SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff Peer Review of Practitioner's Performance	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 1
APPROVALS:	☒ SGMC	
Approved by Medical Staff: 04/2024	☐ SGMC Berrien Campus	
Approved by Hospital Authority: 04/2024	☐ SGMC Lanier Campus	
Effective Date: 04/17/2024	☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to establish procedures for the Medical Staff to identify a minimum set of circumstances that will require further intensive review to determine whether further action is required to improve a Practitioner's performance, to set forth guidelines for such focused review process, and to identify the method by which a Practitioner's performance is monitored on an on-going basis. The goal of this Policy is to develop, implement, and maintain an ongoing system for managing quality and patient safety measurement, assessment, and improvement of a practitioner's performance. It is not the goal of the Policy to establish procedures for the initiation of corrective action proceedings pursuant to the Medical Staff Bylaws.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Clinical Privileges means the authorization by SGMC to a health care practitioner for the provision of health care services, including privileges and membership on the Medical Staff.

"MEC" means Medical Executive Committee.

Practitioner means an individual who is licensed or otherwise by the State of Georgia to provide certain healthcare services.

"QM Committee" means Quality Management Committee.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

I. Evaluation & Review of Performance

1. Evaluations

1. Pursuant to QM 1, SR 1 of the National Integrated Accreditation for Healthcare Organizations ("NIAHO) Accreditation Requirements, SGMC shall develop, implement, and maintain an ongoing system for managing quality and patient safety.

2. As such, the QM Committee, assisted by the Quality Improvement/Patient Safety staff, will generally undertake activities that focus attention on various processes, functions, and areas of SGMC necessary to measure, assess, and improve performance by the Medical Staff, in the following instances:

a. Focused Professional Practice Evaluation (FPPE) and reviews are generally initiated in the following instances: (i) following the appointment of initial Clinical Privileges to a Practitioner; (ii) following the appointment of additional Clinical Privileges to a Practitioner when the Practitioner does not have documented evidence of competency performing the additional Clinical Privileges at SGMC; and (iii) when a question arises regarding a Practitioner's ability or competency to provide safe, quality patient care.

b. On-going Professional Practice Evaluation (OPPE) and reviews, are generally initiated in the following instances: (i) identification of core indicators that trigger case review; (ii) on-going evaluation and review of inpatient cases which are triggered for review by core indicators, (iii) on-going review of representative cases of outpatient cases which are triggered for review by the core indicators; (iv) review of cases that are identified for review by the Chief of Staff, a Department Chairman, the Chief Medical Officer, or the Administrative Director of Quality Improvement/Patient Safety; and (v) review of cases that are reported or identified by persons involved in the case, (including consulting physicians, assistants at surgery, and nursing and administrative personnel).

c. Departments, Sections and Services will also conduct on-going review of Practitioners' performance in compliance with the Medical Staff Bylaws.

3. In accordance with QM.1, SR.1a(1) and a(2) of the NIAHO Accreditation Requirements, the number and scope of these evaluations and review activities will be conducted at least annually and will be proportional to the scope and complexity of the SGMC's operations and services offered. These evaluations and review activities will be documented to include the rationale for selection and measurable progress achieved.

4. If SGMC participates in a Quality Improvement Organization ("QIO") cooperative project, SGMC shall demonstrate that information and supporting documentation is provided to the QIO. If SGMC does not participate in a QIO, the projects and activities are required to be of comparable effort as required by QM.1, SR.1a(3).

5. In accordance with QM.1, SR.2 and SR.3, SGMC shall implement hospital-wide quality assessment and performance improvement efforts to address priorities for improved quality of care and patient safety and that corrective and preventive actions are implemented and evaluated for effectiveness. SGMC will assure that adequate resources are allocated for measuring, assessing, improving, and sustaining its performance and reducing risk to parties.

6. Pursuant to QM.4, SR.1, a management representative shall be identified by senior leadership and shall have the responsibility and authority, in conjunction with senior leadership, for ensuring that the requirements of the QM Committee are determined, implemented, and maintained.

3. Core Indicators

Pursuant to QM 3, SR 1, SGMC shall clearly outline its methodology, practice, and related policies for addressing how quality and performance are measured, monitored, analyzed, and continually improved with the goal of producing positive health outcomes and reduced risks for patients. At least annually, the QM Committee will submit proposed core indicators that trigger case review ("Core Indicators") to the MEC for approval.

