Practitioner may raise a challenge to any rule or policy established by the MEC. If a rule,regulation or policy is felt to be inappropriate, any Practitioner may submit a petition signed by twenty-five percent (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.

Section 14.06 COMPLIANCE WITH LAWS AND REGULATIONS

Any act or omission that may be considered inconsistent with the provisions set forth in these Medical Staff Bylaws and/or the Policies Governing Medical Practices, but which was undertaken to comply with applicable federal or state statutes or regulations, shall not be considered in violation of these Medical Staff Bylaws and/or the Policies Governing Medical Practices. In the event these Medical Staff Bylaws and/or the Policies Governing Medical Practices are inconsistent with such statutes or regulations, the MEC shall initiate in a timely manner the applicable amendment process.

Section 14.07 ELECTRONIC RECORD KEEPING

Whenever these Bylaws call for maintenance of written records, such records may be recorded and/or maintained in an electronic format.

Section 14.08 HEADINGS

The captions or heading used in these Medical Staff Bylaws are for convenience only and are not intended to limit or otherwise define the scope of effects of any provisions of these Medical Staff Bylaws.

Section 14.09 IDENTIFICATION

Although the masculine gender and singular are generally used throughout these Bylaws and associated policies for simplicity, words which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

Section 14.10 COUNTING OF DAYS

In any instance in which the counting of days is required in these Bylaws in connection with the giving of a notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given, or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday which is not a holiday. For the purposes of this Section, the term "holiday" shall mean such days as are commonly recognized as holidays by the U.S. Federal Government.

Section 14.11 SEVERABILITY

If any provision of these Bylaws shall be determined to be invalid, illegal, or unenforceable, the validity, enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

Section 14.12 INDEMNIFICATION

Any individuals acting in good faith for and on behalf of the Medical Center(s) in discharging their responsibilities and participating in Professional Review Activities and Professional Review Actions pursuant to these Bylaws, including, but not limited to, all Governing Body members, Medical Staff committee members, Medical Staff Officers, Department

Chiefs, Section Chairpersons, and other Staff Members or Medical Center employees and/or agents, shall be indemnified when acting in those capacities, to the fullest extent permitted by law. In furtherance of the foregoing, each Applicant shall, upon request of any Medical Center(s), execute releases in favor of Medical Center representatives and third parties from whom information has been requested by the Medical Center(s) or an authorized Medical Center representative.

MUSC Regional Health Network
Medical Centers

Credentialing
Policy and Procedure Manual

Effective: January 1, 2023

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 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 professionals who provide patient care services at each MUSC Health Regional Health Network 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 happen 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 Health Regional Health Network 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 Staff 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 Chief. The Credentials Committee may make recommendations to approve/deny or delay appointments, reappointments and/or privileges.

2. Membership

The Medical Staff Leadership Committee/MSLC of each Regional Health Network division shall serve as the Credentials Committee for the division. The Chairperson of the Credentials Committee is appointed by the Divisional Chief Medical Officer. The appointment for Chairperson shall be for a three (3) year term with eligibility for reappointment for two additional terms. Members of the Credentials Committee shall serve a term concurrent with their membership on the Division MSLC.

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

Access to credentials files is limited to the following: appropriate Medical Staff Office ("MSO") staff, members of the Credentials Committee, members of the Medical Executive Committee, MUSC legal counsel, Medical Center Risk Management, Department/Division Chiefs of physician's specialty, the CEO of the Division, the CEO of MUSC Health, the Divisional Chief Medical Officer and others who may be otherwise authorized. These files shall be privileged pursuant to Medical Staff credentials files and 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, this Credentialing Manual, and associated policies of the MUSC Health Regional Health Network Medical Staff.

B. Qualifications for Medical Staff Membership

Only physicians with Doctor of Medicine (MD) Doctor of Osteopathy (DO) degrees, or equivalent foreign medical degree such as MBBS, or Dentists or Podiatrists (DPM) holding a current, valid academic license or unrestricted license to practice in the State of South Carolina shall be qualified for appointment to the Medical Staff. To be considered for appointment and clinical privileges at each MUSC Health Regional Health Network Medical Center, an applicant must meet all of the following criteria:

- Have a valid and unrestricted license to practice in the State of South Carolina;
- After the Effective Date of the unified Medical Staff Bylaws, any new applicant for MD, DO, MBBS, DPM or Dentist membership shall be eligible for or have obtained board certification and comply with individual board requirements in his/her respective medical or dental specialty board at the time of appointment. 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, or longer if allowed for the applicant's specialty as detailed in the ABMS Member Boards Eligibility Periods and Transition Dates (rev July 2021) may be allowed an applicant from the time of completion of his/her residency or fellowship to obtain initial board certification, or, if an alternative pathway for board certification is allowed for the applicant's specialty, a grace period commensurate with the alternative pathway timeframe. Board recertification and maintenance certification should be in accordance with the criteria established by the applicable specialty and/or in accordance with the criteria established by the applicable specialty and/or subspecialty board. Satisfaction of all maintenance criteria will be assessed at reappointment. If no criteria applicable, recertification must be obtained within two (2) years following any expiration of certification. Failure to achieve or maintain board certification within the time frames required herein may be grounds for revocation and/or denial of Medical Staff membership to be determined by the Medical Executive Committee and Board.. In special cases, for recertification, 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 Chief in the department in which they are assigned, and the Department Chief has attested either in a written or oral format to the divisional Medical Staff Leadership Committee and the MEC for approval. Waiver of board certification requirement can be granted when no board specialty exists, and the Department Chief 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 Medical Staff Leadership Committee may choose to accept or reject such certification. In the event the certification is rejected, the Department Chief may petition the MEC for approval
- Maintain a Federal DEA number and State DHEC License/Certification where applicable;
- Provide satisfactory evidence of appropriate training, education, and competency in the designated specialty;
- Hold current professional malpractice insurance at levels acceptable to the Medical

Center(s).

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.

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.
- Participate in the emergency room and other specialty coverage programs as scheduled or as required by the MEC,MSLC or Department Chief.

Removal: Failure to satisfy the requirements for activity for the MUSC Medical Center, as deemed by the Department Chief, during the appointment period will result in automatic transfer to Courtesy Category. The Practitioner shall have the rights afforded by Article XII and the Fair Hearing Plan of the Medical Staff Bylaws.

2. Courtesy Medical Staff

Members of the Courtesy Medical Staff shall meet the following criteria:

- Participate in the clinical affairs of the MUSC Health Medical Centers
- Be involved in the care or treatment of at least six (6) patients of the MUSC Health Medical Center(s) or clinics during his/her appointment period, or
- Refer patients to other physicians or staff of the MUSC Health Medical Center (s) or those who order diagnostic or therapeutic services at the MUSC Health Medical Center

(s).

- Not admit or regularly participate in the care of more than 25 patients in a calendar year. Should a Practitioner exceed the 25-patient encounter threshold, he/she shall automatically advance to Active Staff status for the remainder of the calendar year and must abide by the Prerogatives and responsibilities outlined in Section 4.01
    - Physicians who meet the following criteria shall not be subject to the aforementioned 25 patient encounter limitation: (i) the physician provides a service that is not otherwise available at the Medical Center; and (ii) the physician's primary practice is located outside of the community.
    - The MSLC may waive the requirement to care for at least six (6) patients during an appointment period for physicians who are members in good standing with another MUSC Health affiliated Medical Center and who continue to meet the qualifications for appointment to the Courtesy Staff of MUSC Health. Additionally, this exception would only occur if physician specific quality and outcomes information has been provided by the affiliated Medical Center upon request. Such information shall be sufficient quality and quantity to allow a reappointment and privileging recommendation by the Credentials Committee.

Prerogatives: Members of the courtesy medical staff shall be appointed to a specific department or service line with the following prerogatives:

- An appointee to this category may exercise the Clinical Privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific privilege exception.
- Attend meetings of the Medical Staff and Department to which he/she is appointed and any MUSC Health education programs.
- Request admitting privileges.

Responsibilities: Appointees to this category must:

- Discharge the basic responsibilities specified in Section 3.09.
- Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for who he/she is providing service.
- Satisfy the requirements set forth in the Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.
- Participate in the emergency department on-call rotation as directed by the MEC and Board when there is an inadequate number of current Active Staff members to address an important patient coverage need, as determined by the MEC and Board. Any unassigned patient encounters incurred as a result of and while participating on the emergency department on-call rotation as assigned by the MEC and Board shall not count toward the patient encounter limitation described in Section 4.02 (a.iv) of the Bylaws.

Removal: Failure to satisfy the requirements for activity for the MUSC Health Medical Centers, as deemed by the MSLC, during the appointment period will result in automatic transfer to the Consulting category.

3. Consulting Medical Staff

Qualifications: Consulting Staff shall consist of a special category of physicians, dentists, or podiatrists, each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

Prerogatives: Members of the Consulting Staff may consult on patients within his/her specialty to the extent he/she holds delineated Clinical Privileges to do so; and attend all meetings of the Medical Staff that he/she may wish to attend as a non-voting visitor.

Responsibilities: Appointees to this category must follow these conditions:

- Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.
- Consulting Staff members must have fewer than fifteen (15) encounters in which they manage direct patient care.
- For Consulting Staff members who have their primary practice outside the community, such members may provide or manage direct patient care, within the scope of their granted Clinical Privileges, in an unlimited number of cases, where there is, as determined by the Board in consultation with and on the recommendation of the Medical Executive Committee, an otherwise unfulfilled community need for the services to be provided by the particular Consulting Staff member.
    - A determination by the Medical Executive Committee and/or Board that there is not an unfulfilled community need for the services of a particular Consulting Staff member shall not be subject to appeal nor entitle the member to any of the procedural rights under these Bylaws.
    - Consulting Staff members whose primary practice is located in the community, and who exceed the accepted number of encounters referenced above must transfer to Active Staff and meet all the requirements as outlined in Section 4.01 of the Bylaws.
- Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

4. Rural Health Clinic (RHC) / Ambulatory Category

a. Qualifications- The RHC staff shall consist of physicians, dentists, or podiatrists, who meet the basic qualifications for Medical Staff membership set forth in these Bylaws currently providers in an MUSC Health Rural Health Care Clinic.

Prerogatives- The RHC member may refer his or her patients for admission to the Medical Center for care by another physician unless otherwise privileged. The referring physician may visit the patient and provide follow-up care, exercise such clinical privileges as are granted and may attend meetings of the Medical Staff and any Medical Staff or Medical Center education programs. Members of this category may not vote unless assigned to a standing committee and do not have call responsibility.

Responsibilities- The RHC Member shall discharge the basic responsibilities of membership and retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Rural Health Clinic for who he/she is providing service. The RHC staff participate in performance improvement and quality activities of the Medical Center sufficient to evaluate outcomes.

D. Medical Staff Appointment Without Privileges

1. Honorary/Administrative Members

This category is restricted to those individuals the Medical Staff wishes to honor or to those physicians who have only administrative positions or administrative appointments and no Clinical Privileges.

- Such staff appointees are not eligible to admit patients to the MUSC Health Medical Centers, 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.
- Physicians with the MUSC Health Medical Centers 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 Health Medical Centers and reduction or termination in Clinical Privileges.

E. Privileges without Membership

1. Allied Health Professionals

Allied Health Professionals 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 Professionals by the 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, supervision agreements, and responsibilities of these individuals shall be in accordance with information in this manual.

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.

2. Telehealth Practitioners

- Telehealth Practitioner-Any Practitioner who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Medical Center through a telehealth procedure (the "Telehealth Physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in this Credentials Manual and Medical Staff Bylaws. An exception is outlined below for those circumstances in which the Practitioner's distant-site entity or distant-site hospital is Joint Commission accredited and the Medical Center places in the Practitioner's credentialing file a copy of written documentation confirming such accreditation.
- Scope of Privileges--The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telehealth, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.
- In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the Telehealth Practitioner's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telehealth physician ONLY if the Medical Center has ensured through a written agreement with the distant-site entity or distant-site hospital that all the following provisions are met:
    - The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)- (7), regarding the distant-site entity's or distant-site hospital's physicians and practitioners providing telehealth services.
    - The distant-site entity, if not a distant-site hospital, is a contractor of services to the Medical Center and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Medical Center to comply with all applicable federal regulations for

the contracted services.

- The distant-site organization is either a Medicare-participating hospital or a distant-site telehealth entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation and the Joint Commission Medical Staff (MS) chapter for hospitals or ambulatory care organizations, as applicable.
- The Telehealth Practitioner is privileged at the distant-site entity or distant-site hospital providing the telehealth services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the Telehealth Practitioner's privileges at the distant-site entity or distant-site hospital.
- The Telehealth Practitioner holds a license issued or recognized by the State of South Carolina; and
- The Medical Center has evidence, or will collect evidence, of an internal review of the Telehealth Practitioner's performance of telehealth privileges at the Medical Center and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telehealth services provided by the Telehealth Practitioner and all complaints the Medical Center has received about the Telehealth Practitioner) for use in the periodic appraisal of the Telehealth Practitioner by the distant-site entity or distant-site hospital.

- For the purposes of this Section, the term "distant-site entity" shall mean an entity that: (1) provides telehealth services; (2) is not a Medicare-participating hospital; (3) is Joint Commission accredited; and (4) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telehealth services. For the purposes of this Section, the term "distant-site hospital" shall mean a Medicare-participating and Joint Commission accredited hospital that provides telehealth services. If the Telehealth Practitioner's site is also accredited by Joint Commission, and the Telehealth Practitioner is privileged to perform the services and procedures for which privileges are being sought in the Medical Center, then the Telehealth Practitioner's credentialing information from that site may be relied upon to credential the Telehealth Practitioner in the Medical Center. However, this Medical Center will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

III. Initial Appointment Application

A. Nature of the Application

Each applicant shall complete the online application provided by the Medical Staff Office via the Credentials Verification Office (CVO).

B. 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.

C. 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.

D. 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 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 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 Medical Center policies and procedures that govern

clinical practice; and
- That he/ she will adhere to the MUSC Health Standards of Behavior.

Release: In connection with the application, applicants agree to release from liability the Medical University Hospital Authority, 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 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 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 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.

E. 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.

F. Verification Process:

After receipt of the completed application for membership, the Medical Staff Office via the Credentials Verification Organization (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.

G. 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 Chief 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 Board. 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 Chief 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 Chief of the applicable Department shall then review the application, and, at his/her discretion, conduct a personal interview. Upon completion of this review, the Chief 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 Chief, 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 Chief. 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 Chief or the Chief Medical Officer 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 Chief 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 Division CEO or the Division Chief Medical Officer 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 Division CEO or the Division Chief Medical Officer 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 XII and the Fair Hearing Plan 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 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 Division CEO or the Division Chief Medical Officer or their designee through the Medical Staff Office, by written notice, will inform the applicant of that decision within 10 days. Notice of the Board's decision is also given through the Medical Staff Office to the Medical Executive Committee, and to the Chief 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 Chief Medical Officer or their designee through the Medical Staff Office, within 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 XII and the Fair Hearing Plan 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 Division CEO or the Division Chief Medical Officer 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. Initial Privileges

For all newly appointed practitioners or for all newly approved privileges, 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 Chief 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 initial year; however, the focused evaluation period will be for a time frame determined by the Department Chief or their designee. 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 Health Regional Health Network.

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 the 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;
- Chief Recommendation: Evaluation form electronically completed by Chief 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 Members and Privileged Practitioners

It shall be a continuing duty of all Medical Staff and privileged practitioners to promptly update credentials information on an ongoing basis. Failure to do so may result in immediate reappraisal by the Credential Committee of the member's staff appointment. 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 Chief 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 Division Chief Medical Officer. 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 Chief, the Medical Executive Committee, or the Chief Medical Officer, 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 XII and the Fair Hearing Plan 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 Division CEO or the Division Chief Medical Officer. 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 Chief Review

The Department Chief evaluation of the applicants request for reappointment or privilege renewal shall be based upon the applicant's education, demonstrated 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 Department Chief shall then review the application. Upon completion of this review, the Chief 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 Chief anticipates recommending an involuntary reduction or total denial of previously granted privileges at MUSC Medical Center, the Department Chief 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 Division Chief Medical Officer, Medical Center Chief of the Medical Staff and the Division CEO. 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 Chief shall trigger a review of the information and circumstances by the Division Chief Medical Officer and the Medical Center Chief of the Medical Staff. In the event of non-resolution, the Department Chief'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.

At the time of reappointment, a Department Chief 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 Chief 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 Chief, 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 Chief 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 Chief 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 Division CEO or the Division Chief Medical Officer 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 Division CEO or the Division Chief Medical Officer 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 XII and the Fair Hearing Plan 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 Division Chief Medical Officer 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 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 Division CEO or the Division Chief Medical Officer or their designee through the Medical Staff Office, by written notice, inform the applicant of that decision within 10 days. Notice of the Board's decision is also given through the Medical Staff Office to the Medical Executive Committee, and to the Chief 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 Division Chief Executive Officer or the Division Chief Medical Officer or their designee through the Medical Staff Office, within 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 XII and the Fair Hearing Plan 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 Division Chief Executive Officer or the Division Chief Medical Officer 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 Chief. 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 Chief, 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. 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 Chief'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 Chief 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, which are further described in Section 3.07 of the Bylaws. 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 Chief 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.

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: Temporary privileges are granted by the Division CEO or authorized designee and/or Division Chief Medical Officer upon recommendation of the Medical Center Chief of Staff 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 Chief 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 Health Regional Health Network 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 Division CEO or his/her designee after consultation with the appropriate Department Chief 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 Chief 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 Chief 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 Division CEO, the Division Chief Medical Officer, or the Chief 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-035 Disaster Privileges for Licensed Independent Practitioners (https://www.musc.edu/medcenter/policy/Med/C035.pdf). 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 Medical 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 Chief.
Under conditions of extreme patient risk, the Chief of the Medical Staff, the Division Chief Medical Officer, the appropriate Department Chief, Credentials Committee Chairperson, or the Division CEO (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 Medical 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 Chief or his/her designee to which he/she is assigned.

MUSC Health Regional Healthcare Network

Medical Staff
Rules and Regulations
January 2023

DEFINITIONS:

1. All defined terms in the **MUSC Health Regional Health Network Unified Medical Staff Bylaws shall be so defined in these MUSC Health Regional Health Network Medical Staff Rules and Regulations and any additions, deletions, or modifications to the Definitions in the Bylaws shall be attributed to these Rules and Regulations.**

Since the English language contains no singular pronoun that 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 and all privileged practitioners to abide by the Rules and Regulations.

II. ADMISSIONS

Who May Admit Patients

A patient may be admitted to any MUSC 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 all conditions and diseases for which the Medical Center(s) has facilities and personnel. 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. Admission orders must be provided by the attending physician. If admit orders are entered by another physician, PA-C or APRN, they must be co-signed by the attending physician.

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. The evaluation can be performed and completed by an APRN or PA-C. Such an evaluation must be completed within 24 hours of admission and must include admission orders. The admission orders must be signed/co-signed by the attending physician prior to discharge,
- 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. An exception is made for hospice patients where daily visits can be made by an RN.
- prompt completeness and accuracy of the medical record,
- necessary special instructions,
- 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, and

- completion of a clinical handoff to the next attending in inpatient settings, during times of intermittent coverage and/or at the end of a clinical rotation. "Best practice" handoffs are both written and verbal, with an opportunity for the oncoming attending to ask clarifying questions.

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/her patients in the Medical Center by being available or having available, an alternate medical staff appointee or a privileged practitioner 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. Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, and an alternate has not been identified then the Chief of Staff, may assume care for the patient or designate any appropriately trained member of the staff; or in the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient may provide care.

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 appropriate to the admitting diagnosis within the clinical department by the Department Chief or the Chief of Staff.

Telemedicine

Telemedicine in the inpatient setting may be permitted if the use of telemedicine is "additive" not "substitutive," meaning that it should be employed only when it would add a needed clinical service that would be otherwise unavailable, either due to general lack of availability of a specialty or due to staffing shortages. This is applicable for all in-patient credentialed providers.

Inpatient telemedicine encounters must be approved by the Department Chair and the Chief Medical Officer. New approvals for inpatient telemedicine should seek approval from the Medical Executive Committee (MEC), when possible.

Reports outlining the use of telemedicine in the inpatient setting will be presented at MEC at least quarterly.

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, APRN or PA-C 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, 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. Please see A-082 Records Retention for more information.

c. 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. See Policy A-082 Records Retention for more information.

d. The attending physician, APRN or PA-C 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 Policy C-021 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. The written admission note shall serve as the progress note for the day of admission unless the patient's condition warrants further progress notes on that date. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be identified in the progress notes and correlated with specific orders, as well as results of tests and treatment.

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.

Informed Consent Requirements

It is the responsibility of the attending physician, APRN, PA-C, resident or intern to assure appropriate informed consent is obtained and documented in the medical record and when appropriate, also document the discussion in a progress note if the provider is present during the procedure. 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 the following 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 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, APRN or PA-C who obtained the consent, (verbal consent may be witnessed by the nurse and indicated on the consent form),
- physician, APRN or PA-C documentation of the consent process in a progress note or on the consent form.

Physician, APRN or PA-C 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 Progress Note/Brief Operative Note: If a full operative/procedure report is not completed and on the record before a patient moves to a different level of care post procedure, an operation/procedure progress note/brief op 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. All required elements must be addressed even if the element is not applicable (N/A).

Operative Report: For all patients (both inpatient and outpatient) the full operative/procedure report shall be entered, written, or dictated into the medical record no later than twenty-four (24) hours from the completion of operation/procedure. The signature of the primary physician/surgeon is required within three (3) 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.) The operative/procedure report must contain the name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s), the name of the procedure performed, a description of the procedure, findings of the procedure, any estimated blood loss, any specimen(s) removed and the postoperative/procedure diagnosis.

Procedure Report: Included but not limited to Interventional Radiology, Heart Catheterizations and Gastroenterology Endoscopies, shall be entered, written, or dictated and into the medical record no later than twenty-four (24) hours from the completion of the procedure. The signature of the primary physician is required within 3 days of the procedure.

Note: When a progress note is entered into the record immediately after the procedure it can become part of the operative report but must be dated, timed, and signed by the physician at the time of completion of the progress note.

In all cases, when the full operative report is dictated, the operative progress note/brief operative report must be completed.

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.

Obstetrical Patient Histories

The history for obstetrical patients, when adequately updated with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical throughout the hospital for surgery and other procedures related to obstetrical patients.

Discharge Summary Requirements

For all inpatient and observation stays, a preliminary discharge summary must be completed within 24 hours of discharge with an official discharge summary and signature by the physician, APRN or PA-C within 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 co-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.

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible practitioner at the time of discharge of all patients.

Complete Medical Records

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

Specific record requirements for physicians shall include the following:

- 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, including a complete and accurate medication list
- all final diagnoses, complications, or procedures
- AJCC staging for diagnosed cancer patients

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 those clinics that use the Medical Center's provider number. MUSC Medical Center outpatient visits 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.

Medical Records Preparation and Completion

Completion Requirements

The following elements in the medical record must be completed as stated:

- 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
- Full Operative report- within 24 hours of surgery

- Full 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
- Home health orders- within 24 hours of discharge
- Standing orders- ASAP after implementation
- Death Note- prior to transport of decedent to Morgue.
- Death Summary – final version within 12 hours of pronounced time of death.

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, APRN or PA-C 3 days following the completion due date, (The exception is outpatient visit notes when the attending physician's, APRN or PA-C 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/death summaries; (4) ED attending notes; (5) inpatient and outpatient operative/procedure reports; (6) outpatient visit notes and (7) admission orders. [See Delinquency Summary Table]

Delinquency Summary Table

Medical Record Required Element	**Required Completion time within:**	**Attending's Signature, APRN or PA-C required within:**	**Deemed Delinquent at:**
Admission H&Ps	24 hours	3 days	4 days
Inpatient & ED consultations	24 hours	3 days	4 days
Death note	Prior to transport of decedent to morgue	12 Hours*	1 day
Discharge Summaries/	Preliminary version within 24 hours Official within 3 days	3 days	4 days
Death summaries	Final version within12 hours of death pronouncement	24 hours (attending signature only)	2 days
ED attending notes	24 hours	3 days (attending signature only)	4 days
Operative	24 hours	3 days (attending signature only)	4 days

Outpatient visit notes	7 days	14 days	14 days
Admission orders	Upon admission	Prior to discharge (Attending signature only)	At discharge
Procedure reports	24 hours	3 days	4 days
In-Basket Folders**	24 hours	3 days	4 days
In-Basket Pool Folders	48 hours	4 days	6 days

*Regarding the death note, APRNs and Pas can perform the death notes if they are signed off on a department specific competency and is in their practice agreement /scope of practice.

**In basket folder items may be signed by another LIP with like privileges when requested by the physician, APRN or PA-C responsible for the In-Basket in order to assure timely review of time-sensitive results.

Physicians, APRNs or PA-Cs will receive two (2) notifications from the Health Information Management (HIM) 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, APRNs or PA-Cs will receive two (2) notifications from the HIM 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 may also result for repeated failure to provide quality documentation (i.e. the quality of histories and physicals, failure to update histories and physicals as required, failure to sign admit orders). These determinations will be made based on medical record reviews conducted under the authority of the Chief Medical Officer.

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, APRN or PA-C 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., Department Chair, and 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 of Staff 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.

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).

Administrative Authority for Medical Records

In extreme and extenuating circumstances, the Medical Staff Leadership Committee has the authority to allow administrative changes in the medical record. These changes would be necessary in rare circumstances when the provider is no longer available, or in other extenuating circumstances, or to enable various chart correction activities (e.g. when a signed note is discovered in the wrong patient's chart). In all cases, these administrative changes will be reported to the MEC and will follow specific Health Information Management policies and procedures.