3. Monitoring

The extent and type of monitoring of Practitioners and specific monitoring plans relating to requests for certain Clinical Privileges are determined by criteria established by the QM Committee and approved by the MEC.

4. Use of Data from Reviews of Practitioner Performance

Individual Departments submit categories of data to be collected to the MEC for approval. Data obtained from the evaluation and reviews described above is used to assess Practitioners' competence and, to identify opportunities for performance improvement. This data shall be made available for consideration by the Department Chairmen, the Professional Qualifications Committee, and the MEC to assist them in performing their responsibilities relating to assessment of professional competence and conduct, including determinations of whether to continue, limit or revoke a Practitioner's existing Clinical Privilege(s).

5. Measures to Resolve Performance Issues: Documentation

The measures employed to resolve performance issues identified through the evaluations and reviews described above may include, but are not limited to: (i) continuing evaluation, review, or monitoring of cases for additional periods of time; (ii) appointment of a Practitioner in the same specialty to directly observe the Practitioner's performance; (iii) and/or referring the performance issues to the MEC for further guidance or action by the MEC.

6. Review by the Medical Executive Committee

a. At their discretion, the Department Chairman and/or the CMO may report case(s)

identified through the evaluation and reviews described above to the MEC for review and consideration.

b. In the event that a Department Chairman and/or the CMO, at any time during the evaluation and review processes described above, determines that a Practitioner's performance at issue is such that corrective action might be warranted pursuant to the Medical Staff Bylaws, the Department Chairman may, in their discretion, present the performance issues to the MEC for consideration and further action.

c. If the QM Committee determines that the Practitioner's performance warrants investigation by the MEC to determine whether corrective action against the Practitioner is warranted, the QM Committee will direct the Chairperson of the QM Committee to request the MEC to such initiate an investigation pursuant to the Medical Staff Bylaws.

Such reports to the MEC may occur at any time during the implementation of the evaluation and review process described in this Policy. Therefore, completion of the evaluation and review processes of this Policy are not required prior to case(s) being reported to the MEC.

7. Confidentiality and Peer Review Privilege

All proceedings involving Practitioners must be held in the strictest confidence and shall not be discussed or disseminated outside the proceedings of this Policy, except as provided in the Medical Staff Bylaws and as required by law. Any breach of this confidentiality by QM Committee members, MEC members or members of the Staff will be considered grounds itself for disciplinary action. The Quality Committee's activities and functions, including activities of persons acting at the direction and request of the MEC or the QM Committee, constitute peer review and medical review activities and are entitled to protections afforded by Georgia peer review and medical review privileges.

II. Method of Implementation

1. Quality Management Committee

a. Clinical Staff in Quality Improvement/Patient Safety shall screen all inpatient discharge records and a representative sample of outpatient cases (including Emergency and Youth Care cases) for Core Indicators.

b. Unless a review method other than chart review is directed by the QM Committee or Department Chairman, the Quality Improvement/Patient Safety Staff shall prepare chart abstract summaries of all cases meeting any of the Core Indicators and any cases that have been identified for review pursuant to this Policy, and shall submit the summaries to the applicable Department Chairperson for review.

c. Focused evaluation and review of newly appointed Practitioners and Practitioners with newly appointed Clinical Privileges continue for the Practitioner's first thirty (30) cases or three (3) months, whichever occurs first. Such review may be continued at the direction of the Department Chairman or the QM Committee.

d. The decision to assign or to continue a period of monitoring or focused evaluation and review is based on the evaluation of a Practitioner's current clinical competence, practice, behavior or ability to perform the applicable Clinical Privileges.

e. The Department Chairperson to whom the cases have been referred shall assign cases for review to a member(s) of the QM Committee. However, if the Department Chairman determines that a review is needed by a person in the same professional discipline who is not a member of the QM Committee, the Department Chairman may assign the case to a member of the Medical Staff who is in the same professional discipline. If the Department Chairman determines that a review by a person who is not a member of the Medical Staff is necessary, upon the approval of the Chief Medical Officer or with the consent of the Administrator, the Department Chairman may so assign the case for external review by an independent person in the same professional discipline. Following presentation of the results of the case review, the Committee may send the case for review by another person or entity in the same professional discipline, either on the Medical Staff or an independent external review, including, but not limited to: (i) when the procedure is not currently performed by another member of the Medical Staff, or (ii) when a Practitioner is in a subspecialty without peer on the Medical Staff.