V. ORDERS

General Requirements

a. When a practitioner uses an electronic signature, he must ensure it is only used in accordance with departmental policies and related regulatory guidelines.

b. When transferring a patient to a different level of care or to a different service, all orders must be individually reviewed and adjusted by the practitioner according to the patient clinical status. See Policy C-146 Medication Reconciliation.

c. When a patient returns to a patient care unit from the operating room (OR) or when a procedure is performed outside of the OR, pre-procedure orders are individually reviewed and adjusted by the physician, APRN or PA-C according to the patient clinical status.

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

e. Medications should be ordered within the *MUSC Formulary of Accepted Drugs* (Formulary System Access)

f. Blanket orders such as “resume pre-op medications” [as outlined above in c.] or “resume home medications” are prohibited.

g. All medication orders must be written according to Policy C-078 Medication Orders

h. Any nursing communication should be used to communicate a singular action for the care of the patient. If the therapy should occur in any frequency, the provider must place a specific order with the exact and directions for completion of the action or therapy.

i. Palliative care consults, ethics consults, or referrals can be placed by any provider or ancillary staff based on the needs of the patient. After completing the consult, recommendations will be communicated back to the attending of record.

Who May Write Orders

Orders may be written by members of the medical staff, residents, and allied health professionals (i.e. advanced nurse practitioners, physician assistants, social workers, psychologists, pharmacists) within the scope of their practice delineated clinical privileges, and approved protocols. All orders must be written

clearly and completely. Orders must include date, time written, and provider authentication. When an order is handwritten, the order must also be legible and include the ordering practitioner page ID for authentication.
Authenticated electronic signatures for orders are acceptable when available.

Order Entry

Orders can only be placed and accepted through the orders entry activities within the electronic health record. Care instructions written outside of the order entry activities are not considered orders; therefore, they will not be acted upon by the clinical staff. Examples include but are not limited to progress notes and discharge forms.

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, APRN, PA-C or a registered dietician through orders entered into the patient's medical record. 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, an advanced nurse practitioner, PA-C 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. The ordering practitioner must sign verbal orders for restraints within twenty-four (24) hours. PRN orders are not acceptable. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the restraint or seclusion.
When restraints are used for behavioral reasons, the patient must be seen by an MD, APRN or PA-C within one hour of initiation.

e. 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, APRN or PA-C 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 Policy

8781 Resuscitation Orders In all cases, the patient has the right to refuse resuscitation verbally or as by written advanced directive. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the DNR.

f. Allow Natural Death (AND) order should be followed according to Policy C-023 Withholding/Withdrawing Life-Sustaining Treatment. When a patient or family presents a signed AND advanced directive, discussion must occur between treating physician, APRN or PA-C and patient (or surrogate). Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the AND order.

g. 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, APRN or PA-C should document review of the POST and conversations about the POST in the medical record. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not complete the POST form.

h. Orders to admit a patient must be signed/co-signed by the admitting physician or by another physician credentialed to admit patients.

i. All PRN medications must include an indication for use.

j. All outpatient in-clinic or retail medication orders must include an associated diagnosis.

k. Any sample medication provided in the clinics must appear on the patient's outpatient medication list.

l. Pharmacists may place laboratory orders without a prescriber's co-signature as part of the therapeutic drug monitoring referral program (Policy C-078 Medication Orders).

m. A discharge orders for home health care must have an appropriately documented face to face encounter between the patient and the ordering physician, APRN or PA-C. For CMS home health, Attending Physician signature required.

Verbal or Telephone Orders

A verbal or telephone order is defined as an order communicated verbally by

either an on-site or off-site practitioner for treatment that normally requires a written order. The request for and use of verbal or telephone orders should be limited, whenever possible, to urgent or emergent situations. In all cases, a verbal or telephone order will not be considered complete until the individual receiving the order, reads back and verifies the content of the order. Non-urgent verbal or telephone order may be acceptable when the practitioner is off-site (without access to the EHR), or when a practitioner is unable to stop the care of a patient to place an order. See Policy C-056 Ordering Modes.

a. The following disciplines may request and accept a verbal or telephone order within the scope of their practice:
   - Physician assistant
   - Advanced practice registered nurse
   - Registered nurse
   - Licensed practical nurse
   - Certified medical assistant (in ambulatory clinics only)
   - Certified ophthalmic personnel (in ambulatory clinics only)
   - Licensed pharmacist
   - State certified pharmacy technician or pharmacy intern (in ambulatory pharmacies only) [SC Code of Laws 40-43-84]
   - 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)
   - Approved research coordinators
   - 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, dates and timed, read back and verified, and flagged for signature by the person accepting the order.

c. The full name and credentials of the practitioner who dictated the order must be documented for an electronic. The pager ID/immediate contact information should also be documented for handwritten orders.

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 96 hours after patient discharge.

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, APRN, PA-C or dentist must be notified by a nurse of the discontinuation. Documentation of notification of the physician, APRN, PA-C or dentist must occur in the medical record.

g. Verbal orders must not be accepted for certain high-risk medications as defined in Policy C-056 Ordering Modes.

h. Non-licensed or non-certified personnel (i.e. unit secretaries, clinical assistants) may not give or accept verbal orders from a practitioner under any circumstances.

i. Orders given verbally and documented through one-step mechanisms are considered a verbal order that will require co-signature by the practitioner communicating the order.

j. All of the above applies to both paper and electronic medical record verbal order entry.

k. When using the electronic system, the appropriate physician, APRN or PA-C must select the verbal order within the sign tab and then submit the order.

l. 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.

Standing Orders/ Guidelines

A standing order or a guideline is an order that can be initiated by a nurse or other individual without a prior specific physician's, APRN's or PA-C's order for that patient. The Medical Staff must approve standing orders after the recommendation and approval of the Pharmacy and Therapeutics Committee (if medications are part of the standing order) as well as nursing leadership. All standing orders must be signed, dated and timed by the ordering practitioner or by another practitioner responsible for the care of the patient in the medical

record as soon as possible.

Standing orders are typically initiated when a patient's condition meets certain predefined clinical criteria as part of an emergency response wherein it is not practical for a nurse to obtain an order before providing care. Standing orders are also provided as part of an evidence-based treatment regimen. Other requirements for Standing Orders are according to Policy C-068 Standing Orders.

Note: A checklist of preprinted treatment options that a physician or practitioner selects from is not considered a standing order.

VI. 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.

Admission orders should be written and signed by the physician on service that is accepting 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, APRN or PA-C:
   - the diagnosis is obscure after ordinary diagnostic procedures have been completed,
   - there is doubt as to the choice of therapeutic measures to be utilized,
   - unusually complicated situations are present that may require specific skills of other practitioners,
   - the patient exhibits severe symptoms of mental illness or psychosis.

b. The practitioner is responsible for requesting consultation when indicated.

c. 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. It is the duty of the Medical Staff Operations Committee, the Department Chair, and the Medical Staff Leadership 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 or other provider, 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 Policy C-040 Consultations. 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, APRN or PA-C 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.

VII. SUBSTANCE ABUSE/PSYCHIATRIC PATIENTS

A patient suspected to be suicidal in intent or with a primary diagnosis of substance abuse or psychiatric disorder shall be admitted to an appropriate psychiatric unit. If these accommodations are not available, the patient shall be stabilized and transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Medical Center to a safe room as a temporary measure. The patient will be afforded psychiatric consultation. Explicit orders regarding precautionary measures are required.

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, APRN, PA-C or another member of the psychiatric evaluation team.

If the patient presents to the emergency room, and needs specialized psychiatric care not provided at the Medical Center, the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the Hospital's EMTALA policy, that the benefits of transfer outweigh the risks.

VIII. ANESTHESIA SERVICES:

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (MAC) including deep sedation, regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

Anesthesia services throughout the Medical Center shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service.

The Medical Center shall maintain policies and procedures governing anesthesia services provided in all Medical Center locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, based on nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

IX. PATIENT DISCHARGE/CONTINUED HOSPITALIZATION

Who May Discharge/Process

Patients shall be discharged only under the direction of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician, APRN or PA-C 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. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge. The Attending Physician shall

keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and Hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to the following:

a. Conditions that may result in the patient's transfer to another facility or level of care;

b. Alternatives to transfer, if any;

c. The clinical basis for the discharge;

d. The anticipated need for continued care following discharge;

e. When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and

f. Written discharge instructions in a form and manner that the patient or family member can understand.

Continued Hospitalization

The Attending Physician is required to document the need for continued hospitalization. This documentation should contain adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate; estimate of additional length of stay the patient will require; and plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or others responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MSLC for review.

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

No patients will be transferred between departments without notification to the Attending Physician. 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 shall be notified immediately. A practitioner will pronounce the patient dead, notify the family ASAP, enter a death note within 12 hours in the medical record, and request and document permission to perform an autopsy, when applicable.

The Medical Center shall refer all inpatient deaths, emergency room deaths and dead on arrival cases to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement. C-017 Organ/Tissue Donation: https://musc.policytech.com/docview/?docid=4890

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

The Organ Procurement Organization shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

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 the county where the Medical Center is located.

c. The attending physician requests an autopsy based on the College of American Pathologists criteria and the Decedent Care Program.

No autopsy shall be performed without written consent of a responsible relative or authorized person unless ordered by the Coroner/Medical Examiner of the county where the Medical Center is located.

Duties of the Physician for Obtaining an Autopsy

a. Determine whether the death falls within the jurisdiction of the Coroner/Medical Examiner of the Coroner/Medical Examiner of the county where the Medical Center is located.

b. Obtain permits for organ donation when applicable according to Policy C-017 Organ and 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.

X. MAYDAY PROCEDURE

In the event that a clinical emergency situation arises within the Medical Center or within any University area designated in Policy C-014 Emergency Medical Response, Medical Staff are to follow specific duties as outlined in the policy.

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, advanced practice registered nurse, and physician assistants. If a physician on the on-call list is called by the Emergency Department physician to provide emergency screening or treatment, the on-call physician must respond within a reasonable time as defined in Policy C-048 EMTALA – Medical Emergencies, Screening and Transfer. If the physician refuses or fails to arrive within the required response time the chain of command should be initiated.

XII. OBLIGATION TO ACCEPT PATIENT TRANSFERS FROM EMERGENCY ROOM

The Medical Center, and its on-call physicians, will accept the transfer from an

emergency room of any patient with an emergent condition who requires specialized capabilities of the Medical Center if the Medical Center has the capability and capacity to treat the patient.

XIII. MEDICATION ADMINISTRATION

All medications will be administered throughout the MUSC health-system using the appropriate procedures and technology to ensure safe, accurate, and timely administration of medication for optimizing patient outcomes. Documentation of the administration should occur in the electronic health record on the medication administration record (MAR) by the person who administered the medication or his/her designee who witnessed the administration.

XIV. TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

Treatment by practitioners of immediate family members or self-treatment should be reserved only for minor illnesses or emergency situations. Practitioners may not self-prescribe. Practitioners should not prescribe to immediate family members any controlled substances when a viable alternative is available. Written records must be maintained of any written prescriptions or administration of any drugs. A practitioner may not perform surgery on an immediate family member except in an emergency situation or where no viable alternative is available.

XV. UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patients' attending and/or treating physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the Hospital's Policy on Disclosure of Treatment Outcomes.

XVI. 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 the following:

C-080 Critical Values

C-025 Universal Protocol

C-021 Use of Abbreviations

C-049 Event Investigation

C-058 Patient Identification

IPC-001 Hand Hygiene

C-146 Medical Reconciliation

XVII. 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 Policy C-074 Resident Supervision. Appropriately credentialed fellows serving as attending physicians are excluded from these requirements.

XVIII. PEER REVIEW

All members of any of the MUSC Medical Center Medical Staff, House Staff, and Professional Staff will be included in the Medical Staff's peer review process.

XIX. HAND HYGIENE

The Medical Staff recognizes the need to ensure a high level of hand hygiene compliance and adherence to infection prevention for all Medical Staff to ensure ongoing success of the infection control and prevention plan of the Medical Center 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. Medical staff who fail to respond in a positive manner to a reminder are subject to the medical staff peer review process. Medical staff who have recurrent hand hygiene noncompliance will be subject to the MEC approved progressive education and discipline process.
Medical staff having four (4) hand hygiene noncompliance events in one (1)

consecutive 12month period will be reason for suspension from the Medical Staff. Re-application for reinstatement is allowed immediately upon completion of a MEC approved process.
Medical staff having two (2) suspensions in a consecutive 12-month period will result in removal of Medical Staff membership and clinical privileges.
Medical staff may formally respond to each noncompliance event with subsequent adjudication by the peer review committee.

XX. PATIENT REQUESTS AND REFUSAL OF TREATMENT3

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient's behalf, must be documented in the patient's permanent hospital record. Patients have the right to request any treatment at any time, and such requests shall be documented in the patient's permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating Practitioner or his/her designee.

XXI. EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff and documented in writing.

XXII. MEDICAL STAFF POLICIES

All members of the Medical Staff are required to follow the policies of the Medical Staff and the Medical Center including policies specific to a Medical Staff Department.

APPENDIX A - FAIR HEARING PLAN

This Fair Hearing Plan ("Plan") is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Fair Hearing Plan and proceedings hereunder.

DEFINITIONS

The following definitions, in addition to those stated in the Medical Staff Bylaws or herein, shall apply to the provisions of this Plan.

1. "Appellate Review Body" means the group designated pursuant to this Plan to hear a request for Appellate Review that has been properly filed and pursued by the practitioner.

2. "Corporation" shall mean QHC of South Carolina

3. "Hearing Committee" means the committee appointed pursuant to this Plan to hear a request for an evidentiary hearing that has been properly filed and pursued by a practitioner.

4. "Parties" means the practitioner who requested the hearing or Appellate Review and the body or bodies upon whose adverse action a hearing or Appellate Review request is predicated.

5. "Practitioner", for purposes of this Plan, means a physician, dentist or podiatrist who has been granted clinical privileges at the Medical Center.

6. "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 includes professional review activities relating to professional review action.

6. "Professional Review Body" means the Medical Center and the Board or the Medical Executive Committee of the Medical Staff when assisting the Board in a professional review activity.

7. "Special Notice" means written notification sent by certified or registered mail, return receipt requested, or delivered by hand with a written acknowledgment of receipt.

ARTICLE I
INITIATION OF HEARING

1.1 RECOMMENDATION OR ACTIONS

1.1.1. The following recommendations or actions shall, if deemed adverse pursuant to Article I, Section 1.2 of this Plan, entitle the practitioner affected thereby to a hearing:

(1) Denial of initial staff appointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;

(2) Denial of reappointment, unless based upon failure to submit a completed application or failure to meet the basic objective criteria for appointment;

(3) Suspension of staff membership for thirty (30) days or more;

(4) Revocation of staff membership;

(5) Denial of requested advancement of staff category, if such denial materially limits the physician's exercise of privileges.

(6) Reduction of staff category due to an adverse determination as to a practitioner's competence or professional conduct;

(7) Limitation of the right to admit patients, unless based upon a reduction of staff category not related to an adverse determination as to a practitioner's competence or professional conduct;

(8) Denial of an initial request for particular clinical privileges, unless based upon failure to meet the basic objective criteria for the privileges requested;

(9) Reduction of clinical privileges for a period of excess of thirty (30) days;

(10) Permanent suspension of clinical privileges;

(11) Permanent revocation of clinical privileges;

(12) Terms of probation, if such terms of probation materially restrict the physician's exercise of privileges for more than thirty (30) days; and

(13) Summary suspension of privileges or staff membership for a period in excess of thirty (30) days.

(14) Denial or restriction of requested clinical privileges,

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

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

a) In the reasonable belief that the action was in the furtherance of quality health care.

b) After a reasonable effort to obtain the facts of the matter.

c) 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

d) 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.

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

1.1.4. Impaired Practitioners: The MUSC Health Medical Centers 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.

1.2 WHEN DEEMED ADVERSE

A recommendation or action listed in Article I, Section 1.1 of this Plan shall be deemed adverse only if it is based upon competence or professional conduct, is practitioner-specific, includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership, and has been:

(1) Recommended by the MEC; or

(2) Taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

(3) Taken by the Board on its own initiative without prior recommendation by the MEC.

1.3 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A practitioner against whom an adverse recommendation or action has been taken pursuant to Article I, Section 1.1 of this Plan shall promptly be given special notice of such action. Such notice shall:

(1) Advise the practitioner of the basis for the action and his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws of this Plan;

(2) Specify that the practitioner has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;

(3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an Appellate Review of the matter;

(4) State that upon receipt of this hearing request, the practitioner will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;

(5) Provide a summary of the practitioner's rights at the hearing; and

(6) Inform the practitioner if the recommended action may be reportable to the National Practitioner Data Bank and appropriate licensing agencies.

1.4 REQUEST FOR HEARING

A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Article I, Section 1.3 to file a written request for a hearing. Such request shall be delivered to the Division CEO either in person or by certified or registered mail.

1.5 WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any Appellate Review to which he/she might otherwise have been entitled. Such waiver in connection with:

(1) An adverse recommendation or action by the Board or their designees, shall constitute acceptance of that recommendation or action (hereinafter, references to decisions by these entities or individuals shall be designated as decisions or actions of the Board); and

(2) An adverse recommendation by the MEC or its designee shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board. The Board shall consider the MEC's recommendation at its next regular meeting following the waiver. In its deliberations, the Board shall review all relevant information and material considered by the MEC and may consider all other relevant information received from any source. The Board's action on the matter shall constitute a final decision of the Board. The Division CEO shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Article I, Section 1.5(2) and shall notify the Division MSLC Chief of Staff and the MEC of each such action.

ARTICLE II
HEARING PREREQUISITES

2.1 NOTICE OF TIME & PLACE FOR HEARING

a. Upon receipt of a timely request for hearing, the Division CEO shall deliver such request to the President or to the Board, depending on whose recommendation or action prompted the request for hearing. The Division CEO shall send the practitioner special notice of the time, place and date of the hearing. The hearing date shall not be less than thirty (30) nor more than ninety (90) days from the date of receipt of the request for hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect shall, at the practitioner's request, be held as soon as arrangements for it reasonably may be made, but not later than thirty (30) days from the date of receipt of the request for hearing.

b. 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.

2.2 STATEMENT OF ISSUES & EVENTS

The notice of hearing required by Article II, Section 2.1 shall contain a concise statement of the Practitioner's alleged act or omissions, and a list by number of specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing. The notice shall further contain a list of witnesses expected to testify in support of the adverse recommendation or action.

2.3 PRACTITIONER'S RESPONSE

Within ten (10) days of receipt of the notice of hearing under Section 2.2, the affected Practitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the due process hearing.

2.4 EXAMINATION OF DOCUMENTS

The Practitioner may request that he/she be allowed to examine any documents to be introduced in support of the adverse recommendation. If the Practitioner so requests, the body initiating the adverse action shall also be entitled to examine all documents expected to be produced by the Practitioner at the hearing. The parties shall exchange such documents at a mutually agreeable time at least ten (10) days prior to the hearing. Copies of any patient charts, which form the basis for the adverse action shall be made available to the Practitioner, at his/her expense, within a reasonable time after a request is made for same.

2.5 APPOINTMENT OF HEARING COMMITTEE

2.5(a) By Medical Staff

A hearing occasioned by an adverse MEC recommendation pursuant to Article I, Section 1.2(1) shall be conducted by a Hearing Committee appointed by the President and composed of three (3) members of the Active Medical Staff from one or more of the MUSC Health Medical Centers. None of the Hearing Committee members shall be partners, associates, relatives or in direct economic competition with the affected individual. Should the President find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize practitioners outside the staff, he/she may, upon approval by the MUSC Health CEO, appoint an independent panel of three (3) practitioners meeting all requirements of this section with the exception of Medical Staff membership.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the President shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of

the determination. The President shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(b) By Board

A hearing occasioned by an adverse action of the Board pursuant to Article I, Section 1.2(2) or 1.2(3) shall be conducted by a Hearing Committee appointed by the Chairperson of the Board and composed of three (3) people. At least one (1) Active Medical Staff member of an MUSC Health Medical Center shall be included on this committee. Should the Board Chairperson find it impossible to appoint a committee meeting the above requirements or otherwise find good cause to utilize a practitioner outside the staff, he/she may, upon approval by the MUSC Health CEO, appoint a practitioner meeting all requirements of this section with the exception of Active Medical Staff membership. One (1) of the appointees to the committee shall be designated as Chairperson. If the matter concerns or arises from issues regarding a practitioner's clinical competence or performance, the Hearing Committee must be composed of three (3) physicians who may or may not be members of the Hospital's Medical Staff.

The affected individual shall have ten (10) days after notice of the appointment of the Hearing Committee members to object and identify in writing, any conflict of interest with any Hearing Committee members which the affected individual believes should disqualify the Hearing Committee member(s) from service. The failure of the affected individual to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Within seven (7) days of the receipt of the objections, the Board Chairman shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, a replacement shall be appointed within seven (7) days of the determination. The Board Chairman shall advise the affected individual accordingly. One (1) of the members so appointed shall be designated as Chairperson.

2.5(c) Service on Hearing Committee

A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee solely because he/she has participated in investigating the action or matter at issue.

ARTICLE III
HEARING PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Article I, Section 1.5.

3.2 PRESIDING OFFICER

Either the Hearing Officer, if one is appointed pursuant to Article VIII, Section 8.1, or the Chairperson of the Hearing Committee shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/She shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

3.3 REPRESENTATION

The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney, a member of the Medical Staff in good standing, a member of his/her local professional society, or other individual of the physician's choice. The MEC or the Board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of its adverse recommendation or action, and to examine the witnesses. Representation of either party by an attorney at law shall be governed by the provisions of Article VIII, Section 8.2 of this Plan.

3.4 RIGHTS OF THE PARTIES

3.4(a) During a hearing, each of the parties shall have the right to:

(1) Call and examine witnesses;

(2) Present evidence determined to be relevant by the Presiding Officer, regardless of its admissibility in a court of law;

(3) Cross-examine any witness on any matter relevant to the issues;

(4) Impeach any witness;

(5) Rebut any evidence;

(6) Have a record made of the proceeding, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof; and

(7) Submit a written statement at the close of the hearing.

If any practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

3.5 PROCEDURE & EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence although these rules may be considered in determining the weight of the evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical, medical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the hearing is held. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. Any party shall be given opportunity on timely motion, to request that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

3.7 BURDEN OF PROOF

(1) When a hearing relates to the matters listed in Article I, Sections 1.1(1), 1.1.(5) or 1.1(8), 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 the action is arbitrary, capricious or impermissibly discriminatory.

(2) For the other matters listed in Article I, Section 1.1, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack any substantial factual basis or that the action is arbitrary, capricious or impermissibly discriminatory. The standards of proof set forth herein shall apply and be binding upon the Hearing Committee and on any subsequent review or appeal.

3.8 RECORD OF HEARING

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 later may be called upon to review the record and render a recommendation or decision in the matter. The method of recording the hearing shall be by use of a court reporter.

3.9 POSTPONEMENT

Request for postponement of a hearing shall be granted by agreement between the parties or the Hearing Committee only upon a showing of good cause and only if the request therefore is made as soon as is reasonably practical.

3.10 PRESENCE OF HEARING COMMITTEE MEMBERS & VOTING

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations of the decision.

3.11 RECESSES & ADJOURNMENT

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 for consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties and without a record of the deliberation being made. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

ARTICLE IV
HEARING COMMITTEE REPORT & FURTHER ACTION

4.1 HEARING COMMITTEE REPORT

Within fourteen (14) days after the transcript of the proceedings has been delivered to the proper officer of the hearing, or if no transcript is ordered, then thirty (30) days after the hearing ends, the Hearing Committee shall make a written report of its findings and recommendations in the matter. The Hearing Committee shall forward the same, together with the hearing record and all other documentation considered by it, to the Board or the MEC, for action consistent with Section 4.2 below. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it. Recommendations must be made by a majority vote of the members and the committee may only consider the specific recommendations or actions of the Board or MEC. The practitioner who requested the hearing shall be entitled to receive the written recommendations of the Hearing Committee, including a statement of the basis for the recommendation.

4.2 ACTION ON HEARING COMMITTEE REPORT

If the MEC initiated the action, and the Hearing Committee's report alters, amends or modifies the MEC's recommendation, the MEC shall take action on the Hearing Committee report no later than twenty-eight (28) days after receipt of same, and prior to any appeal by the practitioner. If the MEC initiated the action and the Hearing Committee has not altered, amended or modified the MEC recommendation, or if the Board initiated the action and the action remains adverse to the practitioner, the practitioner shall be given notice of the right to appeal pursuant to Section 4.3(c) prior to final action by the Board. If the Board initiated the action, and the Hearing Committee recommendation is favorable to the practitioner, the Board shall take action on the Hearing Committee's report no later than twenty-eight (28) days from receipt of same.

4.3 NOTICE & EFFECT OF RESULT

4.3(a) Notice

The Division CEO shall promptly send a copy of the result to the practitioner by special notice, including a statement of the basis for the decision.

4.3(b) Effect of Favorable Result

(1) Adopted by the Board: If the Board's result is favorable to the practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed.

(2) Adopted by the Medical Executive Committee: If the MEC's result is favorable to the practitioner, the Division CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's result in whole or in part, or by referring the matter back to the MEC for further consideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, and consultation with the Corporation as necessary, the Board shall take final action. The Division CEO shall promptly send the practitioner special notice informing him/her of each action taken pursuant to this Article IV, Section 4.3(b)(2). Favorable

action shall become the final decision of the Board, and the matter shall be considered finally closed.