f. Upon determination by the QM Committee that no further assigned review of the case is needed, the QM Committee will either allow the Practitioner to present the case personally before the QM Committee or submit a written presentation of the case. The determination of whether the Practitioner may appear personally or by written response is subject to the discretion of the QM Committee, and is subject to the time frames established by the QM Committee. Legal counsel for the practitioner shall not be present during any personal presentation; although, at the request of the Committee, Legal Counsel for the Company and/or the MEC may be present. No verbatim

or detailed record of the appearance shall be made.

g. Within thirty (30) days of the QM Committee's receipt of the Practitioner's personal or written presentation of the case or the expiration of the time frame within which the QM Committee allows the Practitioner to complete such presentation, the QM Committee will determine whether the Practitioner's performance could be improved by implementation of changes. If the QM Committee so determines, the QM Committee shall direct the Chairperson of the QM Committee to so notify the Practitioner and the MEC of the findings, conclusions, and recommendations, if any, of the QM Committee. If the QM Committee determines that the Practitioner's performance warrants investigation by the MEC to determine whether corrective action against the Practitioner is warranted, the Committee will direct the Chairperson of the Committee to request such initiation of investigation pursuant to the Medical Staff Bylaws.

h. In the event that at any time during the focused review process, the QM Committee determines that the Practitioner's performance at issue is such that corrective action might be warranted pursuant to the Medical Staff Bylaws, the QM Committee may direct Committee Chairperson to request the MEC to initiate investigation to determine whether corrective action is warranted.

i. Practitioners may request to review their individual quality profiles, including cases reviewed by the staff or QM Committee and occurrence rates, if any.

j. Practitioners may request the QM Committee and staff to conduct focused review studies across a specialty, section or department.

2. Additional Review of Practitioner Performance

a. In addition to reviews by the QM Committee as provided above and in the Medical Staff Bylaws, and within the Departments as provided in the Medical Staff Bylaws, peer review activities are carried out as follows:

- ***Emergency Services:*** Cases are reviewed by the QM Committee. Additionally, the Emergency Physicians have other indicators for review focusing on the customer service and process related components, which are reviewed in the Emergency Services meeting. Results of these activities are then forwarded to the Quality Improvement/Patient Safety Department for inclusion into the report to the Quality Improvement & Patient Safety Committee of the Hospital Authority.

- ***Pathology:*** All cases are reviewed by other pathologists and variations noted. Additional review is done on cases sent for consultation. Results of these activities are then forwarded to the Quality Improvement/Patient Safety Department for review by the QM Committee and inclusion in the report to the Quality Improvement & Patient Safety Committee of the Hospital Authority.

- ***Radiation Oncology:*** Fifty cases are randomly selected on a yearly basis for external peer review. These cases are reviewed for appropriateness of the treatment plan and occurrence

of adverse events/outcomes.

- ***Radiology:*** Cases are identified and reviewed based on indicators for misinterpretation of findings and/or diagnosis or referrals from other medical staff members. Additional review, such as blind readings, mammography studies and other focus studies are done on a quarterly basis. Conclusions from these reviews are forwarded to the Quality Improvement/Patient Safety Department for review by the QM Committee and inclusion in the report to the Quality Improvement & Patient Safety Committee of the Hospital Authority.

- ***Anesthesiology:*** Cases are identified through chart review and referred to the Chief of Anesthesiology for their review. Additional indicators are reviewed within the Anesthesia Service and the results are sent to the Quality Improvement/Patient Safety Department for inclusion in the report to the Quality Improvement & Patient Safety Committee of the Hospital Authority.