4.3(c) Effect of Adverse Result

At the conclusion of the process set forth in Section 4.2, if the result continues to be adverse to the practitioner in any of the respects listed in Article I, Section 1.1 of this Plan, the practitioner shall be informed, by special notice of his/her right to request an Appellate Review as provided in Article V, Section 5.1 of this Plan. Said notice shall be delivered to the practitioner no later than fourteen (14) days from the MEC action, or Hearing Committee report, as appropriate under Section 4.2.

ARTICLE V
INITIAL & PREREQUISITES OF APPELLATE REVIEW

5.1 REQUEST FOR APPELLATE REVIEW

A practitioner shall have fourteen (14) days following his/her receipt of a notice pursuant to Article IV, Section 4.3(c) to file a written request for an Appellate Review. Such request shall be delivered to the Division CEO either in person or by certified or registered mail and may include a request for a copy of the report and record of the Hearing Committee and all other material, favorable or unfavorable, if not previously forwarded, that was considered in reaching the adverse result.

5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

A practitioner who fails to request an Appellate Review within the time and manner specified in Article V, Section 5.1 shall be deemed to have waived any right to such review.

Such waiver shall have the same force and effect as that provided in Article I, Section 1.5 of this Plan.

5.3 NOTICE OF TIME & PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for Appellate Review, the Division CEO shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an Appellate Review which shall be not less than twenty-one (21) days from the date of receipt of the Appellate Review request; provided, however, that an Appellate Review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than twenty-one (21) days from the date of receipt of the request for review. At least ten (10) days prior to the Appellate Review, the Division CEO shall send the practitioner special notice of the time, place and date of the review. The time for the Appellate Review may be extended by the Appellate Review Body for good cause and if the request therefore is made as soon as reasonably practical.

5.4 APPELLATE REVIEW BODY

The Appellate Review Body shall be composed of the Board of Trustees or a committee of at least three (3) members of the Board of Trustees. One (1) of its members shall be designated as the Chairperson of the committee.

ARTICLE VI
APPELLATE REVIEW PROCEDURE

6.1 NATURE OF PROCEEDINGS

The proceedings of the Appellate Review Body shall be in the nature of an Appellate Review based upon the record of the hearing before the Hearing Committee, and the committee's report, and all subsequent results and actions thereon. The Appellate Review Body also shall consider the written statements, if any, submitted pursuant to Article VI, Section 6.2 of this Plan and such other material as may be presented and accepted under Article VI, Sections 6.4 and 6.5 of this Plan. The Appellate Review Body shall apply the standards of proof set forth in Article III, Section 3.7.

6.2 WRITTEN STATEMENTS

The practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, but may not raise new factual matters not presented at the hearing. The statement shall be submitted to the Appellate Review Body through the Division CEO at least seven (7) days prior to the scheduled date of the Appellate Review, except if such time limit is waived by the Appellate Body. A written statement in reply may be submitted by the MEC or by the Board, and if submitted, the Division CEO shall provide a copy thereof to the practitioner at least three (3) days prior to the scheduled date of the Appellate Review.

6.3 PRESIDING OFFICER

The Chairperson of the Appellate Review Body shall be the Presiding Officer. He/She shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.4 ORAL STATEMENT

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements supporting their positions. If the Appellate Review Body allows one of the parties to make an oral statement, the other party shall be allowed to do so. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

6.5 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report, and not otherwise reflected in the record shall not be introduced at the Appellate Review, except by leave of the Appellate Review Body. The Appellate Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted, following establishment of good cause by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. If such additional evidence is considered, it shall be subject to cross examination and rebuttal.

6.6 PRESENCE OF MEMBERS & VOTING

A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Appellate Review Body is absent from a substantial portion of the proceedings, he/she shall not be permitted to participate in the deliberations or the decision.

6.7 RECESSES & ADJOURNMENT

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of consultation. Upon the conclusion of oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the Appellate Review shall be declared finally adjourned.

6.8 ACTIONS TAKEN

The Appellate Review Body may affirm, modify or reverse the adverse result or action taken by the MEC or by the Board pursuant to Article IV, Section 4.2 or Section 4.3(b)(2) or, in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it within fourteen (14) days and in accordance with its instructions. Within seven (7) days after such receipt of such recommendations after referral, the Appellate Review Body shall make its final determination.

6.9 CONCLUSION

The Appellate Review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

ARTICLE VII
FINAL DECISION OF THE BOARD

7.1 No later than twenty-eight (28) days after receipt of the recommendation of the Appellate Review Body, or twenty-eight (28) days after waiver of Appellate Review, the Board shall consider the same and affirm, modify or reverse the recommendation. When a matter of hospital policy or potential liability is presented, the Board shall consult with the MUSC Health CEO prior to taking action. The decision made by the full Board after receipt of the written recommendation from the Appellate Review Body will be deemed final, subject to no further appeal under the provisions of this Fair Hearing Plan. The action of the Board will be promptly communicated to the practitioner in writing by certified mail.

ARTICLE VIII

GENERAL PROVISIONS

8.1 HEARING OFFICER APPOINTED & DUTIES

The use of a Hearing Officer to preside at an evidentiary hearing is optional. The use and appointment of such an officer shall be determined by the Board. A Hearing Officer may or may not be an attorney at law, but must be experienced in conducting hearings. He/She shall act as the Presiding Officer of the hearing and participate in the deliberations.

8.2 ATTORNEYS

If the affected practitioner desires to be represented by an attorney at any hearing or any Appellate Review appearance pursuant to Article VI, Section 6.4, his/her initial request for the hearing should state his/her wish to be so represented at either or both such proceedings in the event they are held. The MEC or the Board may also be represented by an attorney.

8.3 NUMBER OF HEARINGS & REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws or of this Plan, no practitioner shall be entitled as of right to more than one (1) evidentiary hearing and Appellate Review with respect to an adverse recommendation or action.

8.4 RELEASE

By requesting a hearing or Appellate Review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability in all matters relating thereto.

8.5 WAIVER

If any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request of appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

FAIR HEARING PLAN
APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____ _____
Chief of Staff Date

MUHA BOARD OF TRUSTEES:

By: _____ _____
Chairperson Date

MEDICAL UNIVERSITY HOSPITAL AUTHORITY

By: _____ _____
Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____
Corporate Legal Counsel Date

Summary of changes to
MUSC Charleston Medical Staff Documents:
December 9, 2022

BYLAWS:

Article I. PURPOSE AND RESPONSIBILITIES

Section 1.04 Added to meet Joint Commission and CMS requirements.

The Medical Staff also is provided with the opportunity and has the right to opt in or out of the MUSC Health Regional Health Care Network Medical Staff Unified Bylaws. If the Medical Staff opts into the unified bylaws, they will follow the unified bylaws and are afforded the right to vote to opt out every two years.

Article III. MEDICAL STAFF MEMBERSHIP & STRUCTURE

Section 3.04 c. Changed as provisional year not necessary and will decrease unnecessary credentialing workload. Will still have focus evaluation during first year.

Deleted- All initial appointments to the staff shall be for a provisional period of one year. Changed to All appointments to the staff shall be for a period not to exceed two years.

Article IV. CATEGORIES OF THE MEDICAL STAFF

Section 4.06 Added a new medical staff category based on need.

LOCUM PROVIDERS- This category is restricted to those Medical Staff and Professional Staff under contract with a Locum agency who temporarily fulfill the duties of another provider or provide independent short-term services. Such members are not eligible for faculty appointments or voting privileges. Qualifications are described in the Credentials Policy.

RULES AND REGULATIONS:

ADMISSIONS (pg. 4) Added new section to govern and limit the use of telemedicine in lieu of in person encounters with patients.

Telemedicine in the inpatient setting may be permitted if the use of telemedicine is "additive" not "substitutive," meaning that it should be employed only when it would add a needed clinical service that would be otherwise unavailable, either due to general lack of availability of a specialty or due to staffing shortages. This is applicable for all in-patient credentialed providers.

Inpatient telemedicine encounters must be approved by the Department Chair and the Chief Medical Officer. New approvals for inpatient telemedicine should seek approval from the Medical Executive Committee (MEC), when possible. Reports outlining the use of telemedicine in the inpatient setting will be presented at MEC at least quarterly.

CREDENTIALS MANUAL

II CLASSIFICATION OF APPOINTED PRACTITIONERS

C. 3. Medical Staff Appointment with Privileges (pg.6)

Added details and qualifications for Locum Providers added to bylaws above.

Qualifications:

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 (ABMS 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.

Maintain a Federal DEA number and State DHEC License/Certification where applicable.

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.

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.

IV Initial Appointment and Privileging Process

E. Provisional Appointment and Initial Privileges (pg. 16)

Eliminated one-year provisional status as added to the bylaws above

VI Reappointment/Privilege Renewal Review Process

A. Department Chairperson Review (pg. 21)

Added language based on Joint Commission standard.

All Department Chairperson reappointment application requests will be reviewed by the Charleston Division Chief Executive Officer or designee.

MUSC Health
Medical University of South Carolina

MUSC Health – Charleston

Section # {External Reference #}	Policy # 8602	Medical Staff Bylaws	
Responsible Department:			
Date Originated Not Set	**Last Reviewed** 02/08/2019	**Last Revised** 02/08/2019	**Effective Date** 03/11/2022

Printed copies are for reference only. Please refer to the electronic copy for the official version.

Medical University of South Carolina Medical Center

Medical Staff Bylaws

~~January 2019~~
December 2022

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 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).

Section 1.04 ***MUSC Health owns and operates multiple health care facilities. The Medical Staff acknowledges that the difference in scope of services among these facilities may necessitate adoption of special rules, regulations, policies, and procedures applicable on a hospital-specific basis. However, wherever possible, the desire of the Medical Staff is to consolidate resources, to standardize policies and procedures, to minimize unnecessary variance in operations to promote their maximum efficiency and effectiveness, and to facilitate a comparably high standard of care at all the Hospitals, while at the same time accommodating the uniqueness of each Hospital and its practice culture. MUSC Health may enter into arrangements with other MUSC Health affiliated clinical entities (e.g., other MUSC Health owned hospitals, surgery centers, or their successor entities.) for the purpose of sharing information relevant to the activities of the medical staff and individual medical staff members. Such arrangements may include, without limitation, sharing of credentialing and peer review information between MUSC Health affiliated clinical entities, and participation in joint committees among MUSC***

Health affiliated clinical entities to address credentialing, privileging, peer review, and performance improvement matters. In addition, the Medical Staff may rely on hospital medical or professional staff support resources to assist in the processing of applications for appointment, reappointment, and privileges. The Medical Staff may collaborate with other MUSC Health affiliated clinical entities and the Board to develop coordinated, cooperative, or joint corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, notice of corrective actions imposed and/or recommended, and coordinated hearings and appeals. The Medical Staff also is provided with the opportunity and has the right to opt in or out of the MUSC Health Regional Health Care Network Medical Staff Unified Bylaws. If the Medical Staff opts into the unified bylaws, they will follow the unified bylaws and are afforded the right to vote to opt out every two years.

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 Co-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) Doctor of Osteopathy (DO) degrees, or Dentists or podiatrists holding a current, valid academic license or 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 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. Maintain Federal DEA and State DHEC license/certification where applicable.

Section 3.03 NON-DISCRIMINATION - The MUSC Medical Center will not discriminate in granting staff appointment and/or clinical privileges based on 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.~~ All appointments to the staff shall be for a period not to exceed two years.

d. Re-a~~A~~ppointments 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.

h. 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

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 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 Chief Medical Officer, APP Best Practice Center and Chief Quality Officer. 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 Chief Medical Officer 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, the President of the Medical Staff, or the Chief Medical Officer of the of the Medical Center, according to Medical Center Policy C-035 Disaster Privileges for Licensed Independent Practitioners (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 practitioner 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.

Article IV. CATEGORIES OF THE MEDICAL STAFF

Section 4.01 THE ACTIVE CATEGORY

a. Qualifications – An 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 (https://www.musc.edu/medcenter/policy/MedicalStaff/CredentialingManual.pdf))
b. Prerogatives – An 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-074 Resident Supervision
Resident Supervision

(iv) Participate in the emergency room and other specialty coverage programs as scheduled or as required by the MEC Co-Chairs 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 – An appointee to this category must:

(i) Be a member of the faculty of the Medical University of South Carolina.

(ii) Participate in the clinical affairs of the MUSC Medical center

(iii) 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

(iv) Refer patients to other physicians or staff of the MUSC Medical Center or those who order diagnostic or therapeutic services at the MUSC Medical Center.

(v) The Credentials Committee may waive the requirement to care for at least six (6) patients during an appointment period for physicians who are members in good standing with an MUSC Health affiliated hospital and who continue to meet the qualifications for appointment to the Affiliate Staff of MUSC. Additionally, this exception would only occur if physician specific quality and outcomes information has been provided by the affiliated hospital upon request. Such information shall be

sufficient quality and quantity to allow a reappointment and privileging recommendation by the Credentials Committee.

b. Prerogatives – An 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 he/she is appointed and any staff of MUSC Medical Center education programs.

(iii) Request admitting privileges.

c. 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 4.03 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 or administrative appointments 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 AFFILIATE COLLEAGUES - This category is restricted to those physicians who meet all the eligibility and membership requirements for appointment to the Medical Staff but who neither request nor are granted clinical privileges. This includes medical staff members of MUHA Health owned and operated hospitals as well as affiliate hospitals, who are in good standing at their respective facility. Such staff appointees are not eligible to admit patients to the Medical Center or to vote in Medical Staff matters. They may, however, attend Medical Staff and Department meetings without voice This category is exempt from malpractice insurance requirements unless required by their respective facility.

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 Co-Chairpersons of the Executive Committee of any status changes.

b. Professional Staff – Members of the Professional Staff 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.

Section 4.06 LOCUM PROVIDERS- This category is restricted to those Medical Staff and Professional Staff under contract with a Locum agency who temporarily fulfill the duties of another provider or provide independent short-term services. Such members are not eligible for faculty appointments or voting privileges. Qualifications are described in the Credentials Policy.

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 to nominate a Secretary or other officers if vacant.

a. This committee shall present a list of names for consideration 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 vote of 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 house staff peer review committee. The Secretary will serve as Vice- President elect.

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 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 practitioner 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- LIPs 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 to allow the committee to have an integrated leadership role within MUSC Medical Center. The MEC shall include:

1) The three (3) officers of the Medical Staff
2) Immediate Past President of the Medical Staff
3) Executive Director of MUSC Medical Center or his/her designee
4) The Dean of the College of Medicine or his/her designee
5) The Chief Physician Executive for MUSC Physicians
6) Chief Medical Officer (CMO) of MUHA
7) Chief Operating Officer (COO) of MUHA
8) Executive Chief Nursing Officer
9) Department of Medicine Chairperson
10) Department of Surgery Chairperson
11) Chief Quality Officer
12) Chief Medical Information Officer
13) CMO of MUSC Physicians or designee
14) President of MUSC Physicians
15) One (1) member as elected by the House Staff (voting)
16) Credentials Committee Chairperson
17) Department of Pediatrics Chairperson
18) Designated Institutional Officer for Graduate Medical Education
19) Department Chair of Emergency Medicine
20) Department of Laboratory Medicine & Pathology Chairperson or his/her designee
21) Department of Anesthesiology and Perioperative Medicine Chairperson or his/her designee
22) Department of Radiology Chairperson or his/her designee
23) Three (3) elected Medical Staff representatives: one (1) each to represent mental health, primary care and surgical specialties to be elected by the Medical Staff members of those represented departments
24) Four ICCE Chiefs appointed by the Chief Medical Officer of MUHA that are not serving on the Medical Center Operations or Quality Executive Committees concurrently.

b. Ex-Officio / Non-voting Members:

1) Director of Pharmacy
2) Senior Healthcare Counsel
3) Director of Accreditations
4) Director, Risk Management

5) Manager, Medical Staff Affairs
6) Faculty Senate Representative
7) APP Representative

c. Membership for all elected members and appointees will be for a two-year period starting on the first day of the calendar year. The house staff member will serve for one year. The MEC will be co-chaired by the Chief Medical Officer of MUHA and the Medical Staff President.

d. All members will have voting rights.

e. If an emergent situation arises between meetings of the MEC that, requires a vote and approval by the MEC, the President of the Medical Staff or the Chief Medical Officer may by written, verbal, or printed notice request a virtual meeting, a vote, or both. The notice shall include a description/explanation of the matter that requires a vote and a mechanism for voting. This request for a vote shall be delivered, either personally or by mail, including electronic mail to each member of the MEC not less than three (3) days before the return deadline for voting. Members may submit their vote either in person or in writing via campus mail, email, fax, text, or as instructed (i.e., electronic survey) to either the office of the Chief Medical Officer of MUHA or as designated. A quorum for this voting would be the majority vote of returned ballots. A record of the official vote will be recorded and maintained by the office of the CMO of MUHA and presented to the MEC at the next scheduled MEC meeting.

f. 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**.**

(xvi) Communicate decisions and discussions of the MEC to their respective, department, division, service line members or employees.

g. 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.

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 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) The authority to amend these bylaws cannot be delegated.

h. 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 either of the Chairpersons.

i. 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.

(iii) Credentials Committee - A Credentials Committee will be maintained by the MEC according to the MUSC Medical Center Credentialing Policy and Procedure Manual.

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

c. Committees- When committees have been assigned or sanctioned as Medical Staff Committees the following will apply:

(i) These committees shall serve as advisory committees to the Medical Executive Committee.

(ii) Each committee shall prepare minutes or a report of its meetings.

(iii) Reports of the committees shall be presented to the MEC upon request.

(iv) Any Medical Staff member serving on a committee including the chairperson may be removed by the President of the Medical Staff or Chief Medical Officer from the committee for failure to remain

as a member of the staff in good standing, for failure to attend meetings, for unsatisfactory performance of the duties assigned to the committee, or by action of the Medical Executive Committee.

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.

Section 8.02

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 8.03 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 8.04 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 8.05 **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 8.06 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 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 pre-anesthesia assessment.

Section 8.07 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 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 8.08 The attending physician is responsible for the complete H&P.

a. Residents, appropriately privileged, may complete the H&P with the attending physician's counter signature.
b. Advanced Registered Nurse Practitioners and physician assistants, appropriately privileged, may complete the H&P without attending co-signature
c. The attending physician may complete an additional attestation sheet to confirm or change the initial history and physical.
d. If changes are needed, the attestation must be completed by the attending within 48 hours of admission or prior to any procedure requiring H&P's.

Article IX. MEDICAL STAFF MEETINGS

Section 9.01 REGULAR MEETINGS

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

b. The annual Medical Staff Meeting shall be held during the last quarter of each calendar 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.

d. In lieu of the annual meeting, matters that require a vote and approval by Medical Staff members as determined by the MEC or by regulation or law throughout the year may be presented to the Medical Staff members by written or printed notice. The notice will include a description/explanation of the matter that requires a vote and a mechanism for voting. This request for a vote 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 three (3) days before the return deadline for voting. Members may submit their vote either in person or in writing via campus mail, email, fax, text, or as instructed (i.e., electronic survey) to either the office of the Chief Medical Officer of MUHA or as designated. A quorum for this voting would be the majority vote of returned ballots. A record of the official vote will be recorded and maintained by the office of the CMO of MUHA and presented to the MEC at the next scheduled MEC meeting.

Section 9.02 SPECIAL MEETINGS - The President of the Medical Staff, the Chief Medical Officer, 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 three
(3) days 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 the annual meeting 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 or one of the Co-Chairs.

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, Chief Medical Officer, 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 affected 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 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 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 practitioner 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.

a. 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 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.

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

(vi) To determine whether the practitioner may have clinical privileges with respect to or membership;

(vii) To determine the scope or conditions of such clinical privileges or membership; or

(viii) To change or modify such clinical privileges or membership.

1) 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.

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

4) 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, APRNs, PA-Cs, dentists, and Affiliated Health Care Professionals respectively.

5) 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.

6) 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.

b. 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 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.

c. 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 Co-Chairs 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) daytime period shall constitute a waiver of the practitioner's right to hearing and to any further appellate review on the issue.

4) The Chief Medical Officer 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.

d. 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 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.

e. CONDUCT OF HEARING AND NOTICE

(i) If a hearing is requested on a timely basis, the hearing shall be held as determined by the Chief Medical Officer 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 Chief Medical Officer 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 Medical 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.

f. 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.

g. 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.

h. 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.

i. EVIDENTIARY MATTERS IN CONTESTED CASES

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

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

(iii) Notice may be taken of judicially cognizable facts. In addition, the Hearing Officer, Arbitrator, or ad hoc Hearing Committee may take notice of generally recognized technical or scientific facts within the Committee's specialized knowledge. Parties shall be notified either before or during the hearing of the material noticed, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material noticed. The Committee's experience, technical competence and specialized knowledge shall be utilized in the evaluation of the evidence.

j. 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.

k. 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 Co-Chairs 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.

l. NOTICE OF DECISION

(i) The Co-Chairs 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.

m. 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 Chief Medical Officer (by personal service or certified mail, return receipt requested), request an appellate review by the Board of Trustees. The Notice of Appeal and Request for Review, with or without consent, shall be presented to the Board of Trustees at its next regular meeting. Such notices requesting an appellate review shall be based only on documented record unless the Board of Trustees, within its sole discretion, decides to permit oral arguments.

(ii) If such appellate reviews not requested within ten (10) days, the affected practitioner shall have deemed to have waived his/her right to appellate review and the decision an issue shall become final.

n. 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.

o. 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 Chief Medical Officer, 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.

p. 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 no 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.

q. 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 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 practitioner 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 Staff on January 16, 2019
Approved by the Medical Executive Committee January 16, 2019
Revisions approved by the Board of Trustees on February 8, 2019

MUSC Health
Medical University of South Carolina

MUSC Health – Charleston

Section # {External Reference #}	Policy # MS-001	MS-001 Credentialing-Manual Medical Staff Office	
Responsible Department: CHS - Medical Staff Office (Main)			
Date Originated 02/01/2006	**Last Reviewed** Not Set	**Last Revised** Not Set	**Effective Date** Not Set

Printed copies are for reference only. Please refer to the electronic copy for the official version.

MUSC Medical Center Credentialing Policy

December 2022~~January 2019~~

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 based on 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 professional 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.

Membership

The Chairperson of the Credentials Committee is appointed by the Vice President for Medical Affairs (or his/her designee) as recommended by the Chief Medical Officer of MUSC Medical Center. The appointment for Chairperson shall be for a three (3) year term with eligibility for reappointment for two additional terms. Members of the Credentials Committee are recommended by Department Chairpersons at the request of the President of the Medical Staff and /or the Chief Medical Officer 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. Both the Chairperson and other members may have their membership extended beyond the stated appointment period if approved by the MEC.

2. Reporting Channels

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

3. Meetings

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

4. Minutes

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

D. Confidentiality

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 Chief Medical Officer 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 (ABMS 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 two years.
- 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-074 Resident Supervision (https://www.musc.edu/medcenter/policy/Med/C074.pdf).
- Participate in the emergency room and other specialty coverage programs as scheduled or as required by the Chief Medical Officer, 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 X 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 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.

~~4.~~3. **Locum Providers** This category is restricted to those Medical Staff and Professional Staff under contract with a Locum agency who temporarily fulfill the duties of another provider or provide independent short-term services. Such members are not eligible for faculty appointments.

Qualifications:

- 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 (ABMS 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;
- Maintain a Federal DEA number and State DHEC License/Certification where applicable;
- 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;
- 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.

~~E.~~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.

2. AFFILIATE COLLEAGUES

This category is restricted to those physicians who meet all the eligibility and membership requirements for appointment to the Medical Staff but who neither request nor are granted clinical privileges. This includes medical staff members of MUHA Health owned and operated hospitals as well as affiliate hospitals, who are in good standing at their respective facility. Such staff appointees are not eligible to admit patients to the Medical Center or to vote in Medical Staff matters. They may, however, attend Medical Staff and Department meetings without voice. This category is exempt from malpractice insurance requirements except as required by their respective facilities. Physicians from MUSC Health affiliated hospitals may be appointed to this category.

~~F.~~E. Professional Staff Appointment with Privileges

1. Allied Health Professionals

Allied Health Professionals 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 Professionals 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, supervision agreements, 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.

~~G.~~F. Telemedicine Providers

Telemedicine providers are practitioners whose sole privileges are for the provision of specific services to MUSC Medical Center patients via telemedicine link. These practitioners are not members of the Medical Staff, are not eligible to vote or attend meetings of the Medical Staff, and are not eligible to admit patients to the MUSC Medical Center. This category is exempt from Board Certification requirements. Credentialing by Proxy is the method that will be used to credential these practitioners at the MUSC Medical Center.

III. Initial Appointment Application

A. Nature of the Application

Each applicant shall complete the online application provided by the Medical Staff Office via the Credentials Verification Office (CVO).

B. 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.

C. 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, driver's license, or passport photograph of self;
- Any additional information required in response to questions on the application form; and

D. 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

F. 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.

G. 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.

H. Verification Process:

After receipt of the completed application for membership, the Medical Staff Office via the Credentials Verification Organization (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 can 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.

I. 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. 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.

B. 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 Chief Nursing Officer is a member of the Credentials Committee and will participate in all application reviews. In particular, the Chief Nursing Officer will make a recommendation based on the status of each Advanced Practice Registered Nurse (APRN) action that comes before the committee. 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 Chief Medical Officer through the Medical Staff Office shall be promptly given to the applicant if the Credentials Committee requires further information about the applicant.

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 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 Chief Medical Officer 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 averse to the applicant, the Executive Director or the Chief Medical Officer 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.

D. 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 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 Chief Medical Officer or their designee through the Medical Staff Office, by written notice, will inform the applicant of that decision within 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 averse to the applicant, the Chief Executive Office or the Chief Medical Officer or their designee through the Medical Staff Office, within 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 Chief Medical Officer 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 averse to an applicant, the matter is referred 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.

E. 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 a period not to exceed two (2) years. 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~~ first 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. Failure to do so may result in immediate reappraisal by the Credential Committee of the member's staff appointment. 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 Chief Medical Officer. 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 Chief Medical Officer, 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 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 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 Chief Medical Officer. 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 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. All Department Chairperson reappointment application requests will be reviewed by the Charleston Division Chief Executive Officer or designee.

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 Chief Medical Officer, 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 Chief Medical Officer 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 Chief Nursing Officer is a member of the Credentials Committee and will participate in all application reviews. In particular, the Chief Nursing Officer will make a recommendation based on the status of each Advanced Practice Registered Nurse (APRN) action that comes before the committee. 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 Chief Medical Officer 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 averse to the applicant, the Executive Director or the Chief Medical Officer 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 Chief Medical Officer 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 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 Chief Medical Officer or their designee through the Medical Staff Office, by written notice, inform the applicant of that decision within 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 Chief Medical Officer or their designee through the Medical Staff Office, within 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 X 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 Chief Medical Officer 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 averse to an applicant, the matter is referred 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 ensure that privileges for all privileged practitioners are current and accurate. Privilege sets are maintained by the MSO. These privileges sets may be either paper or electronic. It is the responsibility of the MSO to communicate privilege lists to Medical Center staff to ensure 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.

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: Temporary privileges are granted by Executive Director or authorized designee and/or Chief Medical Officer 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 Director or his/her designee 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 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 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

C. When all or any part of his/her temporary privileges are terminated or suspended. Disaster Privileges

During disaster(s) in which the disaster plan has been activated, the Executive Director of the Medical Center, the Chief Medical Officer, 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-035 Disaster Privileges for Licensed Independent Practitioners (https://www.musc.edu/medcenter/policy/Med/C035.pdf). 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 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 Chief Medical Officer, 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 or his/her designee to which he/she is assigned

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Approved by Medical Staff on December 8, 2016. Approved by the Medical Executive Committee on January 18, 2017. Revisions approved by the Board of Trustees in February 2017.

MUSC Health – Charleston

Section # {External Reference #}	Policy # 8604	Medical Staff Rules Regulations	
Responsible Department:			
Date Originated Not Set	**Last Reviewed** Not Set	**Last Revised** Not Set	**Effective Date** Not Set

Printed copies are for reference only. Please refer to the electronic copy for the official version.

Medical University of South Carolina Medical Center

Medical Staff Rules and Regulations

~~***October 2019***~~

December 2022

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 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 Health Affairs/ 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. **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. **Practitioner** - an appropriately licensed medical physician, osteopathic physician, Advanced Practice Provider (APRN and PA-C), oral surgeon, or dentist, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice.

9. **Executive Committee** the Medical Executive Committee of the Medical Staff.

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

11. **Affiliated 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.

Authentication - refers to the full name signature, date, time, and 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.
Whereas herein the word "**Hospital**" is used it refers to the MUSC Medical Center and its component hospitals and outpatient activities. Since the English language contains no singular pronoun that 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

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. 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. Admission orders must be provided by the attending physician. If admit orders are entered by another physician, PA-C or APRN, they must be co-signed by the attending physician.

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. The evaluation can be performed and completed by an APRN or PA-C. Such an evaluation must be completed within 24 hours of admission and must include admission orders. The admission orders must be signed/co-signed by the attending physician prior to discharge
- 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

- prompt completeness and accuracy of the medical record,
- necessary special instructions,
- 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, and
- completion of a clinical handoff to the next attending in inpatient settings, during times of intermittent coverage and/or at the end of a clinical rotation. "Best practice" handoffs are both written and verbal, with an opportunity for the oncoming attending to ask clarifying questions.

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.

Telemedicine

Telemedicine in the inpatient setting may be permitted if the use of telemedicine is "additive" not "substitutive," meaning that it should be employed only when it would add a needed clinical service that would be otherwise unavailable, either due to general lack of availability of a specialty or due to staffing shortages. This is applicable for all in-patient credentialed providers.

Inpatient telemedicine encounters must be approved by the Department Chair and the Chief Medical Officer. New approvals for inpatient telemedicine should seek approval from the Medical Executive Committee (MEC), when possible. Reports outlining the use of telemedicine in the inpatient setting will be presented at MEC at least quarterly.

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, APRN or PA-C 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, 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. Please see A-082 Records Retention for more information.

c. 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. See Policy A-082 Records Retention for more information.

d. The attending physician, APRN or PA-C 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 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.

Informed Consent Requirements

It is the responsibility of the attending physician, APRN, PA-C, resident, or intern to assure appropriate informed consent is obtained and documented in the medical record and when appropriate, also document the discussion in a progress note if the provider is present during the procedure. For surgical procedures only, the provider needs to be present during the procedure to obtain consent. 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 the following 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 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, APRN or PA-C who obtained the consent, (verbal consent may be witnessed by the nurse and indicated on the consent form),
- physician, APRN or PA-C documentation of the consent process in a progress note or on the consent form.

Physician, APRN or PA-C 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 Progress Note/Brief Operative Note: If a full operative/procedure report is not completed and on the record before a patient

moves to a different level of care post procedure, an operation/procedure

progress note/brief op 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. All required elements must be addressed even if the element is not applicable (N/A).

Operative Report:
For all patients (both inpatient and outpatient) the full operative/procedure report shall be entered, written, or dictated into the medical record no later than twenty-four (24) hours from the completion of operation/procedure. The signature of the primary physician/surgeon is required within three (3) 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.) The operative/procedure report must contain the name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s), the name of the procedure performed, a description of the procedure, findings of the procedure, any estimated blood loss, any specimen(s) removed and the postoperative/procedure diagnosis.

Procedure Report:
Included but not limited to Interventional Radiology, Heart Catheterizations and Gastroenterology Endoscopies, shall be entered, written, or dictated and into the medical record no later than twenty-four (24) hours from the completion of the procedure. The signature of the primary physician is required within 3 days of the procedure.

Note: When a progress note is entered into the record immediately after the procedure it can become part of the operative report but must be dated, timed, and signed by the physician at the time of completion of the progress note.

In all cases, when the full operative report is dictated, the operative progress note/brief operative report must be completed.

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 24 hours of discharge with an official discharge summary and signature by the physician, APRN or PA-C within 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 regarding activity, discharge, medications, diet, and follow-up instructions. Residents may complete the discharge summary with attending supervision as evidenced by the attending's co-signature on the report.

For inpatient and observation stays less than 24 hours, 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.

Specific record requirements for physicians shall include the following:

- 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, including a complete and accurate medication list
- all final diagnoses, complications, or procedures
- AJCC staging for diagnosed cancer patients
- Death Note- prior to transport of decedent to Morgue.
- Death Summary – final version within 12 hours of pronounced time of death.

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.

Medical Records Preparation and Completion

Completion Requirements

The following elements in the medical record must be completed as stated:

- 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 report- within 24 hours of surgery
- 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
- Home health orders- within 24 hours of discharge
- Death Note- prior to transport of decedent to Morgue.
- Death Summary – final version within 12 hours of pronounced time of death.

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, APRN or PA-C 3 days following the completion due date, (The exception is outpatient

visit notes when the attending physician's, APRN or PA-C 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/death summaries; (4) ED attending notes; (5) inpatient and outpatient operative/procedure reports; (6) outpatient visit notes and (7) admission orders. [See Delinquency Summary Table]

Delinquency Summary Table

Medical Record Required Element	**Required Completion time within:**	**Attending's Signature, APRN or PA-C required within:**	**Deemed Delinquent at:**
Admission H&Ps	24 hours	3 days	4 days
Inpatient & ED consultations	24 hours	3 days	4 days
Death note	Prior to transport of decedent to Morgue	12 hours*	1 day
Discharge Summaries/	Preliminary version within 24 hours Official within 3 days	3 days	4 days
Death summaries	Final version within 12 hours of death pronouncement	24 hours (attending signature only)	**2 days**
ED attending notes	24 hours	3 days (attending signature only)	4 days
Operative	24 hours	3 days (attending signature only)	4 days
Outpatient visit notes	7 days	14 days	14 days
Admission orders	Upon admission	Prior to discharge (Attending signature only)	At discharge
Procedure reports	24 hours	3 days	4 days
In-Basket Folders	24 hours	3 days	4 days
In-Basket Pool Folders	48 hours	4 days	6 days

*Regarding the "death note," APRNs and PAs can perform the death notes if they are signed off on a department specific competency and is in their practice agreement (APRN)/scope of practice guidelines (PA).

Note: In basket folder items may be signed by another LIP with like privileges when requested by the physician, APRN or PA-C responsible for the In-Basket to assure timely review of time-sensitive results.

Physicians, APRNs or PA-Cs will receive two (2) notifications from the Health Information Management (HIM) 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, APRNs or PA-Cs will receive two (2) notifications from the HIM 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 may also result for repeated failure to provide quality documentation (i.e., the quality of histories and physicals, failure to update histories and physicals as required, failure to sign admit orders). These determinations will be made based on medical record reviews conducted under the authority of the Chief Medical Information Officer.

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, APRN or PA-C 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, and 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.

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).

Administrative Authority for Medical Records

In extreme and extenuating circumstances, the Health Information Management Committee (HIMC) with the Chief Medical Information Officer has the authority to make administrative changes in the medical record. These changes would be necessary in rare circumstances when the provider is no longer available, or in other extenuating circumstances, or to enable various chart correction activities (e.g., when a signed note is discovered in the wrong patient's chart). In all cases, these administrative changes will be reported to the MEC and will follow specific Health Information Management policies and procedures.

V. ORDERS

General Requirements

a. When a practitioner uses an electronic signature, he must ensure it is only used in accordance with departmental policies and related regulatory guidelines.

b. When transferring a patient to a different level of care or to a different service, all orders must be individually reviewed and adjusted by the practitioner according to the patient clinical status. See Transfer of Patients Within MUSC Health Charleston. See Medication Reconciliation

c. When a patient returns to a patient care unit from the operating room (OR) or when a procedure is performed outside of the OR, pre-procedure orders are individually reviewed and adjusted by the physician, APRN or PA-C according to the patient clinical status.

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

e. Medications should be ordered within the *MUSC Formulary of Accepted Drugs* (Formulary System)

f. Blanket orders such as “resume pre-op medications” [as outlined above in c.] or “resume home medications” are prohibited.

g. All medication orders must be written according to C-078 Medication Orders.

h. Any nursing communication should be used to communicate a singular action for the care of the patient. If the therapy should occur in any frequency, the provider must place a specific order with the exact frequency and directions for completion of the action or therapy.

i. Palliative care consults, ethics consults, or referrals can be placed by any provider or ancillary staff based on the needs of the patient. After completing the consult, recommendations will be communicated back to the attending of record.

Who May Write Orders

Orders may be written by members of the medical staff, residents, and allied health professionals (i.e., advanced nurse practitioners, physician assistants, social workers, psychologists, pharmacists) within the scope of their practice delineated clinical privileges, and approved protocols. All orders must be written clearly and completely. Orders must include date, time written, and provider authentication. When an order is handwritten, the order must also be legible and include the ordering practitioner page ID for authentication.
Authenticated electronic signatures for orders are acceptable when available.

Order Entry

Orders can only be placed and accepted through the orders entry activities within the electronic health record. Care instructions written outside of the order entry activities are not considered orders; therefore, they will not be acted upon by the clinical staff. Examples include but are not limited to progress notes and discharge forms.

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, APRN, PA-C or a registered dietician through orders entered into the patient's medical record. 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.

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, an advanced nurse practitioner, PA-C 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. The ordering practitioner must sign verbal orders for restraints within twenty-four (24) hours. PRN orders are not acceptable. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the restraint or seclusion.

d. When restraints are used for behavioral reasons, the patient must be seen by an MD, APRN or PA-C within one hour of initiation.

e. 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, APRN or PA-C 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 8781 Resuscitation Orders (formerly C-013) . In all cases, the patient has the right to refuse resuscitation verbally or as by written advanced directive. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the DNR.

f. Allow Natural Death (AND) order should be followed according to C-023 Withholding/Withdrawing Life-Sustaining Treatment. When a patient or family presents a signed AND advanced directive, discussion must occur between treating physician, APRN or PA-C and

patient (or surrogate). Collaboration with the attending physician must occur as soon as feasible if the attending physician did not order the AND order.

g. A validly completed and executed South Carolina Physician Orders for Scope of Treatment ("POST") form may be accepted in any emergency 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, APRN or PA-C should document review of the POST and conversations about the POST in the medical record. Collaboration with the attending physician must occur as soon as feasible if the attending physician did not complete the POST form.

h. Orders to admit a patient must be signed/co-signed by the admitting physician or by another physician credentialed to admit patients.

i. All PRN medications must include an indication for use.

j. All outpatient in-clinic or retail medication orders must include an associated diagnosis.

k. Any sample medication provided in the clinics must appear on the patient's outpatient medication list. For MUHA clinics, the sample will be sent as a prescription to an on-campus retail pharmacy. For MUSC-P clinics, the medication order will be added to the medication list when the sample(s) is provided to the patient.

l. Pharmacists may place laboratory orders without a prescriber's co-signature as part of the therapeutic drug monitoring referral program (Medication Orders).

m. A discharge orders for home health care must have an appropriately documented face to face encounter between the patient and the ordering physician, APRN or PA-C. For CMS home health, Attending Physician signature required.

Verbal or Telephone Orders

A verbal or telephone order is defined as an order communicated verbally by either an on-site or off-site practitioner for treatment that normally requires a written order. The request for and use of verbal or telephone orders should be limited, whenever possible, to urgent or emergent situations. In all cases, a verbal or telephone order will not be considered complete until the individual receiving the order, reads back and verifies the content of the order. Non-urgent

verbal or telephone order may be acceptable when the practitioner is off-site (without access to the EHR), unable to immediately stop the care of a patient (e.g., OR procedure), or communicating a medication order to a retail pharmacy. Ordering Modes

a. The following disciplines may request and accept a verbal or telephone order within the scope of their practice:
   - Physician assistant
   - Advanced practice registered nurse
   - Registered nurse
   - Licensed practical nurse (in ambulatory clinics only)
   - Certified medical assistant (in ambulatory clinics only)
   - Certified ophthalmic personnel (in ambulatory clinics only)
   - Licensed pharmacist
   - State certified pharmacy technician or pharmacy intern (in ambulatory pharmacies only) [SC Code of Laws 40-43-84]
   - 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)
   - Approved research coordinators
   - 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, dates and timed, read back and verified, and flagged for signature by the person accepting the order.

c. The full name and credentials of the practitioner who dictated the order must be documented for an electronic. The pager ID/immediate contact information should also be documented for handwritten orders.

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 96 hours after patient discharge.

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, APRN, PA-C or dentist must be notified by a nurse of the discontinuation. Documentation of notification of the physician, APRN, PA-C or dentist must occur in the medical record.

g. Verbal orders must not be accepted for certain high-risk medications as defined in Ordering Modes.

h. Non-licensed or non-certified personnel (i.e., unit secretaries, clinical assistants) may not give or accept verbal orders from a practitioner under any circumstances.

i. Orders given verbally and documented through one-step mechanisms are considered a verbal order that will require co-signature by the practitioner communicating the order.

j. All of the above applies to both paper and electronic medical record verbal order entry.

k. When using the electronic system, the appropriate physician, APRN or PA-C must select the verbal order within the sign tab and then submit the order.

l. 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.

Standing Orders/ Guidelines

A standing order or a guideline is an order that can be initiated by a nurse or other individual without a prior specific physician's, APRN's or PA-C's order for that patient. The Medical Staff must approve standing orders after the recommendation and approval of the Pharmacy and Therapeutics Committee if medications are part of the standing order. All standing orders must be signed, dated, and timed by the ordering practitioner or by another practitioner responsible for the care of the patient in the medical record as soon as possible.

Standing orders are typically initiated when a patient's condition meets certain predefined clinical criteria as part of an emergency response wherein it is not practical for a nurse to obtain an order before providing care. Standing orders are also provided as part of an evidence-based treatment regimen. Other requirements for Standing Orders are according to C-068 Standing Orders.

Note: A checklist of preprinted treatment options that a physician or practitioner selects from is not considered a standing order.

VI. 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 always have the right to call in a consultant or consultants.

Admission orders should be written and signed by the physician on service that is accepting 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, APRN or PA-C:
   - the diagnosis is obscure after ordinary diagnostic procedures have been completed,
   - there is doubt as to the choice of therapeutic measures to be utilized,
   - unusually complicated situations are present that may require specific skills of other practitioners,
   - the patient exhibits severe symptoms of mental illness or psychosis.

b. The practitioner is responsible for requesting consultation when indicated.

c. 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. 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 C-040 Consultations . 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, APRN or PA-C 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.

VII. 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. Explicit orders regarding precautionary measures are required.

Any patient known or suspected to be suicidal or with a primary diagnosis 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, APRN, PA-C or a member of the Department of Psychiatry.

VIII. 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 Sedation Guidelines for Non-Anesthesiologists.

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 C-044 (see above).

IX. PATIENT DISCHARGE

Who May Discharge

Patients shall be discharged only under the direction of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician, APRN or PA-C 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 shall be notified immediately. A practitioner will pronounce the patient dead, notify the family ASAP, enter a death note in the record, 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.

c. The attending physician requests an autopsy based on the College of American Pathologists criteria and Decedent Care Program Care Program.

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, Organ and 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.

X. HOSPITAL ADMISSION CENSUS

In situations where the hospital bed occupancy is full, the Medical Center may reference and implement A-074 Bed Shortages-EP3 .

XI. MAYDAY PROCEDURE

In the event that a clinical emergency situation arises within the Medical Center or within any University area designated in C-014(B) Emergency Medical Response, Medical Staff are to follow specific duties as outlined in the policy.

XII. 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, advanced practice registered nurse, and physician assistants. If a physician on the on-call list is called by the Emergency Department physician to provide emergency screening or treatment, the on-call physician must respond within a reasonable time as defined in Policy C-048 EMTALA-Medical Emergencies, Screening and Transfer (EMTALA - Medical Emergencies, Screening and Transfer).

If the physician refuses or fails to arrive within the required response time the chain of command should be initiated.

XIII. OBLIGATION TO ACCEPT PATIENT TRANSFERS FROM EMERGENCY ROOM

The Medical Center, and its on-call physicians, will accept the transfer from an emergency room of any patient with an emergent condition who requires specialized capabilities of the Medical Center if the Medical Center has the capability and capacity to treat the patient.

XIV. MEDICATION ADMINISTRATION

All medications will be administered throughout the MUSC health-system using the appropriate procedures and technology to ensure safe, accurate, and timely administration of medication for optimizing patient outcomes. Documentation of the administration should occur in the electronic health record on the medication administration record (MAR) by the person who administered the medication or his/her designee who witnessed the administration.

XV. 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 the following:

Ordering Modes

Critical Results - Reporting and Receiving

Universal Protocol (formerly Time Out Policy-Preventing Wrong Site, Wrong Procedure, Wrong Person) Person Surgery/Procedure)

Use of Abbreviations

Event Investigation & Analysis

Patient Identification

Hand Hygiene - System

Medication Reconciliation

XVI. 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 C-074 Resident Supervision . Appropriately credentialed fellows serving as attending physicians are excluded from these requirements.

XVII. 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.

XVIII. MEDICAL STAFF POLICIES

All members of the Medical Staff are required to follow the policies of the Medical Staff and the Medical Center.

Board of Trustees Credentialing Subcommittee October 2022
The Medical Executive Committee reviewed the following applicants on 10.19.22
and recommends approval by the Board of Trustees Credentialing Subcommittee effective 10.28.22

Medical Staff Initial Appointment and Clinical Privileges

Lidia Bastos Yamada, M.D.	Active Provisional	Neurology
Elizabeth Grier Barrett, M.D.	Active Provisional	Medicine
Amber Star Egbert, B.A., O.D.	Active Provisional	Ophthalmology
Katalina Romero Funke, M.D.	Active Provisional	Medicine
Alexis Garcia, Ph.D.	Active Provisional	Psychiatry
Genoveva Hurtado, AuD	Active Provisional	Otolaryngology
Michelle Suasan Hwabg, MD	Active Provisional	Otolaryngology
Anthony Lamar Mayen, M.D.	Active Provisional	Pediatrics
Rohit Mittal, M.D.	Active Provisional	Surgery
Aness Al Khateeb, M.D.	Colleague- Other	Medicine
Matthew David Cooper, M.D.	Colleague- Other	Emergency Medicine
Tresa Nesbitt, M.D.	Colleague- Other	Medicine
Maureen Alice Tumolo, M.D.	Colleague- Other	Medicine
Sahaj Devin Vallabh, M.D.	Colleague- Other	Medicine

Medical Staff Reappointment and Clinical Privileges

Andrea Marie Abbott, M.D.	Active	Surgery
Milton Byran Armstrong, M.D.	Active	Surgery
M.D.	Active	Surgery
Marissa Blanco Knowlton, M.D.	Active	Pediatrics
Mary Hart Bryan, M.D.	Active	Psychiatry
Christine Marie Carr, M.D.	Active	Emergency Medicine
Kathryn King Cristaldi, M.D.	Active	Pediatrics
Sandra Lynn Fowler, M.D.	Active	Pediatrics
Kristina Kay Gustafson, M.D.	Active	Pediatrics
Daniel Judge, M.D.	Active	Medicine
Edward Francis Kilb, III, M.D.	Active	Medicine
Matthew Fessler Kohler, M.D.	Active	Obstetrics & Gynecology
Zipporah Krishnasami, M.D.	Active	Medicine
Khilen Bhupendra Patel, M.D.	Active	Obstetrics & Gynecology
Rahn Antonio Ravenell, D.P.M.	Active	Orthopaedics
John Flint Rhodes, Jr., M.D.	Active	Pediatrics
Deborah Alice Romeo, M.D.	Active	Anesthesiology
Aljoeson Walker, M.D.	Active	Neurology
John Scott Walton, M.D., B.S.	Active	Anesthesiology
Eyad Almallouhi, M.D.	Active Provisional	Neurology
Marc-Andre Cornier, M.D.	Active Provisional	Medicine
Colleen Ashley Donahue, M.D.	Active Provisional	Surgery
Isabel G Driggers, D.M.D.	Active Provisional	Oral & Maxillofacial Surgery
Missy Maria Lalich, D.O.	Active Provisional	Pediatrics
LalithKumar Solai, M.D.	Active Provisional	Psychiatry
Jeffrey Sutton, M.D.	Active Provisional	Surgery
Harold Michael Szerlip, M.D.	Active Provisional	Medicine
Adam Tanious, M.D.	Active Provisional	Surgery
Alicia Marie Zukas, M.D.	Active Provisional	Neurosurgery
Fred Allen Crawford, Jr., M.D.	Administrative/Honorary	Surgery
M.D.	Affiliate CFC - Colleague	Medicine
Antonia Ashade, M.D.	Colleague- Other	Medicine
Charles Mackie Butler, M.D.	Colleague- Other	Medicine

M.D.	Colleague- Other	Medicine
M.D.	Colleague- Other	Medicine
Amanda Michelle Garman, M.D.	Colleague- Other	Surgery
Anne Smith Hutchison, M.D.	Colleague- Other	Medicine
Steven Mahlon Minter, D.O.	Colleague- Other	Medicine
Loren Garrison Morgan, M.D.	Colleague- Other	Medicine
Jack Edward Neil, M.D.	Colleague- Other	Anesthesiology
Ryan James Orland, M.D.	Colleague- Other	Family Medicine
Gordon Elliot Pennebaker, M.D.	Colleague- Other	Family Medicine
James Huger Richardson, M.D.	Colleague- Other	Medicine
Jerry Wayne Robinson, M.D.	Colleague- Other	Medicine
Joseph Angel Rodrigo, D.O.	Colleague- Other	Anesthesiology
Nusrat UL Shafi, M.D.	Colleague- Other	Family Medicine
Scott R Sommers, M.D.	Colleague- Other	Medicine
M.D.	Colleague- Other	Medicine
John Perry Sutton, III, M.D.	Colleague- Other	Surgery
M.D.	Colleague- Other	Medicine
John Frank Vullo, M.D., B.A.	Colleague- Other	Anesthesiology
Virginia Ellen Wagner, M.D.	Colleague- Other	Pediatrics
William Walter Wegh, D.O.	Colleague- Other	Anesthesiology
Amanda Evelyn White, D.O.,	Colleague- Other	Family Medicine
M.D.	Colleague- Other	Medicine
Robert Paul Zurcher, M.D.	Colleague- Other	Surgery

Medical Staff Reappointment and Change in Clinical Privileges

None

Medical Staff Change in Privileges

None

Professional Staff Initial Appointment and Clinical Privileges

Jesica Cleveland Archie, M.S.N.	Provisional Allied Health	Surgery
C.R.N.A.	Provisional Allied Health	Anesthesiology
Brianna Renee Coulter, P.A.	Provisional Allied Health	Neurology
Natalie J Enter, LPC, M.Ed., B.S.	Provisional Allied Health	Psychiatry
NP	Provisional Allied Health	Surgery
Megan Kellie Huff, F.N.P., BSN	Provisional Allied Health	Emergency Medicine
Patrick Eugene Jurewicz, A.T.C.	Provisional Allied Health	Orthopaedics
Emily Elizabeth Kelley, P.A.	Provisional Allied Health	Surgery
Emily Savannah Linde, AGAC-NP	Provisional Allied Health	Anesthesiology
Bret Loefstedt, M.P.A.S.	Provisional Allied Health	Emergency Medicine
Gregory David Malone, C.R.N.A.	Provisional Allied Health	Anesthesiology
Joseph Charles McTavish, P.A.	Provisional Allied Health	Medicine
Kristine Leigh Meister, P.N.P.	Provisional Allied Health	Pediatrics
Whitney Victoria Merrick, F.N.P.	Provisional Allied Health	Family Medicine
Margaret Catherine Miller, P.A.	Provisional Allied Health	Anesthesiology
Claire Diane Munhall, AGAC-NP	Provisional Allied Health	Otolaryngology
Kimberly Renae Parker, D.N.P.	Provisional Allied Health	Neurology
Candance Patrice Phillips,	Provisional Allied Health	Psychiatry
Kara Smith, FNP-C	Provisional Allied Health	Neurology
Rebekah Phillips Tozer, LISW-CP	Provisional Allied Health	Psychiatry
N.P.	Provisional Allied Health	Surgery
Emily Kathyrn Waller, D.N.P.	Provisional Allied Health	Obstetrics & Gynecology
Jason Warren, D.N.P., B.S.N.	Provisional Allied Health	Emergency Medicine
Jennifer Waters, M.S.W.	Provisional Allied Health	Psychiatry