- ***Psychiatry:*** Cases are reviewed against core indicators and reviewed at the Psychiatry Staff Meetings. Results are forwarded to the Quality Improvement/Patient Safety Department for inclusion in the report to the Quality Improvement & Patient Safety Committee of the Hospital Authority.

b. Review of the Practitioner's performance is conducted bi-monthly for both departments of the Medical Staff. A timetable is established within the Quality Improvement/Patient Safety Department and with other clinical departments when relevant activities need to be completed and when reporting is due to the MEC and Hospital Authority. A core value of the peer review process is the review of practice patterns on an ongoing basis, including not just individual events, but also rates, patterns, or trends over time.

3. Limited License Professionals and Allied Health Professionals

Limited License Professionals and Allied Health Professionals are included in the peer review process, and their performance data is collected, maintained, and made available for consideration by the appropriate Service Chief, Department Chairman, the Limited License Professional/Allied Health Committee, and the MEC as necessary to support their responsibilities for assessing the appropriateness of professional services.

POLICY HISTORY

Original Adoption Date: 09/00

Review/Revision History:
Reviewed: 01/01, 06/04, 07/08, 04/10, 04/24
Reviewed and reformatted: 04/17
Revised: 06/20, 10/22

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: History & Physical Required Content APPROVALS: Approved by Medical Staff: 12/24 Approved by Hospital Authority: 12/24 Effective Date: 12/18/2024	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 3

PURPOSE

The purpose of this Policy is to establish the required content of history and physical examinations ("H& Ps").

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITION

Practitioner means an individual who is licensed or otherwise authorized by the State of Georgia to provide certain health care services.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

1. In accordance with the Medical Staff Bylaws and MS.17, SR.1 of the National Integrated Accreditation for Healthcare Organizations ("NIAHO") Accreditation Requirements, an H&P for each patient shall be completed and documented in the medical record no more than thirty (30) days before an admission or registration, and no more than twenty-four (24) hours after an admission or registration.

2. Pursuant to MS.17, SR.1 and SR.3, an H&P for each patient shall also be completed and placed in the patient's medical record prior to surgery or procedures requiring anesthesia services and within twenty-four (24) hours after admission.

3. In accordance with SR.2, a Doctor of Medicine or Osteopathy or other qualified licensed Practitioner shall perform the H&P described above.

4. In accordance with MS.17, SR.1a of the NIAHO Accrediation Requirements, an H&P completed within thirty (30) days prioir to admission or registration shall include an updated entry in the medical record documenting an examination for any change in the patient's current medical condition completed by a Doctor of Medicine or Osteopathy or other qualified licensed Practitioner. Pursuant to SR.1b, any H&P update of the patient's current medical condition shall, at a minimum, document the following:

a. That the patient has been examined;
b. That the H&P has been reviewed; and
c. Any changes in the patient's condition, or if no changes, that "no change" has occurred in the patient's condition since the H&P was completed.

This examination and update of the patient's current medical condition shall be completed and placed in the medical record within twenty-four (24) hours after admission or registration, and prior to surgery or other procedure requiring anesthesia services.

5. Consistent with SR 3, the required content of H&Ps will be dependent upon an assessment of the patient's condition, any co-morbidities in relation to the reason for admission or surgery, and treatment plan. The minimum requirements for content of H&Ps is set forth in the Attachment to this Policy;

6. Pursuant to SR.4 and the Medical Staff Bylaws, the Medical Staff may elect to permit an outpatient assessment rather than an H&P for patients receiving specific outpatient surgical or procedural services. If the Medical Staff chooses to allow assessments for specific outpatient surgical or procedural services, the Medical Staff shall do so in accordance with SR.4a and SR.4b.

7. The Practitioner is responsible for authenticating and signing the H&P, changing or updating the H&P, and ensuring Progress Notes are dictated or written by the Practitioner or non-physician authorized to provide this information.

8. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Physician's office record transferred to SGMC, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

Attachment: Required Minimum Content for History and Physical Examinations.