Meghan Zokas West, D.N.P.	Provisional Allied Health	Pediatrics
Allison M Bonesteel, LMSW	Provisional Allied Health CFC	Family Medicine
Kittipong Srisuwan, C.R.N.A.	Colleague- Other	Anesthesiology
Frances Strickland, MSN, FNP	Colleague- Other	Family Medicine
Sarah Elizabeth Barrett, P.A.	Colleague- Other	Surgery
P.A.	Colleague- Other	Orthopaedics
FNP	Colleague- Other	Emergency Medicine
Chandler Alan Hash, N.P.	Colleague- Other	Pediatrics
Melissa Leigh Hayslip, FNP-C	Colleague- Other	Pediatrics
Kristy Jo Kethe, C.R.N.A., BSN	Colleague- Other	Anesthesiology
C.R.N.A.	Colleague- Other	Anesthesiology
FNP	Colleague- Other	Medicine
FNP-BC	Colleague- Other	Medicine
C.R.N.A.	Colleague- Other	Anesthesiology

Professional Staff Reappointment and Clinical Privileges

Ludd, LMSW	Provisional Allied Health	Psychiatry
Erin M Bisca, M.A., LPC	Provisional Allied Health	Psychiatry
A.P.R.N.	Provisional Allied Health	Psychiatry
Kiften Stephens Carroll, FNP	Provisional Allied Health	Surgery
LPC, LADC	Provisional Allied Health	Psychiatry
Krista M Dickerson, LMSW	Provisional Allied Health	Psychiatry
P.A.	Provisional Allied Health	Pediatrics
Janell Ashlynn Green, C.N.M.	Provisional Allied Health	Obstetrics & Gynecology
A.T.C	Provisional Allied Health	Orthopaedics
Marissa Helen Kemp, D.N.P.	Provisional Allied Health	Pediatrics
NP	Provisional Allied Health	Neurosurgery
Molly Dawn Saxon, M.P.A.S.	Provisional Allied Health	Anesthesiology
Heidi Michele Warren, LMSW	Provisional Allied Health	Psychiatry
Elyse Eun-Min Wertis, M.S.	Provisional Allied Health	Radiology
Laura Michelle Young, LISW-CP	Provisional Allied Health	Pediatrics
Leslie Marie Armstrong, P.A.	Colleague- Other	Medicine
C.R.N.A.	Colleague- Other	Anesthesiology
F.N.P.	Colleague- Other	Family Medicine
C.R.N.A.	Colleague- Other	Anesthesiology
Christopher C. Cornor, C.R.N.A.	Colleague- Other	Anesthesiology
Anita McNeil Dixon, A.G.N.P.-C	Colleague- Other	Medicine
Angela Grant, N.P.	Colleague- Other	Medicine
Madeline Hillsman, P.A.	Colleague- Other	Emergency Medicine
Jessica Elizabeth Newell, F.N.P.	Colleague- Other	Surgery
Kimberly Dawn Powell, F.N.P.	Colleague- Other	Medicine
Kathleen I Riggin, M.S.N.	Colleague- Other	Medicine
Lisa Marie Sand, P.A.	Colleague- Other	Medicine
BC	Colleague- Other	Medicine
Daniel Gerard Sanner, C.R.N.A.	Colleague- Other	Anesthesiology
C.R.N.A.	Colleague- Other	Anesthesiology
Brittney Nicole Skiles, C.R.N.A.	Colleague- Other	Anesthesiology
Shane David Skiles, C.R.N.A.	Colleague- Other	Anesthesiology
Ernest Weston Stokes, III, P.A.	Colleague- Other	Surgery
Kayla Morgan Taylor, P.A.	Colleague- Other	Medicine
Julie Doar Thomas, P.A.	Colleague- Other	Emergency Medicine
Jamie B Thompson, C.R.N.A.	Colleague- Other	Anesthesiology
Jean A Vawter, F.N.P.	Colleague- Other	Urology
Kelly L Warnock, N.P.	Colleague- Other	Medicine
C.R.N.A.	Colleague- Other	Anesthesiology
Lelia Plaxco Wilcox, C.R.N.A.	Colleague- Other	Anesthesiology

Sarah Feldman Wilkes, AGAC-NP	Colleague- Other	Medicine
Kristi H Williams, C.R.N.A.	Colleague- Other	Anesthesiology
Brett A. Williamson, C.R.N.A.	Colleague- Other	Anesthesiology

Professional Staff Reappointment and Change in Privileges

None

Professional Staff Change in Privileges

None

END OF ROSTER

Board of Trustees Credentialing Subcommittee November 28, 2022
The Medical Executive Committee reviewed the following applicants on Nov 16, 2022

and recommends approval by the Board of Trustees Credentialing Subcommittee effective 11.28.22

Medical Staff Initial Appointment and Clinical Privileges

Brett Van Leer-Greenberg, M.D.	Active Provisional	Medicine
Waleed Mohammed, M.B.B.S.	Active Provisional	Medicine
Walter Beversdorf, M.D.	Active Provisional	Pathology & Lab. Med.
Robert Lawrence Borowski, D.O.	Active Provisional	Medicine
Sarah R Breevoort, M.D.	Active Provisional	Neurology
Melanie Anne Lobel, M.D.	Active Provisional	Psychiatry
Ellen M Maher, M.D.	Active Provisional	Medicine
William Mellick, III, Ph.D.	Active Provisional	Psychiatry
Marcy Nagpal, M.D.	Active Provisional	Obstetrics & Gynecology
Victoria M Sexton, Psy.D.	Active Provisional	Pediatrics
Victoria Anne Sullivan, M.D.	Active Provisional	Family Medicine
Joshua Tutek, Ph.D.	Active Provisional	Psychiatry
Claudio Guareschi, M.D.	Provisional Affiliate	Surgery
Troy Belser Gamble, Jr., M.D.	Provisional Affiliate- Colleague- Other	Family Medicine
Chris Stephen McCauley, M.D.	Provisional Affiliate- Colleague- Other	Obstetrics & Gynecology
John Bayne Selby, Jr., M.D.	Provisional Affiliate- Colleague- Other	Radiology
Inderpal Singh, M.D.	Provisional Affiliate- Colleague- Other	Medicine
Zeeshan Azeem, M.D.	Provisional Affiliate- Colleague- Other	Medicine
Matthew Leighton Draughon, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology
Micah Graham Monk, D.O.	Provisional Affiliate- Colleague- Other	Family Medicine
Shanna Barnes Taylor, M.D.	Provisional Affiliate- Colleague- Other	Medicine
James Earl West, M.D.	Provisional Affiliate- Colleague- Other	Medicine

Medical Staff Reappointment and Clinical Privileges

Kathleen Teresa Brady, M.D.	Active	Psychiatry
Howard London Brilliant, M.D.	Active	Orthopaedics
Brandon David Brown, M.D.	Active	Family Medicine
Thomas Karl Byrne, M.D.	Active	Surgery
Nicole Brooks Cain, M.D.	Active	Pediatrics
William Thomas Creasman, M.D.	Active	Obstetrics & Gynecology
Stephen Austin Fann, M.D.	Active	Surgery
James A. Lester Glenn, M.D.	Active	Medicine
William E. Haley, M.D.	Active	Neurology
Lakshmi Devi Katikaneni, M.D.	Active	Pediatrics
David Nigel Bruno Lewin, M.D.	Active	Pathology & Lab. Med.
John Christopher Maize, Sr., M.D.	Active	Dermatology
Sandi Lynn McKenzie, M.D.	Active	Pediatrics
Pamela Bowe Morris, M.D.	Active	Medicine
Arni Clayton Nutting, M.D.	Active	Pediatrics
Bruce Harris Thiers, M.D.	Active	Dermatology
Thomas Edward Werth, M.D.	Active	Medicine
Marion Edward Wilson, Jr., M.D.	Active	Ophthalmology
John Kevin Corless, M.D.	Active Provisional	Medicine
Nicole Cagle-Richardson, M.D.	Affiliate	Pediatrics
Erin Victoria Sparks, M.D.	Affiliate	Neurology
Coleman Lee Floyd, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology
Jennifer Nicole Georgi, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology
Evan Heyward Lee, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology
Luz Yolanda Mendez, M.D.	Provisional Affiliate- Colleague- Other	Medicine

Philip Clifford Moore, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology
Sophia Lorraine Paige, M.D.	Provisional Affiliate- Colleague- Other	Obstetrics & Gynecology
Lorraine Pusser Willcox, M.D.	Provisional Affiliate- Colleague- Other	Anesthesiology

Medical Staff Reappointment and Change in Clinical Privileges

None

Medical Staff Change in Privileges

None

Professional Staff Initial Appointment and Clinical Privileges

Denise A. Bradshaw, F.N.P.	Active Provisional	Family Medicine
Eve Bahler, P.A.	Provisional Allied Health	Otolaryngology
Alison Jean Belleau, N.P.	Provisional Allied Health	Surgery
Marie Hayes, Ph.D., M.A.	Provisional Allied Health	Psychiatry
Abigail Erin Husk, F.N.P.	Provisional Allied Health	Urology
Heather Lee Inch, AGAC-NP	Provisional Allied Health	Surgery
Nicholas Linde, P.A.	Provisional Allied Health	Medicine
Kelly Gleffe Passarello, M.P.A.S.	Provisional Allied Health	Surgery
Lauren Sydnor Springs, P.A.C.	Provisional Allied Health	Family Medicine
Derek M Toth, LMSW	Provisional Allied Health	Psychiatry
Brooklin Trudell, P.A.	Provisional Allied Health	Surgery
Soay Corbett, A.P.R.N.	Provisional Allied Health CFC	Family Medicine
Kela Marie Hamilton, D.N.P.	Provisional Allied Health CFC	Family Medicine
Jessica Grimsley, F.N.P.	Provisional Allied Health- Colleague- Other	Family Medicine
Angela A Morris, A.P.N.	Provisional Allied Health- Colleague- Other	Family Medicine
Karen Nelms, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Kori L Adkins, F.N.P., B.S.	Provisional Allied Health- Colleague- Other	Pediatrics
Inyene Sunday Amos, AGAC-NP	Provisional Allied Health- Colleague- Other	Medicine
Corey Michael Brambley, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Ashton Cagle Godwin, F.N.P.	Provisional Allied Health- Colleague- Other	Medicine
Jennifer Anne Morris, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Ivanna J. Ross, P.A.	Provisional Allied Health- Colleague- Other	Obstetrics & Gynecology
Jennifer J Walton, N.P.	Provisional Allied Health- Colleague- Other	Medicine
Jennifer Lynn Weigt, N.P.	Provisional Allied Health- Colleague- Other	Medicine
Carol Lynn Jones, CSFA	Locums	Surgery

Professional Staff Reappointment and Clinical Privileges

Jeanne M Barreira, C.N.M.	Allied Health	Obstetrics & Gynecology
Ali Linnemann Burnette, F.N.P.	Allied Health	Pediatrics
Shannon Christine Cornell, N.P.	Allied Health	Medicine
Rebecca Patton Cumbee, P.A.	Allied Health	Urology
Rona S Cushman, N.N.P.	Allied Health	Pediatrics
Joseph Ryan Davis, A.T.C.	Allied Health	Orthopaedics
Chad Davis, M.S.N.	Allied Health	Medicine
Matthew K. Ewald, P.A.C.	Allied Health	Emergency Medicine
Rachel Holmes Fox, C.R.N.A.	Allied Health	Anesthesiology
Jessica Kristen Gardner, M.S.N.	Allied Health	Pediatrics
Joy Ann Lauerer, D.N.P.	Allied Health	Department of Nursing
Carla Eleanor Newman, LISW-CP	Allied Health	Psychiatry
Elizabeth Hudson Parker, M.A.	Allied Health	Psychiatry
Crystal Prothro, A.T.C.	Allied Health	Orthopaedics
Jennifer Lynn Ridgeway, P.A.C.	Allied Health	Surgery
Whitney Hardy Savino, N.N.P.	Allied Health	Pediatrics
Jane E Swing, C.R.N.A.	Allied Health	Anesthesiology
Karen van Bakergem, LISW-CP	Allied Health	Pediatrics

Amanda Lauren Watts, P.A.	Allied Health	Pediatrics
Cristy L. Blackmon, F.N.P.	Allied Health- Colleague- Other	Family Medicine
Susan Michelle Babb, C.R.N.A.	Provisional Allied Health	Anesthesiology
Michael Craig Browning, C.R.N.A.	Provisional Allied Health	Anesthesiology
Alison Paige Bull, P.A.C.	Provisional Allied Health	Medicine
Jason Cage, C.R.N.A.	Provisional Allied Health	Anesthesiology
Jennifer Baker Fleming, P.A.C.	Provisional Allied Health	Family Medicine
Meredith Gentry, P.A.C.	Provisional Allied Health	Neurology
April Marie Griffin, F.N.P.	Provisional Allied Health	Medicine
James Alexander Hogg, P.A.	Provisional Allied Health	Neurology
Chloe Jackson, P.A.	Provisional Allied Health	Medicine
Amber M. Jarnecke, Ph.D.	Provisional Allied Health	Psychiatry
Jacquelyn Joseph, P.A.C.	Provisional Allied Health	Surgery
Meghan McCarthy, D.N.P.	Provisional Allied Health	Neurosurgery
Aislinn Marie McIlvenny, P.A.C.	Provisional Allied Health	Surgery
Connie Phillip, A.P.R.N.	Provisional Allied Health	Medicine
Kelly Elizabeth Regnery, P.A.C.	Provisional Allied Health	Family Medicine
Morgan Renee Roberts, P.A.C.	Provisional Allied Health	Surgery
Tanya C Saraiya, Ph.D.	Provisional Allied Health	Psychiatry
Gabrielle Shebiro, P.A.	Provisional Allied Health	Orthopaedics
Jenna Dean Simon, P.A.C.	Provisional Allied Health	Neurology
Peter Wilson, P.A.	Provisional Allied Health	Family Medicine
Tiffany Ann Doyle, FNP-BC	Provisional Allied Health CFC	Medicine
Michael Todd Adams, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Karina Coats, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Justin Michael Coats, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Hugh Trapold Cochran, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Nathan Rutledge Dail, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Joby Reagan Edmonds, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Dennis M. Fraley, Jr., C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Wenting Han, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Roy A Harvey, A.D.N.	Provisional Allied Health- Colleague- Other	Anesthesiology
Megan Page Herring, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Ashley Brooke Hill, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Whitney Johnson, AGAC-NP	Provisional Allied Health- Colleague- Other	Medicine
Jalal Shoukri Kablan, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Betty D Kapp, C.R.N.A., BSN	Provisional Allied Health- Colleague- Other	Anesthesiology
Katie Booth Kitchen, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
John Kokenes, MSN, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Michael Thomas Munson, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Mathew John Murphy, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Mary Josephine Ochieng, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Martin Francis Powers, Jr., C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Benjamin Matthew Pugh, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
David Christopher Runge, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Rachel Mechelle Spiers, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
Marquis Thompson, P.A.	Provisional Allied Health- Colleague- Other	Medicine
Christopher M Ward, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology
James M Zorgias, C.R.N.A.	Provisional Allied Health- Colleague- Other	Anesthesiology

Professional Staff Reappointment and Change in Privileges

None

Professional Staff Change in Privileges

Elizabeth Poindexter, P.A.	Allied Health	Anesthesiology

END OF ROSTER

Medical Executive Committee

Medical Executive Committee **Presiding:** Dr. Rob Cina **Date:** September 21, 2022 **Meeting Place:** MS Teams **Recording:** Elaine Jenkins **Meeting Time:** 7:30 am **Adjournment:** 8:26 am	**Members present**: Dr. Atz, Dr. Baliga, Dr. Basco, Dr. Boylan, N. Brahney, Dr. Bundy, Dr. Cina, Dr. Clark, Dr. Clyburn, K. Denty, H. Dorr, M. Ebersole, Dr. Edwards, V. Fairbairn, Dr. Herzke, L. Kerr, J. Melroy, Dr. Reeves, Dr. Russell, Dr. Salgado, Dr. D. Scheurer, Dr. Zaas **Members excused:** Dr. Andrews, Dr. Brendle, Dr. Carroll, Dr. Costello, Dr. Crawford, Dr. DiSalvo, Dr. DuBois, M. Field, M. Fulton, P. Hart, Dr. Hong, M. Kocher, D. Krywko, L. Leddy, Dr. Mack, S. Patel, Dr. Reeves, S. Scarbrough, Dr. M. Scheurer, Dr. Streck. **Guests:** Judy Walling, Bruce Crookes

Agenda/Topic	Debate & Discussion	Conclusions	Recommendation/ Follow-Up What/When/Who
Executive Session	n/a	n/a	
Review of Minutes	Minutes from August 17, 2022 MEC meeting approved	***Approval***	***Approved***
Credentials Committee - **Nora Brahney on Dr. Edwards behalf**	Monthly credentialing roster presented. No controverseys or exceptions. Request for Exemption- - Dr. Takacs and the provider from the Black River region	MEC recommends the approval of roster to the Board of Trustees	**Approved** **Approved**
GME Report • **Dr. Clyburn**	- Still working on the VA issues with counting time - Fellowship interviews are being done now	***Information***	
Quality Report • **Dr. Bundy**	- Scorecard - CLABSI call to action - Tiered briefs participation - Vizient preview	***Information***	 22_09_21 MEC Bundy.pptx
Communications Report - **Dr. Herzke**	- Modification to credentialing bylaws in October - Brief op note - Launch of the Care Management Resource Center, available hospital wide	***Information***	
Joint Commission Readiness • **Lois Kerr**	- Will be working on some language around inpatient telehealth visits - Kim Denty will be taking over presentations	***Information***	

MEDICAL EXECUTIVE COMMITTEE

New Business - **Bruce Crookes**	• Policy Updates - Partner with Radiology to mark the order for a radiology film for RFP as "Stat RFO", with the capability for the surgeon to PACU prior to the radiologist reading the film. The radiologist will read the film at a later time and provide a final impression for findings. - Op note or a Brief Op Note Icon in the patient's chart.		***Approval***	Approved
Consent Items				
Policies *(Consent)*	***Policies for Approval:*** • (C-055) Patient Controlled Analgesia (PCA) (v.2) • (C-023) Withholding/Withdrawing Life-Sustaining Treatment (v.2) • (C-192) Donated Device (v.3)		***Approval***	Approved
Standing Orders *(Consent)*	***Standing Orders for Approval:*** • (6090) Pain Management Standing orders for IV start (v.2) • (6469) MUSC Health Adult Hypoglycemia Standing Order (v.1) • (8540) Oxygen Titration (v.1) • (6031) Orthopedics-Non-Operative Fracture Orders (v.2) • (6496) Adult Oncology Distress Screen (v.1) • (5955) Lab Orders for New Adult Malignant Hematology Patients (v.1) • (6484) Adult Oncology Critical Value Charting (v.1)		***Approval***	Approved
Data & Service Reports *(Consent)*	**Data Reports:** o	**Service reports reviewed:**	***Information***	
Subcommittee Minutes *(Consent)*	**Committee Minutes:** o		***Information***	
Adjournment 8:26 am	The next meeting of the Medical Executive Committee will be October 19, 2022 at 7:30 am via TEAMS/In Person			

Elizabeth Mack

Elizabeth Mack, MD, Secretary of the Medical Staff

Medical Executive Committee

Medical Executive Committee **Presiding:** Dr. Rob Cina **Date:** October 19, 2022 **Meeting Place:** MS Teams **Recording:** Elaine Jenkins **Meeting Time:** 7:30 am **Adjournment:** 8:30 am	**Members present**: Dr. Basco, Dr. Boylan, N. Brahney, Dr. Bundy, Dr. Clark, Dr. Clyburn, Dr. Crookes, K. Denty, Dr. DiSalvo, H. Dorr, M. Ebersole, Dr. Edwards, Dr. Eiseman, V. Fairbairn, Dr. Herzke, L. Kerr, Jessica Johnson, Kiersten Leban, J. Melroy, Dr. Munden, Dr. Reeves, Dr. Russell, Dr. Salgado, Dr. D. Scheurer, Dr. M. Scheurer, Dr. Zaas, Dr. Zukas **Members excused:** Dr. Andrews, Dr. Atz, Dr. Baliga, Dr. Brendle, Dr. Carroll, Dr. Cina, Dr. Costello, Dr. Crawford, M. Field, M. Fulton, P. Hart, Dr. Hong, M. Kocher, D. Krywko, L. Leddy, Dr. Mack, S. Patel, Dr. Reeves, S. Scarbrough, Dr. Streck. **Guests:** Robert Harrington, Cheryl Rodriguez, Dr. Baruah, Marsha Porter		
Agenda/Topic	**Debate & Discussion**	**Conclusions**	**Recommendation/ Follow-Up What/When/Who**
Executive Session	n/a	n/a	
Review of Minutes	Minutes from August 17, 2022 MEC meeting approved	***Approval***	
Credentials Committee • **Dr. Edwards**	Monthly credentialing roster presented. 151 Files to review: - 52 Initial Appointments - 99 Reappointments - No significant changes in privileges - No controversies for exceptions	MEC recommends the approval of roster to the Board of Trustees	**Approved**
GME Report • **Dr. Clyburn**	- Working on GME Strategic Manpower - Active discussions with the Veterans Administration Hospital	***Information***	
Quality Report • **Dr. Bundy**	- Scorecard - CLABSI call to action - Summary of Recommendations to prevent CLABSI - Inpatient Vizient Scorecard	***Information***	 22_10_19 MEC Bundy.pptx
Periop QUAPI Report • **Dr. Crookes**	- Two Policy Changes: Retained Foreign Object Protocol (RFO) Changes the brief operative note	***Information***	 MEC Policy changes and Brief Op Note cl

				Default on Periop Executive approval that the Radiology QUAPI approved. To be placed back on agenda for further discussion
Communications Report • **Dr. Herzke**	- See attached presentation		***Information***	CMO update MEC 10-19.pptx
Regional Bylaw Discussion/Bylaw Changes • **Harrington/Kerr**	- Unified bylaws See attached presentation outlining changes		***Information***	Proposed Bylaws, Credentials Manual
Consent Items				
Policies *(Consent)*	***Policies for Approval:*** • (C-064) Pain Screening, Assessment and Management (FYI Only)		***Approval***	
Standing Orders *(Consent)*	***Standing Orders for Approval:*** • OB Standing Orders • (8768) Ambulatory Care Clinics LifeImage MIES Nominating Images • GYN Standing Orders		***Approval***	**Will be presented for approval at the November meeting.**
Data & Service Reports *(Consent)*	**Data Reports:** o	**Service reports reviewed:**	***Information***	
Subcommittee Minutes *(Consent)*	**Committee Minutes:** o Can be located and viewed in the MUSC BOX under MEC		***Information***	
Adjournment 8:30 am	The next meeting of the Medical Executive Committee will be November 16, 2022 at 7:30 am via TEAMS/In Person			

Elizabeth Mack

Elizabeth Mack, MD, Secretary of the Medical Staff

AGREEMENTS ENTERED INTO BY THE
MEDICAL UNIVERSITY HOSPITAL AUTHORITY
SINCE OCTOBER 2022
BOARD OF TRUSTEES MEETING

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:

AETNA
ATC Healthcare Services, Inc.
Centers for Medicare & Medicaid Services
Cigna
Humana Choice Care
McKesson Pharmacy Optimization LLC
Select Health of South Carolina
TriCare (Value Options)
UHC

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:

Dialysis Clinic, Inc. (DCI) X3

Affiliation Agreements –

Florida Institute of Ultrasound, Inc.
Lander University
Professional Medical Training Center
Trevecca Nazarene University
Ben Lippen School Health Science Academy Nurse Aide Training Program
Columbus Central University School of Medicine – Belize
Laboure College

Clinical Services Agreements –

BioMedical Applications of South Carolina, Inc

Consulting Contracts over $50k –

Executive Consulting Group, LLC, d/b/a ECG Management Consultants
Richard Terhune