POLICY HISTORY

Original Adoption Date: 02/05/02

Review/Revision History:

Revised: 05/02, 03/03, 7/08, 02/13, 03/16, 10/22

Reviewed and format updated: 04/17

Reviewed: 06/20, 12/24

SOUTH GEORGIA MEDICAL CENTER
REQUIRED MINIMUM CONTENT FOR HISTORY AND PHYSICAL EXAMINATIONS

Inpatient Admissions	Ambulatory Surgery & Observation	OP Chemotherapy, Transfusions of Blood/Blood Products & Radiation Therapy
Complete H&P exam should contain: a. Chief complaint b. History of present illness c. Relevant past, social & family histories appropriate to the patient's age d. Review of systems e. For children & adolescents, an evaluation of the patient's developmental age, consideration of educational needs and daily activities as appropriate, immunization status, the family's and/or guardian's expectations for involvement in the assessment, treatment and continuous care of the patient. f. Current physical and mental assessment g. Statement of the conclusions or impressions drawn from the admission H&P exam h. A statement of the course of action planned during hospitalization i. List of current medications and dosages j. Known allergies	H&P exam should contain at least the following: a. Relevant history of illness or injury b. Current physical and mental assessment c. Examination/review of systems relevant to the procedure d. List of current medications and their dosages e. Known allergies f. Impression drawn from the history, physical examination and tests	H&P exam should contain the following: a. Results of diagnostic studies appropriate to the procedure before the procedure is performed b. Interim note with diagnostic studies as appropriate

SOUTH GEORGIA MEDICAL CENTER
REQUIRED MINIMUM CONTENT FOR HISTORY AND PHYSICAL EXAMINATIONS

Endoscopic Procedures	**Invasive Procedures Performed in Emergency Department**	**1. Invasive Procedures Performed in Radiology Department** **2. Anesthesia Pain Clinic**	**IV Conscious Sedation* Additional Requirements**
The appropriate outpatient short form should be completed. H&P to include: a. Relevant history of illness or injury b. Current physical and mental assessment c. List of current medications and dosages d. Known allergies e. Impression drawn from the history, physical examination and tests f. Results of diagnostic tests appropriate to the procedure These are necessary prior to the procedure being performed.	Any invasive procedure performed in the Emergency Department or performed on a patient admitted through the Emergency Department should include: a. Indications for the procedure b. Documentation of the physical condition of the patient relative to the procedure being performed These are necessary prior to the procedure being performed.	H&P exam should include: a. Heart & lung examination b. Patient diagnosis c. Indications for the procedure d. Documentation of the physical condition of the patient relative to the procedure These are necessary prior to the procedure being performed. The staff physician ordering the procedure shall be responsible for the completion of the documentation.	H&P exam should contain the following: a. Chief Complaint/reason b. ASA Classification c. Allergies d. Review of systems specific to Cardiopulmonary Disease e. Physical assessment f. Airway assessment g. Current medications h. History of any adverse or allergic drug reactions with anesthesia and sedation This is necessary prior to the procedure being performed. On MRIs requiring conscious sedation the staff physician ordering the procedure shall be responsible for the H&P. If the ordering physician is not a member of the SGMC staff, the physician performing the procedure shall be responsible for the completion of the appropriate documentation.

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff, LLP & AHP Support	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 4
APPROVALS: **Approved by Medical Staff** 02/2023 **Approved by Hospital Authority:** 03/2023 **Effective Date:** 04/17/2002	☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa ☐ SGMC Smith Northview	

PURPOSE

The purpose of this Policy is developed and implemented by the Medical Staff Support Committee. The Medical Staff recognizes that impaired Staff Members are individuals who have dedicated their lives to helping others and are now in need of help, and recognizes that providing this help must remain a primary goal of the Medical Staff Support Policy. Therefore, this policy follows a non-punitive approach, in which the Medical Staff works as an advocate for rather than an adversary of the provider, while seeking to protect patients from harm. The Medical Staff further recognizes that when the Staff Member denies a problem, necessary action must be taken for the protection of both the Staff Member and the patient.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

"*Approved treatment program*" is a program for alcoholism or substance abuse treatment that is approved by the Georgia Professional Health Program, Inc. as further described at https://gaphp.org/.

"*Chief Executive Officer*" or CEO means the Chief Executive Officer of South Georgia Medical Center.

"*Designated Chairmen*" are the Chief of Staff or his/her designee, the Chief Medical Officer, and the chairman of the Department in which the individual has Clinical Privileges or Clinical Functions, or his/her designee.