University Active Project List > 250,000: December 2022								
Project #	**Description**	**MUSC Approved Budget**	**Funds Committed to Date**	**Balance to Finish**	**A/E**	**Contractor**	**Status**	**Projected Final Completion**
Approved Projects								
9835	Energy Performance Contract	$30,000,000	$27,500,000	$2,500,000	Ameresco	Ameresco	Construction	December 2022
9840	BSB Envelope Repairs	12,200,000	4,780,000	7,420,000	REI	Hawkins	Construction	December 2023
9844	HCC 3rd Floor Renovations	4,500,000	3,388,700	1,111,300	MPS	Hill	Construction	June 2023
9845	BSB Replace AHU 3	1,200,000	1,124,000	76,000	RMF	Triad	Construction	December 2022
9846	Pharmacy Addition/Innov Instruc Classroom Renov	58,000,000	54,128,000	3,872,000	Compass 5	Whiting Turner	Construction	December 2022
9847	HCC Mechanical Systems Replacement	3,500,000	3,485,000	15,000	RMF	CR Hipp	Construction	December 2022
9848	BSB Replace AHU #4 and #4A (serve animal area)	1,700,000	1,631,000	69,000	RMF	Triad	Construction	June 2023
9851	BSB AHU #1 Replacement	5,800,000	5,366,000	434,000	RMF	CR Hipp	Consttruction	June 2023
9852	MUSC Combined Heat & Power Facility	1,500,000	1,500,000	-	Ameresco		Design	TBD
9854	CHP President Street Academic Building	50,000,000	561,000	49,439,000	SMHa		Design	June 2025
9855	COM Office/Academic Building	172,000,000	1,634,000	170,366,000	Liollio		Design	June 2026
9856	Anderson House Interior Repairs	1,400,000	134,000	1,266,000	Compass 5		Design	June 2023
9857	CRI AHU #1 and #2 Replacement	4,600,000	-	4,600,000	TBD		A/E Selection	December 2023
9859	HCC AHU #5 & #6 Replacement	1,500,000	164,000	1,336,000	DWG		Design	December 2023
9860	HCC Medium Voltage Fedders A & B Replacement	1,500,000	42,000	1,458,000	GWA		Design	June 2023
9861	MRE Chiller #1 Replacement	2,500,000	88,000	2,412,000	RMF		Design	December 2023
9862	T-G AHU 2. 3. 4, & 6 Replacement	2,500,000	200,000	2,300,000	MECA		Design	December 2023
9863	T-G Generators Replacement	3,500,000	200,000	3,300,000	GWA		Design	December 2023
51355	BSB Chiller #6 Replacement	1,500,000	1,100,000	400,000	MECA	McCarter	Construction	March 2023
51356	HCC Generator #3 Replacement	3,000,000	188,000	2,812,000	GWA		Design	June 2023
51357	HCC Lab Air System Replacement	1,300,000	119,500	1,180,500	DWG		Design	March 2023
51358	Campus Elevators Modernization	4,300,000	-	4,300,000	RMF		Design Award Pends	December 2023
51359	IOP Cooling Tower Upgrade	1,800,000	981,000	819,000	RMF	McCarter	Construction	March 2023
51360	HCC 4th Floor Roof Replacement	1,300,000	1,210,000	90,000	BEE	Bone Dry	Construction	March 2023
51361	CON 1st Floor Renovation	3,700,000	320,000	3,380,000	Rosenblum Coe		Design	March 2024

University Active Project List > 250,000: December 2022								
Project #	**Description**	**MUSC Approved Budget**	**Funds Committed to Date**	**Balance to Finish**	**A/E**	**Contractor**	**Status**	**Projected Final Completion**
51362	135 Cannon AHU #1 - #4 Replacement	1,000,000	-	1,000,000	CEMS		Design Award Pends	June 2023
50095	T-G Humidifier Replacement	700,000	595,000	105,000	RMF	Triad	Construction	Substantially Complete
50098	BSB Heat Exchanger Replacement	350,000	245,000	105,000	RMF	Triad	Construction	December 2022
50121	Quad F Building Roof Replacement	600,000	514,000	86,000	BEE	Bone Dry	Construction	December 2022
50122	CSB Fuel Tanks Replacement	990,000	874,000	116,000	S&ME	JB Petroleum	Construction	Substantially Complete
50123	CODM Clinics Building Cooling Tower Upgrade	980,000	411,000	569,000	RMF	McCarter	Construction	June 2023
50126	Miscs Research Hoods Phoenix Control Upgrades	450,000	282,000	168,000	N/A	Hoffman	Construction	October 2022
50127	DDB Air Cooled Chiller Replacement	450,000	414,000	36,000	MECA	McCarter	Construction	December 2022
50131	University Facilities Condition Assessment	741,504	721,504	20,000	SSR		Design	October 2022
50133	CSB Suite 215/216 Renovations	660,000	647,000	13,000	RMF	Satchell	Construction	December 2022
50134	CSB Exterior Envelope Brick Repairs	500,000	63,000	437,000	BEE		Design	TBD
50145	CSB Wound Care Renovations	900,000	680,000	220,000	MPS	Branks	Construction	December 2022
50146	CSB 816 HVAC Replacement	400,000	36,000	364,000	RMF		Design	March 2023
50149	Colbert Library Roof Replacement	900,000	50,000	850,000	WMBE		Design	March 2023
50151	BSB AHU #5 Replacement	575,000	56,500	518,500	RMF		Design	June 2023
50153	IOP 3rd Floor Resident Space	$440,000	$37,150	$402,850	Liollio		Design	June 2023

MEDICAL UNIVERSITY OF SOUTH CAROLINA
PROFESSIONAL SERVICES
FOR REPORTING
DECEMBER 8, 2022

MUSC Indefinite Quantity Contract Releases

DWG, Inc. Consulting Engineers MUSC ARC Flash Study Mulitiple sites	$79,819.90
DWG, Inc. Consulting Engineers MUSC ARC Flash Study Multiple Sites	$117,895.60
RMF Engineering, Inc. Campus Elevator Modernization	$77,180.00
CEMS Engineering, Inc. 135 Cannon Street AHU 1-4 Replacement	$121,000.00
Compass 5 Partners, LLC BSB 7 East Lab and Office Renovations	$148,137.00
DWG, Inc. Consulting Engineers HCC Cooling Towers 3&4 Replacement	$120,000.00

MEDICAL UNIVERSITY OF SOUTH CAROLINA
CONSTRUCTION CONTRACTS
FOR REPORTING
DECEMBER 8, 2022

MUSC General Construction Projects:

McCarter Mechanical CSB 816 HVAC Replacements	$ 189,304.00
Whiting-Turner Contracting Company New College of Pharmacy Addition (CO#13)	$ 1,009,260.14

Other Contracts:

New College of Pharmacy Addition & Innovative Instructional Redesign:

PMC Commercial Interiors, Inc. Lockers	$ 278,666.20

Hollings Cancer Center 3rd Floor Renovation:

R&W Wiring LLC Card Access	$ 61,846.25
Internetwork Engineering IT Network Equipment	$ 89,068.26

MEDICAL UNIVERSITY OF SOUTH CAROLINA (MUSC) BOARD OF TRUSTEES
CONSENT AGENDA
December 9, 2022
101 Colcock Hall

Research & Institutional Advancement Committee: Terri Barnes, Chair

Consent Agenda for Information

Item 22. Institutional Advancement Report ..... Kate Azizi
Vice President for Institutional Advancement

Education, Faculty & Student Affairs Committee: Barbara Johnson-Williams, Chair

Consent Agenda for Approval

Item 23. Endowed Chair Appointments ..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

College of Medicine

Chris Cowan, Ph.D., Professor and Chair in the Dept. of Neuroscience, for appointment to the SmartState Endowed Chair for Brain Imaging, effective December 9, 2022.

Ashish A. Deshmukh, Ph.D., Associate Professor in the Department of Public Health Sciences, as the AT&T Distinguished SmartState Endowed Chair in Cancer Equity, effective August 29, 2022.

Christine Holmstedt, DO, Professor in the Department of Neurology to the Countess Alicia Paolozzi SmartState Endowed Chair in Translational Neurology effective April 1, 2023.

Philip Howe, Ph.D., Professor and Chair in the Department of Biochemistry and Molecular Biology, for appointment to the Ralph F. Hirschmann, Ph.D. Endowed Chair in Biochemistry Research, effective December 9, 2022.

Kevin Hughes, M.D., Professor in the Department of Surgery, for appointment to the McCoy Rose, Jr., M.D. Endowed Chair in Surgical Oncology, effective December 9, 2022.

Angela LaRosa, M.D., Professor in the Department of Pediatrics, for appointment to the Jeffrey Edwin Gilliam Memorial Chair for the Study of Developmental Disabilities, effective December 9, 2022.

Byung Joo Lee, DDS, Clinical Associate Professor in the College of Medicine, Department of Otolaryngology-Head and Neck, as the Wendy and Keith Wellin Endowed Chair in Maxillofacial Prosthodontics and Dental Oncology, effective June 1, 2022.

Madelene Lewis, M.D., Professor in the Department of Radiology, for appointment to the Stephen S. Schabel Endowed Chair in Radiology, effective December 9, 2022.

David Long, Ph.D., Associate Professor in the Dept. of Biochemistry & Molecular Biology to the Gaylord and Dorothy Donnelley Endowed Chair, effective December 9, 2022.

Pamela Morris, M.D., Professor in the Department of Medicine, Division of Cardiology, for appointment to the Paul V. Palmer Endowed Chair in Cardiovascular Disease Prevention, effective December 9, 2022.

Item 24. Faculty Tenure ..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

Academic Affairs

Shannon Jones, MLS, MEd, AHIP, Professor, Director of Libraries, effective January 1, 2023.

College of Health Professions

Clint C. Blankenship, PharmD, PA-C, Associate Professor, Department of Clinical Sciences, Division of Physician Assistant Studies, effective January 1, 2023.

Michelle L. Woodbury, Ph.D., OTR/L, Associate Professor, Department of Health Sciences and Research, effective January 1, 2023.

College of Medicine

Heather A. Boger, PhD., Associate Professor, Department of Neuroscience, Academic Investigator/ Educator track, effective January 1, 2023.

Christine M. Carr, M.D., Professor, Department of Emergency Medicine; Dual in Dept. of Public Health Sciences, Clinician Educator track, effective January 1, 2023.

Bhishamjit S. Chera, MD, Professor, Department of Radiation Oncology, Clinician Educator track, effective January 1, 2023.

Ashish A. Deshmukh, Ph.D., Associate Professor, in the Department of Public Health Sciences on the Academic Investigator track, effective August 29, 2022.

John R. Freedy, MD, Ph.D., Professor, Department of Family Medicine, Clinician Educator track, effective January 1, 2023.

Faye N. Hant, DO, Professor, Department of Medicine, Division of Rheumatology, Clinician Educator track, effective January 1, 2023.

Benjamin F. Jackson, M.D., Associate Professor, Department of Pediatrics, Division of Pediatric Emergency Medicine, Clinician Educator track, effective January 1, 2023.

Wei Jiang, M.D. Associate Professor, Department of Microbiology and Immunology; Dual in the Department of Medicine, Division of Infectious Diseases, Academic Investigator track, effective January 1, 2023.

David G. Koch, DO, Professor, Department of Medicine, Division of Gastroenterology & Hepatology, Clinician Educator track, effective January 1, 2023.

Jeffrey E. Korte, Ph.D., Professor, Department of Public Health Science, Academic Clinician track, effective January 1, 2023.

Jacqueline M. Kraveka, DO, Associate Professor, Department of Pediatrics, Division of Pediatric Hematology/ Oncology, Academic Clinician track, effective January 1, 2023.

Diann M. Krywko, M.D., Professor, Department of Emergency Medicine. Clinician Educator track, effective January 1, 2023.

Renee H. Martin, Ph.D., Professor, Department of Department of Public Health Sciences, Academic Clinician track, effective January 1, 2023.

Eric M. Matheson, M.D., MSCR, Associate Professor, Department of Family Medicine, Clinician Educator track, effective January 1, 2023.

John D. Melville, M.D., Associate Professor, Department of Pediatrics, Division of Child Abuse Pediatrics, Clinician Educator track, effective January 1, 2023.

Cynthia L. Talley, M.D., Department of Surgery, Division of General Surgery, effective January 1, 2023.

Benjamin A. Toll, Ph.D., Professor, Department of Public Health Sciences; Dual in Psychiatry and Behavioral Sciences, Academic Clinician track, effective January 1, 2023.

Chenthamarakshan Vasu, Ph.D., Professor, Department of Microbiology and Immunology, Academic Investigator track, effective January 1, 2023.

Item 25. Faculty Appointments..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

College of Medicine
Ashish A. Deshmukh, Ph.D., as Associate Professor with tenure, on the Academic Investigator track, in the Dept. of Public Health Sciences, effective August 29, 2022. He will also hold the AT&T Distinguished SmartState Endowed Chair in Cancer Equity and serve as Co-Leader of the Cancer Control Program at the Hollings Cancer Center.

Kathleen Maksimowicz-McKinnon, D.O., M.P.H., as Associate Professor, on the Clinician Educator track, in the Department of Medicine, Division of Rheumatology and Immunology, effective September 1, 2022.

College of Dental Medicine
Sompop Bencharit, DDS, MS, PhD, FACP, as Professor without Tenure, on the Academic Investigator/Clinician track, in the Department of Oral Rehabilitation, effective date November 28, 2022. Dr. Bencharit will also serve as the Assistant Dean for Innovation.

Item 26. Distinguished University Professor..... Dr. Lisa Saladin
Executive Vice President for Academic Affairs and Provost

College of Medicine
Diann Krywko, M.D., FACEP, Professor and Chair of the Dept. of Emergency Medicine, for designation as Distinguished University Professor, effective December 9, 2022.

MUSC Board of Trustees Report
Institutional Advancement Update

December 2022

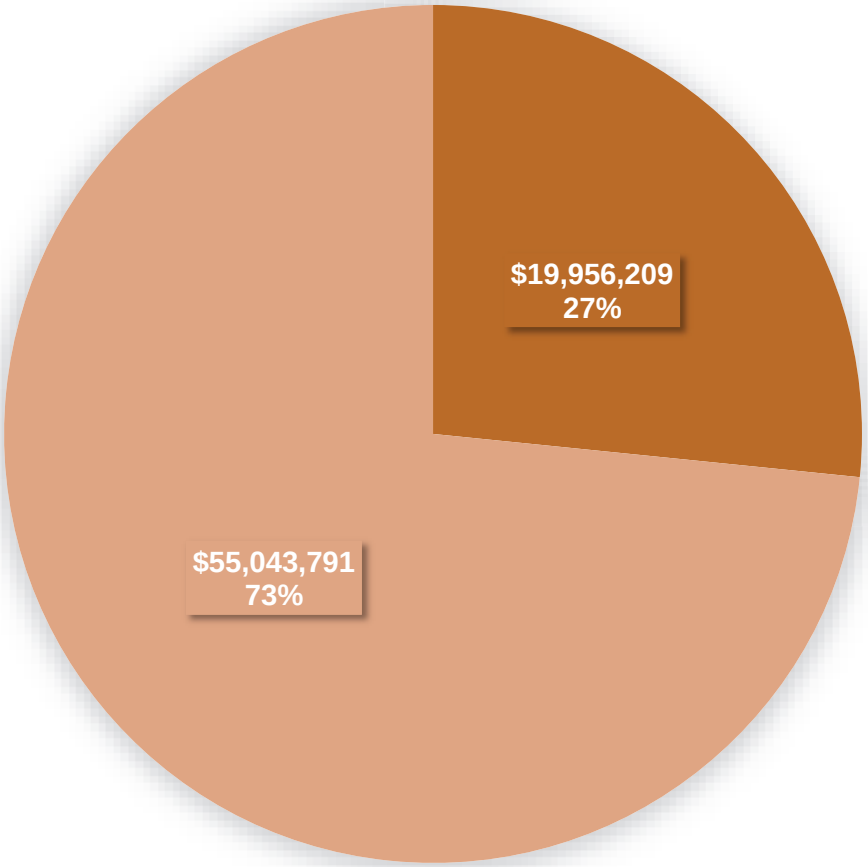
FY23 Progress
as of November 14, 2022

Dollars Raised

Goal:
$75,000,000

Achieved to Date:
$19,956,209

Progress to Goal:
27%

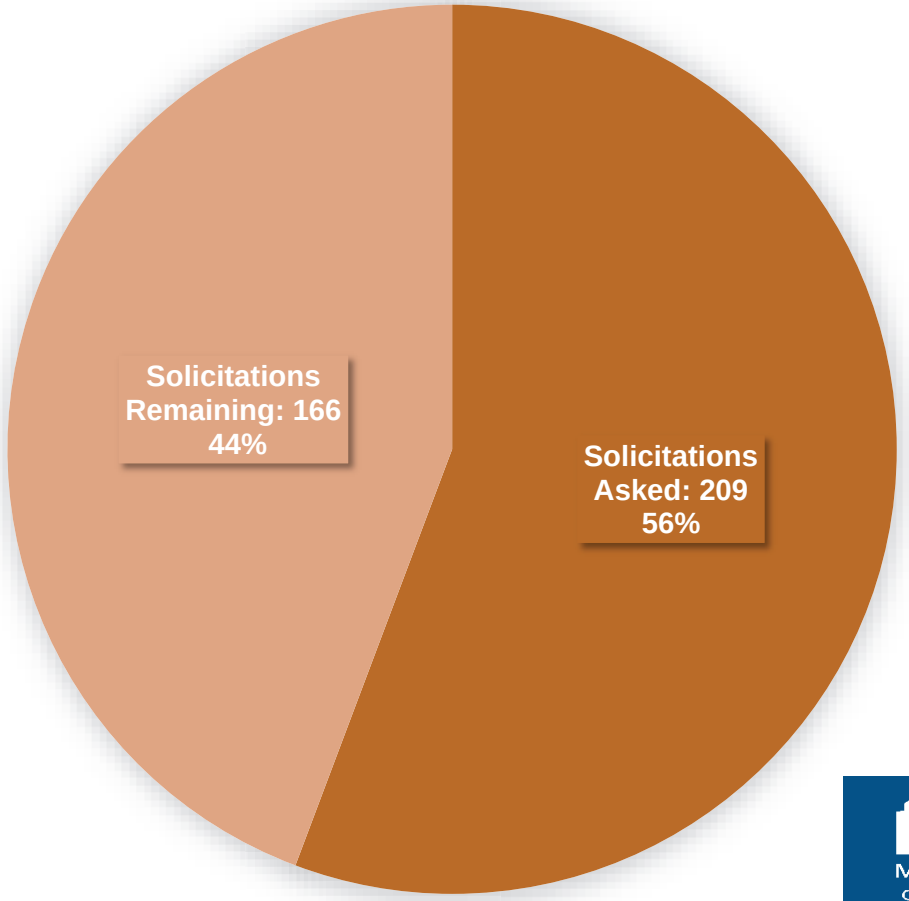


MUSC
Medical University of South Carolina

FY23 Progress
as of November 14, 2022

Solicitations

- $25K+ Solicitations Asked Goal: **375**
- Achieved to Date: **209**
- Progress to Goal: **56%**



MUSC
Medical University of South Carolina

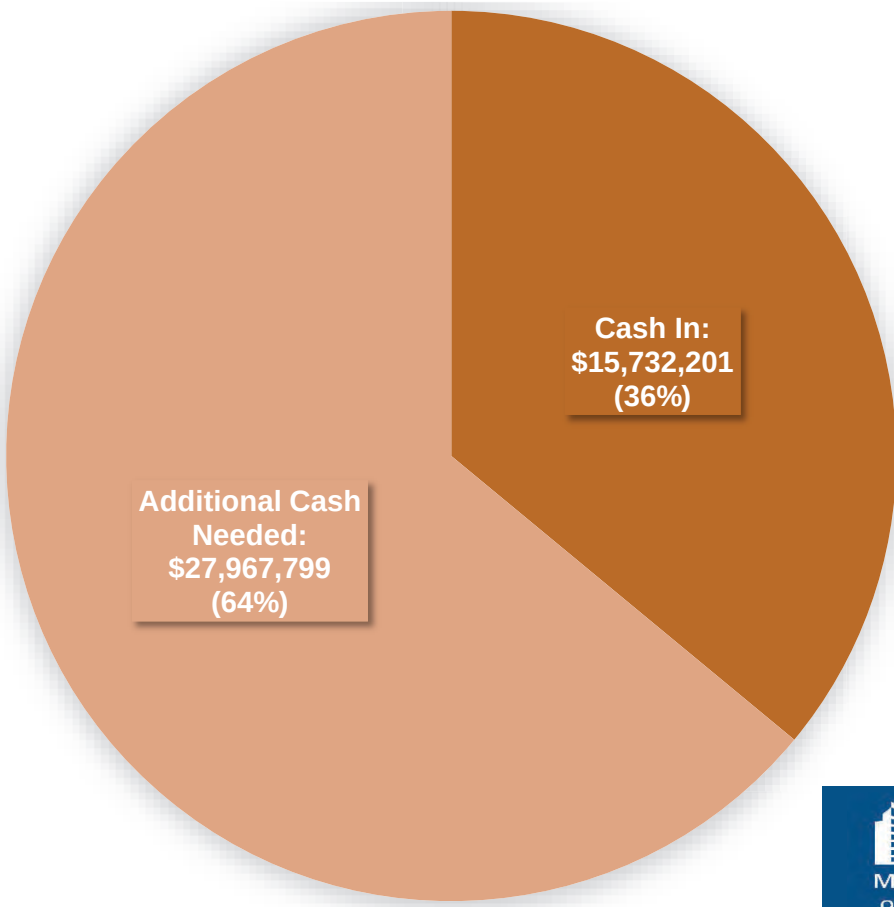
FY23 Progress
as of October 31, 2022

Cash In

Cash into MUSCF
Goal: **$43.7M**

Achieved as of:
10.31.22: **$15,732,201**

Progress to Goal: **36%**



MUSC
Medical University
of South Carolina

Impact of Philanthropy

MUSC and Shriners Hospitals for Children launch a new affiliation to support the only statewide burn center for kids

A $3 million gift established the Shriners Children's Endowed Professorship in Pediatric Burn Care, and MUSC will provide matching funds

Opportunity to recruit a new endowed professor, and expand cutting-edge research and best-in-class pediatric burn care delivery

Christopher W. Cowan, PhD
Abbreviated Curriculum Vitae
Professor
(843) 792-2935
cowanc@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
Postdoctoral Fellowship		Children's Hospital Boston	Boston		US	2005	
Ph.D.		Baylor College of Medicine	Houston		US	1998	
Ph.D.	Cellular and Molecular Biology	Baylor College of Medicine		Texas	United States	1998	
B.A.	Neuroscience and Behavior	Wesleyan University				1993	
B.A.		Wesleyan University	Middletown		US	1993	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Harvard Medical School (Boston, MA)	Postdoctoral Fellow-Neurobiology	September 1999	September 2005

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

Associate Professor	Medical University of South Carolina	College of Medicine	Psychiatry and Behavioral Sciences	2016-06-01	2017-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Neuroscience	2016-06-01	2017-06-30
Professor	Medical University of South Carolina	College of Medicine	Psychiatry and Behavioral Sciences	2017-07-01	
Professor	Medical University of South Carolina	College of Medicine	Neuroscience	2017-07-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	The University of Texas Southwestern Medical School		Psychiatry		2005-09-01	
Assistant Professor	The University of Texas Southwestern Medical School		Ophthalmology		2005-09-01	
Associate Professor	Harvard Medical School		Psychiatry		2012-09-01	2099-01-01
Associate Professor with Tenure	The University of Texas Southwestern Medical School		Psychiatry		2012-09-01	
Associate Professor with Tenure	The University of Texas Southwestern Medical School		Ophthalmology		2012-09-01	

Ashish A Deshmukh, PhD

Abbreviated Curriculum Vitae

Associate Professor
deshmukha@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

2007	B.S., Pharmacy, Pune University, Nashik, India
In Progress	MPH, Health Policy and Management

Post-Graduate Training

Post Doctoral Fellow, The University of Texas MD Anderson Cancer Center, Clinical Decision Science, Cancer Prevention Research Training Program and Health Services Research , January 2014, December 2016

Additional Training

No activities entered.

Certifications

No activities entered.

Professional Licensures

No activities entered.