"Impaired Staff Member" or *"Impaired Provider"* for the purpose of this Policy refers to a Physician, Dentist, Limited License Professional ("LLP"), or Allied Health Professional ("AHP"), who because of age, physical, psychiatric or other medical conditions or because of the use of alcohol, illegal drugs or prescribed or over-the-counter drugs that impair clinical judgment or ability may be unable to provide appropriate patient care or may otherwise constitute a direct and immediate threat to the health, welfare, and safety of patients, other staff members, and SGMC personnel.

"Positive result" of an alcohol or other drug test means the detection of alcohol or another drug in concentrations deemed significant by the U.S. Department of Health and Human Services on both an initial screening test and a confirmatory test of the same specimen.

"Provider" means a Physician, Dentist, LLP or AHP.

"Reasonable suspicion" is one based on documentation of specific, contemporaneous physical, behavioral, or performance indicators consistent with probable substance abuse or psychiatric or other medical conditions.

"SAMSHA" means the Substance Abuse and Mental Health Services Administration, a branch of the U.S. Department of Health and Human Services.

POLICY

1. General. In conjunction with the Medical Staff Bylaws, this Policy provides a mechanism for management of Medical Staff through corrective or rehabilitative action pursuant to MS 14, SR 1 of the National Integrated Accreditation for Healthcare Organizations ("NIAHO") Accreditation Requirements. Such action may result from behavior that is likely to be detrimental to patient safety or the delivery of quality care and/or other conduct disruptive to SGMC operations. Any officer of the Medical Staff, the CEO or the CMO may initiate this corrective or rehabilitative action.

2. Promotion. This Medical Staff Support Policy will be promoted to Medical Staff members and Hospital employees by the Medical Staff Support Committee to promote visibility and use. The promotion should emphasize the advocacy program and non-punitive nature of this Policy. In addition, confidentiality of reports should be stressed to encourage reporting of potentially impaired providers. The Medical Staff goals are to support the impaired provider to obtain rehabilitation services and to protect patient safety within the organization.

3. Education. The Medical Staff Support Committee, working in harmony with other members of the Medical Staff, Medical Staff Officers, Hospital Administration and various committees, strives to promote educational opportunities to assist individuals to be aware of efforts to maintain good health and to recognize signs of impairment of their own health as well as that of others.

3. Reports.

   a. Third Party Reports. Reports to the Medical Staff Support Committee about a Provider who may be an impaired Provider should be encouraged and accepted from nurses, colleagues,

other SGMC personnel, patients and family members. Anonymous reports will be accepted, with appropriate consideration given to the inherent benefits and detriments of such reports.

1) Immediate Reports. Immediate reports shall be made if a SGMC employee or Provider:

i. has a reasonable suspicion that a Provider is impaired and is currently providing or attempting to provide services to a patient at SGMC; or

ii. reasonably believes that a Provider's impairment has contributed to an accident or incident.

If an immediate report is required by this provision: (i) a Hospital employee shall immediately notify his or her supervisor or director, who shall immediately notify a Designated Chairman; and (ii) a Provider who suspects impairment shall report directly to the Designated Chairman. The Designated Chairman receiving the report shall notify the Chairman of the Medical Staff Support Committee.

2) Self-Reporting. Providers that are impaired or such report is substantiated shall be encouraged to voluntarily report and enroll in the Georgia PHP program. Failure of a Provider to self-report and enroll in the Georgia PHP program may result in the Medical Staff engaging in reporting to the Georgia PHP Program or to engage in mandatory reporting to the State Board, as required by state laws.

3) Notifications following Receipt of Reports. The Designated Chairman will notify the person making a report that the report has been received, The Designated Chairman will request for the Medical Staff Support Committee to provide any updates and progress reports to the Medical Executive Committee. Any compliance letters from a treating provider or the Georgia PHP shall be protected as privileged peer preview and medical review and shall only be submitted by Georgia PHP to the Chairman of the Medical Support Committee or his or her designee.

b. Self-reporting. All Providers must submit a written report to the CMO or his or her designee of any change in the Provider's psychiatric or other medical status that might possibly affect the quality of patient care rendered by the Provider within the limits of their Clinical Privileges or Clinical Functions. Such reports should be made immediately upon the Provider becoming aware of the change. If the Provider desires to continue providing patient care in SGMC, the Provider shall be referred to the Medical Support Committee Chairman for consultation. Depending upon the circumstances, the Medical Support Committee may require Provider to report to the Georgia PHP program and engage in regular follow up with the Medical Support Committee.

4. Request for Testing and Evaluation.

a. Reasonable Suspicion testing. If any Designated Chairman, based on a personal review and evaluation of the report, finds a basis for a reasonable suspicion of impairment, the

Designated Chairman may request that the individual provide specimens for the purpose of determining the alcohol or other drug content of the individual's system or submit to other appropriate psychiatric or other medical evaluation.

b. Post-incident testing. A Provider whose performance either is reasonably believed to have contributed to an accident or incident at a SGMC-owned or operated facility, or cannot be discounted as a contributing factor to an accident or incident, may be tested for the presence of alcohol or other drugs in his or her system upon request of any Designated Chairman, the Chief Executive Officer, the Chief Operating Officer or the Medical Director. Such testing shall be performed immediately upon request and as soon as possible following the accident or incident, with a goal of collecting the specimen within twenty-four hours of the accident or incident in order to obtain more accurate information regarding the Provider's status at the time of the accident or incident.

c. Procedures for Testing or Evaluation.

Substance Abuse. Specimen collected shall comply with applicable procedures from time to time established by SGMC, which shall be in accordance, to the extent reasonably possible, with guidelines published by SAMHSA. All persons involved in the collection, testing and reporting under this procedure shall respect the privacy and confidentiality of the information obtained and report information relating to the collection and testing in a manner to observe such confidentiality.

Specimens for alcohol or other drug testing may include a person's blood, urine or hair. The Designated Chairman requesting the test shall specify the type of sample to be collected for testing. The Designated Chairman requesting the test or his or her designee shall monitor the collection of the specimens and shall document in the Provider's Medical Staff file the collection procedures followed, assignment of confidentiality code, and the Provider's written acknowledgement of the specimen and assigned code. The specimen shall be labeled using the confidentiality code to avoid identification of the individual involved. The specimens will be transported to the SGMC Laboratory for confidential (coded) testing at a laboratory that is certified by and in compliance with guidelines from time to time established by SAMHSA.

A Specimen Custody and Control Form shall be completed and used to provide a chain of custody for any specimen collected. Efforts shall be made to minimize the number of persons handling specimens.

If the Provider to be tested refuses to cooperate with the collection process, such refusal shall be communicated to the Designated Chairman who requested the testing. Such refusal shall be documented in the medical staff file and may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

All specimens will be tested by a laboratory that is certified by and in compliance with guidelines from time to time established by SAMHSA. Test results shall be reported in writing to the Designated Chairman identifying all results. The method of reporting

results shall be sensitive to confidentiality and privacy. Results may not be provided orally or by telephone.

All positive test results shall be reviewed by a CMO or his or her designee who must review medical history, diet, herbal, over the counter and prescription drug use.

Any specimens for which positive results are found shall be preserved and retained for at least two (2) years, or until resolution of all legal or administrative challenges involving such specimen, whichever is longer.

Reports of positive test results shall be maintained and securely filed by Medical Staff Affairs confidential file for the Provider for a period of at least five (5) years or until all legal and administrative challenges to the test results are resolved. Reports of negative results shall be retained for at least one year or for such longer time period as may be requested by the Provider. All such records shall be treated confidentially.

Test results and related reports may be made available to the Designated Chairmen and the Chairman of the Medical Support Committee. Test results and related reports with respect to an Allied Health Professional will be made available to the sponsoring physician(s). Test results may be considered by any official Medical Staff Committee or other deliberative body with responsibility of making recommendations or decisions concerning Medical Staff membership or Clinical Privileges or Clinical Functions. Any further distribution of such information will be made on a need to know basis.

Psychiatric Disorders. Psychiatric evaluation must be performed by a psychiatrist approved by the Chief of Staff and/or CMO, who may be an independent psychiatrist unassociated with SGMC. The evaluating psychiatrist will report to the Chairman of the Medical Support Committee. The Provider's failure to cooperate with the evaluation or refusal to consent to release of reports may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

Based on the evaluation, the psychiatrist must determine the extent of the impairment and assist the Designated Chairmen in determining the appropriate level of restrictions on the Provider's Clinical Privileges or Clinical Functions, if applicable.