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2022-08-29

Non-MUSC Rank and Promotion History

Associate Professor , UTHealth School of Public Health, 2021

Assistant Professor , College of Public Health and Health Professions, 2016, 2018

Assistant Professor, UTHealth School of Public Health, 2018, 2021

Christine A Holmstedt, DO
Abbreviated Curriculum Vitae
Professor
(843) 792-3020
holmsted@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
D.O.	Medicine	Lake Erie College of Osteopathic Medicine		Pennsylvania	United States	2005	
B.S.	Nutrition	Long Island University		New York	United States	2000	
B.S.	Biology	State University of NY at Stony Brook		New York	United States	1994	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Medical University of South Carolina	Cerebrovascular Disease Fellowship	October 2009	July 2010
Post-Doctorate	UPMC, Hamot Health Foundation	Osteopathic Rotating Internship	July 2005	June 2006
Post-Doctorate	UPMC, Hamot Health Foundation	Clinical Neurology Residency (Chief Resident July 2008-October 2009)	July 2006	October 2009

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification
NIHSS					2005-Present		
Modified Rankin Scale					2011		
BLS Provider					2005-Present		
American Osteopathic Board of Neurology and Psychiatry (AOBPN)					08/2012		

ACLS Provider	2005-Present

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description
SC State License								
PA State License								

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Instructor	Medical University of South Carolina	College of Medicine	Neuroscience	Neurology	2009-10-14	2010-06-30
Assistant Professor	Medical University of South Carolina	College of Medicine	Neurology		2010-07-01	2015-06-30
Professor	Medical University of South Carolina	College of Graduate Studies			2011-08-05	
Associate Professor	Medical University of South Carolina	College of Medicine	Neurology		2015-07-01	2019-12-31
Associate Professor	Medical University of South Carolina	College of Medicine	Emergency Medicine		2016-09-01	2019-12-31
Professor	Medical University of South Carolina	College of Medicine	Emergency Medicine		2020-01-01	
Professor	Medical University of South Carolina	College of Medicine	Neurology		2020-01-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

Philip Henry Howe, PhD

Abbreviated Curriculum Vitae

Professor
(843) 792-4687
howep@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
Ph.D.	Biochemistry	Medical College of Georgia		Georgia	United States	1988	
B.A.		Augusta State University		Georgia	United States	1978	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Vanderbilt University, Department of Cell Biology	Postdoctoral Fellow	September 1988	September 1990

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Professor	Medical University of South Carolina	College of Dental Medicine	Biochemistry and Molecular Biology		2011-07-01	
Professor	Medical University of South Carolina	College of Medicine	Biochemistry and Molecular Biology		2011-07-01	
Professor	Medical University of South Carolina	College of Graduate Studies			2011-08-10	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Research Assistant Professor	Vanderbilt University		Cell Biology		1989-09-01	
Assistant Staff/Professor	Cleveland Clinic Foundation, Research Institute		Cell Biology		1990-11-01	1996-11-01
Adjunct Professor	Cleveland State University		Biology		1992-09-01	2099-01-01
Assistant Professor	Case Western Reserve University		Physiology & Biophysics		1992-09-01	
Associate Staff/Professor	The Lerner Research Institute, Cleveland Clinic Foundation		Cell Biology		1996-11-01	2001-01-01
Associate Professor	Case Western Reserve University		Physiology & Biophysics		1998-09-01	
Staff/Professor	The Lerner Research Institute, Cleveland Clinic Foundation		Cell Biology		2001-01-01	
Adjunct Professor	Kent State University		Biomedical Sciences		2001-09-01	2099-01-01
Professor	Case Western Reserve University		Physiology & Biophysics		2003-09-01	
Professor	Cleveland Clinic Lerner College of Medicine		Molecular Medicine		2006-09-01	
Professor	The Lerner Research Institute, Cleveland Clinic Foundation		Cancer Biology		2006-09-01	

Kevin Hughes, MD

Abbreviated Curriculum Vitae

Professor
(843) 876-4420
hughkevi@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
M.D.	Medicine	Dartmouth Medical School				1979	
B.A.	Chemistry	Dartmouth College				1976	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Professor	Medical University of South Carolina	College of Medicine	Surgery	Oncologic and Endocrine Surgery	2021-10-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

Angela C. LaRosa, MD

Abbreviated Curriculum Vitae

Professor
(843) 876-1511
larosaa@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
M.S.	Clinical Research	Medical University of South Carolina		South Carolina	United States	2003	
M.D.	Medicine	West Virginia University School of Medicine		West Virginia	United States	1997	
B.A.	Economics	Boston College		Massachusetts	United States	1991	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	General Academic Pediatrics, MUSC, Charleston, SC	Fellowship	July 2000	March 2003
Post-Doctorate	Medical University of South Carolina	Fellowship, Developmental and Behavioral Pediatrics	July 2000	March 2003
Post-Doctorate	West Virginia University, Morgantown, WV	Internship	July 1997	June 1998
Post-Doctorate	West Virginia University, Morgantown, WV	Residency	July 1998	June 2000

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification
Developmental-Behavioral Pediatrics					11/2004/2014		
American Board of Pediatrics					10/24/2000		

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description
South Carolina #21756								

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	Medical University of South Carolina	College of Medicine	Pediatrics	Developmental-Behavioral Pediatrics	2003-04-01	2010-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Pediatrics	Developmental-Behavioral Pediatrics	2010-07-01	2017-12-31
Professor	Medical University of South Carolina	College of Graduate Studies			2011-07-01	
Professor	Medical University of South Carolina	College of Medicine	Pediatrics	Developmental-Behavioral Pediatrics	2018-01-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

Byung Loo Lee
Abbreviated Curriculum Vitae
Clinical Associate Professor
leeby@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

2012	D.D.S., Dental Surgery, University of Illinois at Chicago College of Dentistry
2008	B.S., Biochemistry, University of Illinois at Chicago
In Progress	M.B.A., Healthcare, Innovation & Teaching, Johns Hopkins University/Carey Business School

Post-Graduate Training

Fellowship, MD Anderson Cancer Center , Maxillofacial Prosthetics and Oncologic , July 2015, July 2016

Residency, University of Pittsburgh School of Dental Medicine, Certificate of Advanced Study in Prosthodontics, July 2012, June 2015

Additional Training

No activities entered.

Certifications

American Board of Prosthodontics, Type of Certification: Board Eligible, Certification Number: N/A, Effective Date: 2022-03-22

Professional Licensures

Texas Medical License, Month / Year Originally Conferred: July 2016, Month/Year Expires: June 2022, 32072

MUSC Rank and Promotion History

Clinical Associate Professor, Medical University of South Carolina, College of Dental Medicine, Oral and Maxillofacial Surgery, 2022-06-01

Clinical Associate Professor, Medical University of South Carolina, College of Medicine, Otolaryngology - Head and Neck Surgery, 2022-06-01

Non-MUSC Rank and Promotion History

Adjunct Assistant Professor of Surgery, Texas A&M College of Medicine, 2022-03-22

Madelene C. Lewis, MD

Abbreviated Curriculum Vitae

Professor
(843) 792-1957
lewism@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
M.D.	Medicine	East Carolina University		North Carolina	United States	2006	
B.S.	Biochemistry	East Carolina University		North Carolina	United States	2001	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Medical University of South Carolina	Women's Imaging Fellowship	September 2011	June 2012
Post-Doctorate	Medical University of South Carolina, Department of Radiology	Radiology Residency	July 2007	August 2011
Post-Doctorate	Medical University of South Carolina, Department of Radiology	Chief Resident, Radiology Residency Program	January 2010	January 2011
Post-Doctorate	Trident Medical Center University, Transitional Year, Department of Family Medicine	Internship	July 2006	June 2007

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification
American Board of Radiology					5/2011-Present		
ABR Written Exam					Pass, 9/2009		
ABR Physics					Pass, 9/2008		

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description
USMLE STEP 3								
USMLE STEP 2								
USMLE STEP 1								
South Carolina Medical License, #28863								

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Clinical Instructor	Medical University of South Carolina	College of Medicine	Radiology and Radiological Science		2011-09-01	2012-06-30
Assistant Professor	Medical University of South Carolina	College of Medicine	Radiology and Radiological Science		2012-07-01	2016-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Radiology and Radiological Science		2016-07-01	2020-06-30
Professor	Medical University of South Carolina	College of Medicine	Radiology and Radiological Science		2020-07-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

David T. Long, PhD
Abbreviated Curriculum Vitae
Associate Professor
(843) 792-6949
longdt@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
Ph.D.	Biochemistry	Duke University		North Carolina	United States	2008	
B.S.	Molecular Biology	University of California, Berkeley		California	United States	2003	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Harvard Medical School	Biological Chemistry and Molecular Pharmacology	November 2008	June 2014

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	Medical University of South Carolina	College of Dental Medicine	Biochemistry and Molecular Biology		2014-07-28	2020-06-30
Assistant Professor	Medical University of South Carolina	College of Medicine	Biochemistry and Molecular Biology		2014-07-28	2020-06-30

Associate Professor	Medical University of South Carolina	College of Dental Medicine	Biochemistry and Molecular Biology	2020-07-01
Associate Professor	Medical University of South Carolina	College of Medicine	Biochemistry and Molecular Biology	2020-07-01

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank

Pamela Bowe Morris, MD

Abbreviated Curriculum Vitae

Professor
843-876-4787
morrispa@musc.edu

Personal Information

Country of Origin: United States

Contact Information

State or Province: South Carolina

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
M.D.	Medicine	Duke University		North Carolina	United States	1981	
B.A.	Biology and Psychology	Wellesley College				1977	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Duke University Medical Center, Durham, NC	Intern, Internal Medicine	September 1981	September 1982
Post-Doctorate	Duke University Medical Center, Durham, NC	Resident, Internal Medicine	September 1982	September 1983
Post-Doctorate	Duke University Medical Center, Durham, NC	Senior Resident, Internal Medicine	September 1983	September 1984
Post-Doctorate	Duke University Medical Center, Durham, NC	Fellow, Cardiology	September 1984	September 1986

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification
Certification Board of Cardiac Computed Tomography					2009		
American Board of Internal Medicine: Cardiovascular Diseases					1991		
American Board of Internal Medicine					1984		
American Board of Clinical Lipidology					2005		

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description
South Carolina Medical License								

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	Medical University of South Carolina	College of Medicine	Medicine	Cardiology	2005-10-01	2015-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Medicine	Cardiology	2015-07-01	2018-12-31
Professor	Medical University of South Carolina	College of Medicine	Medicine	Cardiology	2019-01-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	Duke University Medical Center, Durham, North Carolina		Department of Medicine	Cardiology	1986-09-01	
Assistant Professor	Mayo Medical School, Rochester, Minnesota		Department of Medicine	Cardiology	1990-09-01	

MEDICAL UNIVERSITY OF SOUTH CAROLINA

ACADEMIC AFFAIRS FACULTY

ABBREVIATED CURRICULUM VITAE

Date: January 26, 2022

Name: Jones (**Last**) Shannon (**First**) _____ (**Middle**)

Citizenship and/or Visa Status: U.S. Citizen

Office Address: 171 Ashley Ave. Ste. 419
Charleston, SC 29425

Telephone: (843) 792-8839

Education: *(Baccalaureate and above)*

Institution	Years attended	Degree/Date	Field of Study
University of Pittsburgh	2	Certificate/2013	Health Sci. Librarianship
Virginia Commonwealth Univ. Richmond	3	M.Ed./8/2012	Adult Learning/HR
North Carolina Central Univ. Durham	3	MIS/5/2004	Mgmt Info Services
U.S. NLM, NIH - Bethesda	2	Associate/2004	Fellowship Program
North Carolina Central Univ. Durham	3	MLS	Library Science
North Carolina State Univ. Raleigh	4	BA/12/1998	English

Internship	Place	Dates

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
3	Professor	Medical Univ. of South Carolina	MUSC Libraries

First Appointment to MUSC: Rank Associate Professor **Date:** 01/01/2014

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Medical University of South Carolina
COLLEGE OF HEALTH PROFESSIONS
ABBREVIATED CURRICULUM VITAE

Date: March 10, 2022

Name: Blankenship (**Last**) Clint (**First**) Collis (**Middle**)

Citizenship and/or Visa Status: US

Office Address: 115-B Rutledge Avenue, MSC 962
Charleston, SC 29425-9620

Telephone: 843-792-7490

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

Institution	Years Attended	Degree/Date	Field of Study
University of Kentucky	2006-2010	Doctorate/2010	Pharmacy
University of Nebraska	2003-2004	Masters/2004	Physician Assistant Studies
University of Kentucky	1999-2001	Bachelors/2001	Physician Assistant Studies
Western Kentucky University	1988-1996	Bachelors/1996	Biology

Graduate Medical Training: ***(Chronological)***

	Place	Dates
Internship		

	Place	Dates
Residencies or Postdoctoral:		

Board Certification: National Commission on Certification of Physician Assistants — **Date:** Exp. 12-31-2023

Date:

Licensure: Certified Physician Assistant, Kentucky — **Date:** Exp. 3-31-2022

Registered Pharmacist, Kentucky — **Date:** Exp. 2-28-2023

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2004-2006	Assistant Professor	University of Kentucky	Clinical Sciences
2006-2008	Part-time Faculty	University of Kentucky	Clinical Sciences
2010-2011	Visiting Faculty	University of Kentucky	Clinical Sciences
2012-2020	Assistant Professor	Medical University of South Carolina	Health Professions
2020-present	Associate Professor	Medical University of South Carolina	Clinical Sciences

First Appointment to MUSC: Rank Assistant Professor **Date:** 1-1-2012

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Medical University of South Carolina
COLLEGE OF HEALTH PROFESSIONS
ABBREVIATED CURRICULUM VITAE

Date: March 18, 2022

Name: Woodbury (Last) | Michelle (First) | Lynne (Middle)

Citizenship and/or Visa Status: Citizen

Office Address: 77 President Street MSC-700 | Office C307, Charleston SC 29425
Telephone: 843-792-1671

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

Institution	Years Attended	Degree/Date	Field of Study
University of Florida	2002 - 2006	PhD	Rehabilitation Science
Columbia International University	1993 – 1995	MA	Intercultural Studies
Elizabethtown College	1982 – 1986	BS	Occupational Therapy

Graduate Medical Training: ***(Chronological)***

	Place	Dates
Internship		
NA		

	Place	Dates
Residencies or Postdoctoral:		
VA Associate Investigator | Malcom Randall VA Medical Center, Gainesville FL		2006 - 2008

Board Certification: National Board of Certification for Occupational Therapy (#913876) **Date:** 1986
Date:

Licensure: Occupational Therapist, Registered | South Carolina (#920) **Date:** 1993
Date:

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2014 – present	Associate Professor	MUSC	Department of Health Science and Research
2010 – 2014	Assistant Professor	MUSC	Department of Health Science and Research
2006 – 2010	Research Assistant Professor	University of Florida	Department of Occupational Therapy
2004 – 2006	Adjunct Assistant Professor	MUSC	Department of Occupational Therapy
1998 – 2004	Assistant Professor	MUSC	Department of Occupational Therapy

First Appointment to MUSC: Rank Assistant Professor **Date:** 07/01/1998

Medical University of South Carolina

College of Medicine

ABBREVIATED CURRICULUM VITAE

Date: 2-2-2022

Name: Boger (**Last**) Heather (**First**) Anne (**Middle**)

Citizenship and/or Visa Status: United States of America

Office Address: 173 Ashley Ave., BSB 410D **Telephone:** 876-2230

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

Institution	Years attended	Degree/Date	Field of Study
Presbyterian College	1997-2001	B.S./2001	Biology
Medical University of South Carolina	2001-2006	Ph.D./2006	Biomedical Sciences

Graduate Medical Training: ***(Chronological)***

	Place	Dates
Internship		

	Place	Dates
Residencies or Postdoctoral:		
Postdoctoral Fellowship, Umea University, Umea, Sweden		8/2006-12/2006
Postdoctoral Fellowship, Medical University of South Carolina, Chas, SC		1/2007-8/2011

Board Certification: **Date:**

Licensure: **Date:**

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2007-2008	Adjunct Professor	College of Charleston	Biology
2011-2017	Assistant Professor	Medical University of South	Neurosciences
2017-pres	Associate Professor	Medical University of South	Neurosciences

First Appointment to MUSC: Rank Assistant Professor **Date:** 9-1-2011

Medical University of South Carolina
College of Medicine
ABBREVIATED CURRICULUM VITAE

Date: 11/4/21

Name:	Carr,	Christine	Marie
	(Last)	**(First)**	**(Middle)**

Citizenship and/or Visa Status: United States
Office Address: 169 Ashley Ave MSC 300 , Charleston, SC, 29425 **Telephone:** (843) 792-9709

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

Institution	**Years attended**	**Degree/Date**	**Field of Study**
Cornell University	1984-86	BS	Molecular and Cell Biology
Medical University of South Carolina	1986-87	PhD candidate	Pharmacology
Medical University of South Carolina	1988-1992	MD	Medicine

Graduate Medical Training: ***(Chronological)***

Internship	**Place**	**Dates:**
Internship	The Johns Hopkins Hospital Emergency Medicine	1992-93
Residencies or Postdoctoral:		
Resident	The Johns Hopkins Hospital Emergency Medicine	1993-95

Board Certification:	**Date:**
American Board of Emergency Medicine.	1996, 2006, 2016
American Medical Informatics Association 10x10 Certificate in Medical Informatics	2010
American Association Physician Leadership, Certificed Physician Executive (CPE)	2016

Licensure:	**Date:**
South Carolina	1995-present

Faculty appointments: ***(Begin with initial appointment)***

Years	**Rank**	**Institution**	**Department**
1995-2000	Clinical Instructor	Medical University of South Carolina	Medicine
2000	Clinical Instructor	Medical University of South Carolina	Anesthesia and Perioperative Medicine, Division of Emergency Medicine
2000-2001	Instructor	Medical University of South Carolina	Anesthesia and Perioperative Medicine, Division of Emergency Medicine
200-2005	Assistant Professor	Medical University of South Carolina	Anesthesia and Perioperative Medicine, Division of Emergency Medicine
2005-2014	Assistant Professor	Medical University of South Carolina	Medicine, Division of Emergency Medicine
2014-2017	Associate Professor	Medical University of South Carolina	Medicine, Division of Emergency Medicine
2016-2017	Associate Professor	Medical University of South Carolina	Public Health Sciences
2017-2017	Professor	Medical University of South Carolina	Medicine, Division of Emergency Medicine
2017-2022	Professor	Medical University of South Carolina	Public Health Sciences
2017-2022	Professor	Medical University of South Carolina	Emergency Medicine
2022-present	Distinguished University Professor	Medical University of South Carolina	Emergency Medicine
2022-present	Distinguished University Professor	Medical University of South Carolina	Public Health Sciences

First Appointment to MUSC: **Rank:** Clinical Instructor **Date:** 1995

Bhishamjit Singh Chera, MD
July 2021 - June 2023
Abbreviated Curriculum Vitae
Professor
cherabs@musc.edu

Personal Information

Country of Origin: India
Languages: English

Contact Information

No activities entered.

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
M.D.	Medicine	Medical University of South Carolina				2004	
B.S.	Biology	Winthrop College				2000	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Internship	Medical University of South Carolina	Internal Medicine	July 2004	June 2005
Residency	University of Florida Shands Cancer Center	Department of Radiation Oncology	June 2005	June 2009

Additional Training

Start Date	End Date	Institution	Specialty	Type

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification
ABR Board Certified	Board Certified	Radiation Oncology		N/A	2010		

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description
SC Medical License	February 2022	June 2023	SC Labor Licensing Regulation	South Carolina				
NC Medical License	October 2009	October 2022	NC Medical Board	North Carolina				

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Professor	Medical University of South Carolina	College of Medicine	Radiation Oncology		2022-03-01	
Professor	Medical University of South Carolina	College of Medicine	Otolaryngology - Head and Neck Surgery		2022-03-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Assistant Professor	University of North Carolina School of Medicine		Radiation Oncology		2009	
Associate Professor with Tenure	University of North Carolina School of Medicine		Radiation Oncology		2015	

Ashish A Deshmukh, PhD

Abbreviated Curriculum Vitae

Associate Professor
deshmukha@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

2007	B.S., Pharmacy, Pune University, Nashik, India
In Progress	MPH, Health Policy and Management

Post-Graduate Training

Post Doctoral Fellow, The University of Texas MD Anderson Cancer Center, Clinical Decision Science, Cancer Prevention Research Training Program and Health Services Research , January 2014, December 2016

Additional Training

No activities entered.

Certifications

No activities entered.

Professional Licensures

No activities entered.

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2022-08-29

Non-MUSC Rank and Promotion History

Associate Professor , UTHealth School of Public Health, 2021

Assistant Professor , College of Public Health and Health Professions, 2016, 2018

Assistant Professor, UTHealth School of Public Health, 2018, 2021

John R. Freedy, MD, PhD

Abbreviated Curriculum Vitae

Professor
843-876-7047
freedyjr@musc.edu

Personal Information

No activities entered.

Contact Information

Office Number: Suite 405
Office Building: P.O. Box MSC 192
Street 1: Cannon Place - 135 Cannon St.
Street 2: Charleston, South Carolina 29425

Degrees

2002	M.D., Medicine, Medical University of South Carolina, South Carolina, United States
1990	Ph.D., Clinical Psychology, Kent State University, Ohio, United States
1988	M.A., Clinical Psychology, Kent State University, Ohio, United States
1984	B.A., Honors, Psychology, University of North Carolina at Chapel Hill, North Carolina, United States

Post-Graduate Training

Fellowship, MUSC Trustees Leadership Academy Fellow, Family Medicine, July 2008, June 2009

Fellowship, National Institute for Program Director Development (NIPPD), Family Medicine, July 2008, June 2009

Fellowship, Association of Departments of Family Medicine Leadership Education for Academic Development and Success (LEADS) Fellowship, Family Medicine, July 2019, June 2020

Fellowship, MUSC COM Leadership School, Family Medicine, July 2012, June 2013

Fellowship, Community Educator Leadership Training in Charleston (CELTIC) Fellowship; Medical University of South Carolina (MUSC), Department of Family Medicine, July 2005, June 2006

Internship, Medical University of South Carolina/Veterans Administration Medical Center, Charleston, SC, Psychology Intern, September 1989, August 1990

Post-Doctorate, National Institute of Mental Health National Crime Victims Research and Treatment Center, Medical University of South Carolina, Fellowship, Post-doctoral Fellow, September 1990, April 1991

Post-Doctorate, Trident/MUSC Family Medicine Residency Program Charleston, SC, Resident Physician, July 2002, June 2005

Post-Doctorate, American Balint Society, Leadership Fellow, March 2004, December 2007

Additional Training

No activities entered.

Certifications

American Board of Family Medicine, Effective Date: 2005-2015, 2015-2023

American Balint Society, Type of Certification: Credentialled Balint group leader, Specialty: Family Medicine, Certification Number: None given, Effective Date: 2007-03-01, Lifetime Board Certification: Yes

Professional Licensures

South Carolina Board of Medical Examiners

Clinical Psychology South Carolina Board of Examiners in Psychology

MUSC Rank and Promotion History

Clinical Assistant Professor, Medical University of South Carolina, College of Medicine, Psychiatry and Behavioral Sciences, 1998-09-01, 2004-06-30

Professor, Medical University of South Carolina, College of Medicine, Family Medicine, 2017-07-01

Associate Professor, Medical University of South Carolina, College of Medicine, Family Medicine, 2011-07-01, 2017-06-30

Assistant Professor, Medical University of South Carolina, College of Medicine, Psychiatry and Behavioral Sciences, 1992-07-01, 1998-08-31

Assistant Professor, Medical University of South Carolina, College of Medicine, Family Medicine, 2005-07-01, 2011-06-30

Instructor, Medical University of South Carolina, College of Medicine, Psychiatry and Behavioral Sciences, 1991-08-01, 1992-06-30

Non-MUSC Rank and Promotion History

No activities entered.

Faye N. Hant, D.O., MSCR

Abbreviated Curriculum Vitae

Contact Information

Suite 822 Z, MSC 637

Clinical Science Building - 96 Jonathan Lucas Street

Charleston, South Carolina 29425

Email: hant@musc.edu

Phone: 843-792-1991

Degrees

2007	M.S.C.R., Clinical Research, Medical University of South Carolina, South Carolina, United States
2001	D.O., Medicine, Nova Southeastern University, Florida, United States
1995	B.S., Biological Sciences, Florida State University, Florida, United States

Post-Graduate Training

Post-Doctorate, Medical University of South Carolina, Rheumatology Fellowship, July 2004, June 2007

Post-Doctorate, University of Connecticut, Resident, Internal Medicine, July 2002, June 2004

Post-Doctorate, University of Connecticut, Osteopathic Rotating Internship (ACGME/AOA approved), July 2001, June 2002

Certifications

International Society for Clinical Densitometry- Certified Clinical, Effective Date: 2005

American Board of Internal Medicine in Rheumatology, Effective Date: 2007

American Board of Internal Medicine, Effective Date: 2004

Professional Licensures

South Carolina, Effective Date: 2004

MUSC Rank and Promotion History

Professor, Medical University of South Carolina, College of Medicine, Medicine, Rheumatology & Immunology, 2022-01-01

Associate Professor, Medical University of South Carolina, College of Medicine, Medicine, Rheumatology and Immunology, 2014-07-01, 2021-12-31

Assistant Professor, Medical University of South Carolina, College of Medicine, Medicine, Rheumatology and Immunology, 2007-08-01, 2014-06-30

Benjamin F Jackson, MD

843-792-2823
jacksobf@musc.edu

Contact Information

Roper Medical Office Bldg - 125 Doughty St. MSC 917
Charleston, South Carolina 29425

Degrees

2003	M.D., Medicine, Medical University of South Carolina, South Carolina, United States
1999	B.A., History, Wake Forest University, North Carolina, United States

Post-Graduate Training

Fellowship, University of Alabama at Birmingham, Pediatric, July 2006 - June 2009
Internship, University of Alabama at Birmingham, Internship, July 2003 - June 2004
Residency, University of Alabama at Birmingham, Pediatrics, July 2004 - June 2006

Certifications

University of Alabama EMS Medical Director's Course, Effective Date: 2006 - 2009
The American Board of Pediatrics, Board Certification, Specialty: Pediatric, Sub-Specialty: Emergency Medicine, Certification Number: 1686, Effective Date: 2011-01-01
The American Board of Pediatrics, Board Certification, Specialty: Pediatrics, Effective Date: 2006-01-01, Expiration Date: 2016-12-31
Human Subjects Protection Training Program for Investigators, Effective Date: 2005 - 2009
Effective Date: 2007 - 2009
Effective Date: 2006 - Present
Effective Date: 2003 - Present

Professional Licensures

South Carolina Medical License #31651
Alabama State License #26387

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Pediatrics, Pediatric Emergency Medicine, 2016-01-01
Assistant Professor, Medical University of South Carolina, College of Medicine, Pediatrics, Pediatric Emergency Medicine, 2009-07-27 - 2015-12-31

Medical University of South Carolina College
of Medicine
ABBREVIATED CURRICULUM VITAE

Date: 02/17/2022

Name: Jiang (Last) Wei (First) (Middle)

Citizenship and/or Visa Status: U.S. citizen

Office Address: 173 Ashley Ave. BSB208D
Charleston, SC, 29425

Telephone: 843-876-2457

Education:

Institution	Years attended	Degree/Date	Field of Study
Capital Medical University	1986	MD/1997	Medicine
Capital Medical University	1998	MS/2001	Immunology/HIV
Case Western Reserve University	2009	MS/2012	Biostatistics

Graduate Medical Training:

	Place	Dates
Internship		
NA		
Residencies or Postdoctoral:	**Place**	**Dates**
Residency in medicine/Infectious Diseases	Ditan Hospital, Beijing, China	1991-1997
Postdoc/HIV immunopathogenesis	Case Western Reserve University	2002-2008

Board Certification: 10203C089758 Chinese Board of Internal Medicine, Infectious Diseases, 7/1/1997

Licensure: 971100071069382 Teacher qualification in the Educational Institute, National Educational Committee, China

Faculty appointments

Years	Rank	Institution	Department
2008-2012	Instructor	Case Western Reserve University	Medicine/Infectious Disease
2012-2018	Assistant Professor	Medical University of South Carolina	Microbiology & Immunology
2018-present	Associate Professor	Medical University of South Carolina	Microbiology & Immunology

First Appointment to MUSC: Rank Assistant Professor **Date:** 08/01/2012

David G. Koch, M.D., MSCR

Abbreviated Curriculum Vitae

Contact Information

Suite 265, MSC 702

Thurmond Gazes - 30 Courtenay Drive

Charleston, South Carolina 29425

Email: kochd@musc.edu

Phone: 843-876-4265

Degrees

2009	M.S.C.R., Clinical Research, Medical University of South Carolina, South Carolina, United States
2001	M.D., Medicine, Louisiana State University, Louisiana, United States
1997	B.S., Zoology, Louisiana State University, Louisiana, United States

Post-Graduate Training

Post-Doctorate, Medical University of South Carolina, Fellowship, July 2004, July 2007

Post-Doctorate, University of Alabama, Birmingham, Internship, July 2001, July 2002

Post-Doctorate, University of Alabama, Birmingham, Resident, July 2002, July 2004

Certifications

Board Certification, Internal Medicine, Effective Date: 08/2004

Board Certification, Gastroenterology, Effective Date: 08/2007, Renewed 11/2017

Professional Licensures

South Carolina

Alabama

MUSC Rank and Promotion History

Professor, Medical University of South Carolina, College of Medicine, Medicine, Gastroenterology & Hepatology, 2020-07-01

Associate Professor, Medical University of South Carolina, College of Medicine, Medicine, Gastroenterology & Hepatology, 2012-07-01, 2020-06-30

Assistant Professor, Medical University of South Carolina, College of Medicine, Medicine, Gastroenterology & Hepatology, 2007-07-01, 2012-06-30

Jeffrey E. Korte, PhD
July 2021 - June 2022
Abbreviated Curriculum Vitae
Professor
843-876-1122
korte@musc.edu

Contact Information

Office Number: 302M
Office Building: P.O. Box MSC 835
Street 1: Cannon Place - 135 Cannon St.
Street 2: Charleston, South Carolina 29425

Degrees

1999	Ph.D., Epidemiology, University of North Carolina at Chapel Hill, North Carolina, United States
1997	M.S.P.H., Epidemiology, University of North Carolina at Chapel Hill, North Carolina, United States
1992	B.A., Psychology, Rice University

Post-Graduate Training

Post-Doctorate, International Agency for Research on Cancer, Postdoctoral Fellow, September 1999, September 2001

Additional Training

No activities entered.

Certifications

No activities entered.

Professional Licensures

No activities entered.

MUSC Rank and Promotion History

Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2021-07-01

Professor, Medical University of South Carolina, College of Graduate Studies, 2006-04-14

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2016-01-01, 2021-06-30

Assistant Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2006-02-01, 2009-06-30

Assistant Professor, Medical University of South Carolina, College of Medicine, Medicine, Biostatistics and Epidemiology, 2009-07-01, 2012-12-31

Assistant Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2013-01-01, 2015-12-31

Non-MUSC Rank and Promotion History

Research Assistant Professor, University of Texas Health Science Center at San Antonio, Obstetrics and Gynecology, 2001-09-01

Jacqueline M Kraveka, DO

Abbreviated Curriculum Vitae

843-792-2957
kravekjm@musc.edu

Contact Information

CR 306, MSC 917
Children's Research Inst. - 173 Ashley Ave.
Charleston, South Carolina 29425

Degrees

1994	D.O., Medicine, Nova Southeastern University, Florida, United States
1989	B.A., History and Pre-Med, Columbia University in the City of New York, New York, United States

Post-Graduate Training

Fellowship, Medical University of South Carolina, Pediatrics, July 1997, June 2000
Residency, Miami Children's Hospital, Pediatrics, July 1994, June 1997

Certifications

The American Board of Pediatrics , Type of Certification: Board Certification, Specialty: Pediatrics, Sub-Specialty: Hematology-Oncology, Certification Number: 1533, Effective Date: 2000-01-01
The American Board of Pediatrics, Type of Certification: Board Certification, Specialty: Pediatrics, Effective Date: 1997-01-01, Expiration Date: 1999-12-31

Professional Licensures

South Carolina Medical License, Originally Conferred: May 1997, Expires: June 2023, South Carolina Board of Medical Examiners, South Carolina, 0471

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Pediatrics, Pediatric Hematology/Oncology, 2012-01-01
Assistant Professor, Medical University of South Carolina, College of Medicine, Pediatrics, Pediatric Hematology/Oncology, 2000-07-01, 2011-12-31

Non-MUSC Rank and Promotion History

Adjunct Associate Professor, Clemson University, Clemson, SC, Engineering and Science, Bioengineering, 2013-09-01

Medical University of South Carolina

College of Medicine

ABBREVIATED CURRICULUM VITAE

Date: March 23, 2022

Name: Krywko (Last) Diann (First) Marie (Middle)

Citizenship and/or Visa Status: USA

Office Address: 169 Ashley Ave. MSC 300, MUSC
Charleston, SC 29425

Telephone: 843-792-9707

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

Institution	Years attended	Degree/Date	Field of Study
Michigan State University	1988-1992	BS, June 1992	Physiology
Wayne State University School of Medicine	1992-1996	MD, June 1996	MD

Graduate Medical Training*: (Chronological)*

	Place	Dates
Internship		
The University of Michigan Emergency Medicine Program	Ann Arbor, MI	1996-1997
Residencies or Postdoctoral:		
The University of Michigan Emergency Medicine Residency	Ann Arbor, MI	1997-1999

Board Certification: American Board of Emergency Medicine — **Date:** 2000/2009/2019

Licensure:

State of Michigan	**Date:** 1996-2009
State of South Carolina	**Date:** 2008- Present

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2017-Present	Professor	Medical University of South Carolina	Emergency Medicine
2010-2017	Associate Professor	Medical University of South Carolina	Medicine
2008-2010	Assistant Professor	Medical University of South Carolina	Medicine
2009-2011	Adjunct Faculty, Professor	Medical University of South Carolina	College of Health Professions
2007-2011	Lecturer 1	University of Michigan	School of Health Professions and Studies
2002-2008	Assistant Professor	University of Michigan	Emergency Medicine
2000-2002	Clinical Instructor I	University of Michigan	Emergency Medicine
1999-2000	Clinical Instructor	University of Michigan	Surgery

First Appointment to MUSC: Rank Assistant Professor **Date:** 2008

Renee L. Martin, PhD
July 2021 - June 2022
Abbreviated Curriculum Vitae
Professor
843-876-1913
hebertrl@musc.edu

Contact Information

Office Number: Ste 305M
Office Building: P.O. Box MSC 835
Street 1: Cannon Place - 135 Cannon St.
Street 2: Charleston, South Carolina 29425

Degrees

2001	Ph.D., Biostatistics, Medical University of South Carolina, South Carolina, United States
1992	M.S., Statistics, University of Tennessee - Knoxville, Tennessee, United States
1990	B.S., Mathematics, Nicholls State University

Post-Graduate Training

No activities entered.

Additional Training

No activities entered.

Certifications

No activities entered.

Professional Licensures

No activities entered.

MUSC Rank and Promotion History

Research Assistant Professor, Medical University of South Carolina, College of Medicine, Medicine, Biostatistics and Epidemiology, 2009-07-01, 2009-12-31

Research Assistant Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2004-05-01, 2009-06-30

Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2020-01-01

Professor, Medical University of South Carolina, College of Graduate Studies, 2006-03-26

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2014-07-01, 2019-12-31

Assistant Professor, Medical University of South Carolina, College of Medicine, Medicine, Biostatistics and Epidemiology, 2010-01-01, 2012-12-31

Assistant Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2013-01-01, 2014-06-30

Non-MUSC Rank and Promotion History

Instructor, Nicholls State University, Mathematics, 1992-09-01

Graduate Teaching Assistant, University of Tennessee, Statistics, 1990-09-01

Graduate Assistant, University of Tennessee, Design of Experiments Institute, Statistics, 1991-09-01

Eric M. Matheson, MD

Abbreviated Curriculum Vitae

Associate Professor
843-876-7080
matheson@musc.edu

Personal Information

No activities entered.

Contact Information

Office Number: 405H1
Office Building: P.O. Box MSC 192
Street 1: Cannon Place - 135 Cannon St.
Street 2: Charleston, South Carolina 29425

Degrees

2009	M.S.C.R., Clinical Research, Medical University of South Carolina, South Carolina, United States
2001	M.D., Medicine, Eastern Virginia Medical School, Virginia, United States
1995	B.A., Biology, University of Virginia, Virginia, United States

Post-Graduate Training

Master of Science in Clinical Research, Medical University of South Carolina, Clinical Research, August 2007, May 2009

Post-Doctorate, Internship, September 2001, September 2002

Post-Doctorate, Residency, September 2002, September 2004

Additional Training

No activities entered.

Certifications

American Board of Family Medicine, Effective Date: 2004-present

Professional Licensures

South Carolina

Florida

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Family Medicine, 2014-07-01

Assistant Professor, Medical University of South Carolina, College of Medicine, Family Medicine, 2010-01-01, 2014-06-30

Instructor, Medical University of South Carolina, College of Medicine, Family Medicine, 2007-07-01, 2009-12-31

Non-MUSC Rank and Promotion History

No activities entered.

John Donald Melville, MD, MS

Abbreviated Curriculum Vitae
843-723-3600
melvillj@musc.edu

Contact Information

RN 530F, MSC 917
Roper Medical Office Bldg - 125 Doughty St.,
Charleston, South Carolina 29425

Degrees

2012	M.S., Clinical Investigation, University of Texas Health Science Center, San Antonio, Texas, United States
2002	M.D., Medicine, University of California, San Diego, California, United States
1998	M.S., Computer Science, Brigham Young University, Utah, United States
1997	B.S., Computer Science, Brigham Young University, Utah, United States

Post-Graduate Training

Fellowship, University of Texas Health Science Center, Pediatrics, July 2010, June 2013
Residency, Akron General Medical Center and Akron Children's Hospital, Internal Medicine and Pediatrics, July 2005 - June 2006

Certifications

Pediatric Advanced Life Support, Effective Date: 2013
CPR for Healthcare Providers, Effective Date: 2013
American Board of Pediatrics, Type of Certification: Board Certification, Specialty: Pediatrics, Certification Number: 86974, Effective Date: 2006-07-01
American Board of Pediatrics, Type of Certification: Board Certification, Specialty: Pediatrics, Sub-Specialty: Child Abuse Pediatrics, Certification Number: 300, Effective Date: 2013-07-01
American Board of Internal Medicine, Type of Certification: Board Certification, Specialty: Internal Medicine, Certification Number: 259528, Effective Date: 2007-07-01, Expiration Date: 2010-06-30

Professional Licensures

Texas Medical License, Originally Conferred: February 2010, Expires: March 2015, Texas Medical Board, Texas, N5242
South Carolina Medical License, Originally Conferred: July 2016, Expires: June 2023, South Carolina Board of Medical Examiners, South Carolina, 39702
Ohio Medical License, Originally Conferred: April 2013, Expires: July 2018, Ohio Professional License, Ohio, 35.121093
DEA Registration, Month / Year Originally Conferred: August 2017, Drug Enforcement Agency, FM3839783

California Medical License, Originally Conferred: August 2008, Expires: July 2010, Medical Board of California, California, A 105284

Alaska Medical License, Originally Conferred: November 2008, Expires: December 2010, Alaska Department of Commerce, Community, and Economic Development, Alaska, MEDS5800

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Pediatrics, Child Abuse Pediatrics, 2016-09-26

Non-MUSC Rank and Promotion History

Assistant Professor, Northeast Ohio Medical University, Pediatrics, 2013-09-01 - 2016-09-23

Cynthia L Talley, MD

Abbreviated Curriculum Vitae

Associate Professor
843-792-3780
talleyc@musc.edu

Personal Information

No activities entered.

Contact Information

Office Number: 426-C
Office Building: P.O. Box MSC 613
Street 1: Clinical Science Bldg. - 96 Jonathan Lucas St.
Street 2: Charleston, South Carolina 29425

Degrees

2004	M.D., Medicine, University of Tennessee, College of Medicine, Tennessee, United States
2000	B.S., Biology, University of Tennessee - Knoxville, Tennessee, United States

Post-Graduate Training

Post-Doctorate, American College of Surgeons, Certificate in Applied Surgical Education Leadership (CASEL), October 2019, October 2020

Post-Doctorate, Vanderbilt University, Trauma Fellow, July 2010, June 2011

Post-Doctorate, Vanderbilt University, Surgical Critical Care Fellow, July 2009, June 2011

Post-Doctorate, University of Tennessee Graduate School of Medicine, General Surgery Resident, July 2004, June 2009

Post-Doctorate, Association for Surgical Education, Surgical Education Research Fellow, April 2010, April 2011

Additional Training

No activities entered.

Certifications

Pediatric Advanced Life Support

Fundamentals of Laparoscopic Surgery

Fundamentals of Critical Care Support

FEMA National Response Framework, An Introduction

FEMA National Incident Management System (NIMS) An Introduction

FEMA Introduction to Incident Command System, ICS-100

FEMA ICS for Single Resources and Initial Action Incident, ICS-200

Disaster Management and Emergency Preparedness

Basic Life Support

Advanced Trauma Operative Management Instructor

Advanced Trauma Operative Management, Type of Certification: na, Certification Number: na, Effective Date: 2019

Advanced Trauma Life Support Instructor

Advanced Trauma Life Support Course Director

Advanced Surgical Skills for Exposure in Trauma

Advanced Cardiac Life Support

Advanced Burn Life Support

Advance Trauma Life Support

Professional Licensures

Tennessee Medical License #45432

South Carolina Medical License #81769

Kentucky Medical License #44731

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Surgery, General Surgery, 2018-12-01

Non-MUSC Rank and Promotion History

Instructor, Vanderbilt University, Surgery, Trauma and Surgical Critical Care, 2010-07-01, 2011-06-30

Associate Professor, University of Kentucky, Surgery, Trauma & Acute Care Surgery, 2016-07-01, 2018-11-08

Assistant Professor, University of Kentucky, Surgery, Trauma & Acute Care Surgery, 2011-08-01, 2016-07-01

Benjamin Andrew Toll, PhD
July 2021 - June 2022
Abbreviated Curriculum Vitae
Professor
843-876-1132
toll@musc.edu

Contact Information

- Office Number: 303C
- Office Building: P.O. Box MSC 835
- Street 1: Cannon Place - 135 Cannon St.
- Street 2: Charleston, South Carolina 29425

Degrees

2002	Ph.D., Clinical Psychology, Nova Southeastern University, Florida, United States
1999	M.S., Clinical Psychology, Nova Southeastern University, Florida, United States
1996	B.A., Psychology, Cornell University

Post-Graduate Training

Post-Doctorate, Yale University School of Medicine, Postdoctoral Fellowship, September 2002, September 2004

Post-Doctorate, Yale University School of Medicine, Internship, September 1999, September 2001

Post-Doctorate, Yale University School of Medicine, New Haven, CT, Psychology Intern, Division of Substance Abuse, September 2001, September 2002

Professional

Licensures

Psychologist License Number 002518, State of Connecticut, Department of Public Health

Psychologist License, Month / Year Originally Conferred: March 2015, South Carolina, 1349, Pscychology

2016-12-31

MUSC Rank and Promotion History

Professor, Medical University of South Carolina, College of Medicine, Psychiatry and Behavioral Sciences, 2017-01-01

Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2017-01-01

Associate Professor, Medical University of South Carolina, College of Medicine, Psychiatry and Behavioral Sciences, 2015-03-01, 2016-12-31

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2015-03-01,

Non-MUSC Rank and Promotion History

Associate Research Scientist, Yale School of Medicine, Psychiatry, 2004-07-01, 2006-06-01

Associate Professor, Yale School of Medicine, Psychiatry, 2012-07-01, 2099-01-01

Assistant Professor, Yale School of Medicine, Psychiatry, 2006-07-01, 2012-06-01

Chenthamarakshan Vasu, PhD
Abbreviated Curriculum Vitae
Professor
843-792-1032
vasu@musc.edu

Personal Information

No activities entered.

Contact Information

- Office Number: BS208E
- Office Building: P.O. Box MSC 504
- Street 1: Basic Science Building - 173 Ashley Ave.
- Street 2: Charleston, South Carolina 29425

Degrees

Degree	Discipline	Institution	City	State or Province	Nation	Year Conferred	Title of Dissertation or Thesis
Ph.D.	Biochemistry and Immunology	Rashtrasant Tukadoji Maharaj Nagpur University			India	1997	
M.Sc.	Zoology	University of Calicut			India	1989	
B.Sc.	Zoology	University of Calicut			India	1987	

Post-Graduate Training

Type	Institution	Specialty	Begin Month/Year	End Month/Year
Post-Doctorate	Department of Medical Microbiology, University of Malaya, Kuala Lumpur, MALAYSIA	Post-doctoral Research Fellow	September 1997	August 1999
Post-Doctorate	Department of Surgery and Microbiology & Immunology, University of Illinois at Chicago	Post-Doctoral Research Associate	August 1999	August 2002
Post-Doctorate	Department of Surgery and Microbiology & Immunology, University of Illinois at Chicago	Senior Post-Doctoral Research Associate	August 2002	August 2004

Additional Training

Start Date	End Date	Institution	Specialty	Type

No data available in table

Certifications

Organization Name	Type of Certification	Specialty	Sub-Specialty	Certification Number	Effective Date	Expiration Date (if none, see note above)	Lifetime Board Certification

No data available in table

Professional Licensures

Title	Month / Year Originally Conferred	Month/Year Expires	Organization	State of Issue	Country for International Issue	Number (if applicable)	Type	Description

No data available in table

MUSC Rank and Promotion History

Faculty Rank	Institution	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Associate Professor	Medical University of South Carolina	College of Dental Medicine	Microbiology and Immunology		2011-08-16	2020-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Surgery	General Surgery	2011-08-16	2020-06-30
Associate Professor	Medical University of South Carolina	College of Medicine	Microbiology and Immunology		2011-08-16	2020-06-30
Professor	Medical University of South Carolina	College of Graduate Studies			2011-10-31	
Professor	Medical University of South Carolina	College of Dental Medicine	Microbiology and Immunology		2020-07-01	
Professor	Medical University of South Carolina	College of Medicine	Surgery	General Surgery	2020-07-01	
Professor	Medical University of South Carolina	College of Medicine	Microbiology and Immunology		2020-07-01	

Non-MUSC Rank and Promotion History

Faculty Rank	Institution/Organization	College	Department	Division	Effective Start Date of Rank	Effective End Date of Rank
Research Assistant Professor (non-salaried)	University of Illinois at Chicago		Surgery and Microbiology and Immunology		2002-09-01	
Assistant Professor (Tenure-track)	University of Illinois at Chicago		Surgery and Microbiology and Immunology		2004-08-01	2099-01-01

Ashish A Deshmukh, PhD

Abbreviated Curriculum Vitae

Associate Professor

deshmukha@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

2007	B.S., Pharmacy, Pune University, Nashik, India
In Progress	MPH, Health Policy and Management

Post-Graduate Training

Post Doctoral Fellow, The University of Texas MD Anderson Cancer Center, Clinical Decision Science, Cancer Prevention Research Training Program and Health Services Research , January 2014, December 2016

Additional Training

No activities entered.

Certifications

No activities entered.

Professional Licensures

No activities entered.

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Public Health Sciences, 2022-08-29

Non-MUSC Rank and Promotion History

Associate Professor , UTHealth School of Public Health, 2021

Assistant Professor , College of Public Health and Health Professions, 2016, 2018

Assistant Professor, UTHealth School of Public Health, 2018, 2021

Kathleen Maksimowicz-McKinnon
Abbreviated Curriculum Vitae
Associate Professor
maksimow@musc.edu

Personal Information

No activities entered.

Contact Information

No activities entered.

Degrees

2019	MPH, Epidemiology, University of Pittsburgh, Pittsburgh, Pennsylvania, United States
1997	D.O., Medicine, NOVA- Southeastern College of Osteopathic Medicine , Ft. Lauderdale, Florida, United States
1991	B.S., Biology, Florida State University, Tallahassee, Florida, United States

Post-Graduate Training

Fellowship, Cleveland Clinic, Rheumatology , July 2002, June 2004

Internship, Sun Coast Hospital, Osteopathic , July 1997, June 1998

Residency, Henry Ford Hospital, Internal Medicine, July 1998, June 2002

Additional Training

No activities entered.

Certifications

American Board of Internal Medicine , Type of Certification: Board Certification, Specialty: Rheumatology , Certification Number: 203467, Effective Date: 2004-01-01, Expiration Date (if none, see note above): 2023-04-01

American Board of Internal Medicine , Type of Certification: Board Certification, Specialty: Internal Medicine, Certification Number: 203467, Effective Date: 2001-01-01, Expiration Date (if none, see note above): 2023-04-01

Professional Licensures

Michigan Medical License (DO), Month / Year Originally Conferred: June 1998, Month/Year Expires: June 2023, 5101014012

MUSC Rank and Promotion History

Associate Professor, Medical University of South Carolina, College of Medicine, Medicine, Rheumatology & Immunology, 2022-09-12

Non-MUSC Rank and Promotion History

Clinical Associate Professor of Medicine, Henry Ford Hospital, 2016-06-01

Assistant Professor, University of Pittsburgh Medical Center , 2004-07-01, 2012-08-31

Clinical Associate Professor of Medicine , Wayne State University , 2016-06-01

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DateĀ 10/10/2022

Name: Bencharit (**Last**) Sompop (**First**) (**Middle**)

Citizenship and/or Visa Status: USA

Office Address: 521 N 11 St. Richmond, VA 23298 **Telephone:** 919-623-4560

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

Institution	**Years Attended**	**Degree/Date**	**Field of Study**
Chulalongkorn University	1988-1994	DDS/1994	Dentistry
University of North Carolina at Chapel Hill	1996-1999	Certificate/ 1999	Prosthodontics
University of North Carolina at Chapel Hill	1996-1999	MS/1999	Prosthodontics
University of North Carolina at Chapel Hill	1999-2003	PhD/2003	Oral Biology
University of North Carolina at Chapel Hill	2007-2008	Certificate/ 2008	Clinical Research

Graduate Medical Training*: (Chronological)*

	Place	**Dates**
Internship		

First Appointment to MUSC: Rank Professor **Date:** 11/28/2022

	Place	Dates
Residencies or Postdoctoral:		
	Chulalongkorn University, Bangkok, Thailand	1996
	University of North Carolina at Chapel Hill, Chapel Hill, NC	1999

Board Certification:	Prosthodontics	**Date:**	11/2009
		Date:	
		Date:	
Licensure:	Thailand	**Date:**	4/1994
	NC-Instructor License	**Date:**	2/2003
	VA-Dentistry	**Date:**	7/2016
	NC-Dentistry	**Date:**	1/2022

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
1994	Instructor	Chulalongkorn University	Prosthodontics
2005	Assistant Professor	University of North Carolina at Chapel Hill	Prosthodontics
2005	Assistant Professor	University of North Carolina at Chapel Hill	Pharmacology
2016	Associate Professor	Virginia Commonwealth University	General Practice
2016	??=392@5Ā >=6??=>	Virginia Commonwealth University	! 9=; 5493:2Ā$ <79=55>9=7
2021	Associate Professor	Virginia Commonwealth University	Oral and Craniofacial Molecular Biology

Medical University of South Carolina

College of Medicine

ABBREVIATED CURRICULUM VITAE

Date: March 23, 2022

Name: Krywko (Last) Diann (First) Marie (Middle)

Citizenship and/or Visa Status: USA

Office Address: 169 Ashley Ave. MSC 300, MUSC
Charleston, SC 29425

Telephone: 843-792-9707

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

Institution	Years attended	Degree/Date	Field of Study
Michigan State University	1988-1992	BS, June 1992	Physiology
Wayne State University School of Medicine	1992-1996	MD, June 1996	MD

Graduate Medical Training*: (Chronological)*

	Place	Dates
Internship		
The University of Michigan Emergency Medicine Program	Ann Arbor, MI	1996-1997
Residencies or Postdoctoral:		
The University of Michigan Emergency Medicine Residency	Ann Arbor, MI	1997-1999

Board Certification: American Board of Emergency Medicine — **Date:** 2000/2009/2019

Licensure:

State of Michigan	**Date:** 1996-2009
State of South Carolina	**Date:** 2008- Present

Faculty appointments: ***(Begin with initial appointment)***

Years	Rank	Institution	Department
2017-Present	Professor	Medical University of South Carolina	Emergency Medicine
2010-2017	Associate Professor	Medical University of South Carolina	Medicine
2008-2010	Assistant Professor	Medical University of South Carolina	Medicine
2009-2011	Adjunct Faculty, Professor	Medical University of South Carolina	College of Health Professions
2007-2011	Lecturer 1	University of Michigan	School of Health Professions and Studies
2002-2008	Assistant Professor	University of Michigan	Emergency Medicine
2000-2002	Clinical Instructor I	University of Michigan	Emergency Medicine
1999-2000	Clinical Instructor	University of Michigan	Surgery

First Appointment to MUSC: Rank Assistant Professor **Date:** 2008