Physical Disorders. Evaluation of possible physical disorders must be performed by an appropriate physician or physicians approved by the Chief of Staff. The evaluating physician will report to the Chairman of the Medical Support Committee or the Chief of Staff or his designee requesting the evaluation the Provider's refusal to consent to evaluation or to release of reports. Such refusal may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

The evaluating or treating physician(s) shall assist the Designated Chairmen in determining the appropriate level of restrictions on the Provider's Clinical Privileges or Clinical Functions, if applicable.

5. Intervention.

a. Substance Abuse. Upon receipt of a positive test result, the Designated Chairman may temporarily suspend Provider's Clinical Privileges or Clinical Functions and he or she will be relieved of any SGMC responsibilities or duties while receiving assessment and treatment and the provider shall be referred to the Georgia PHP program.

b. Psychiatric Disorders. Following evaluation and diagnosis of a psychiatric disorder resulting in impairment, a psychiatrist approved by the Chairman of the Medical Support Committee shall determine the frequency and nature of psychiatric care. The approved psychiatrist shall report to the Chairman of the Medical Support Committee or his or her designee when the Provider is sufficiently stable for removal of restrictions on Clinical Privileges or Clinical Functions. Such report shall be made available to the Designated Chairmen and the Chief Executive Officer.

c. Physical Disorders. Following evaluation and diagnosis of a physical disorder resulting in impairment, a physician approved by the Chairman of the Medical Support Committee shall provide ongoing evaluation and management of the disorder. The approved physician shall report to the Designated Chairman or his designee to include the Medical Affairs Office when the Provider is sufficiently stable for removal of restrictions on Clinical Privileges or Clinical Functions. Such report shall be made available to the Designated Chairmen and the Chief Executive Officer.

6. Reinstatement.

Upon receipt of the treating physician's report and other documentation required above, the Provider's Clinical Privileges or Clinical Functions may be reinstated by the Medical Executive Committee.

Proctoring of patient care may be required following reinstatement. The Department Chairman shall initially determine the number and type of cases which must be proctored.

a. Substance abuse. Following reinstatement of Clinical Privileges or Clinical Functions, the Provider must receive follow-up assessment at an approved treatment program. Such assessment must include random monitored urine drug screens. During the treatment and monitoring, the Georgia PHP shall provide compliance reports to the Chairman of the Medical Support Committee or his or her designee. The Chief of Staff may approve in writing deviations from the above requirements. Deviation or failure to comply without such written approval shall result in automatic removal from the Medical Staff.

b. Psychiatric or other medical disorders. The treating psychiatrist or other physician shall determine the frequency of follow-up care or assessments following reinstatement of Clinical Privileges or Clinical Functions. The psychiatrist or other physician shall send a written, non-restricted report regarding the individual's status to the Chairman of the Medical Support Committee at least quarterly during the treatment and monitoring. If the

Provider's condition remains stable for two years, the report's frequency may be changed to yearly or at the discretion of the psychiatrist or other physician.

c. Relapse. Upon receipt of evidence of relapse of a substance abuse problem or recurrence of a psychiatric or other medical condition resulting in impairment, or a physician's statement of pending relapse or recurrence, the Provider must re-enter an approved treatment program or resume psychiatrist or other medical treatment. Refusal to re-enter a treatment program or to resume psychiatric or other medical treatment shall result in automatic removal from the Medical Staff and/or LLP or AHP appointment.

7. Refusal.

A Provider's refusal to cooperate with substance abuse testing or psychiatric or other medical evaluations, refusal to consent to release of non-restricted reports of treatment or follow-up, or refusal to cooperate with treatment shall constitute grounds for suspension or revocation of all or any part of the Provider's Clinical Privileges, Clinical Functions, Medical Staff membership, or LLP or AHP status.

8. Hearing rights.

Action taken with respect to a Practitioner's Medical Staff membership or Clinical Privileges or application for membership or Clinical Privileges as a result of refusal to cooperate with testing, treatment or follow-up shall give the affected Practitioner the right to a hearing and appellate review as provided in Article XII of the SGMC Medical Staff Bylaws. LLPs who do not maintain Clinical Privileges and AHPs shall be entitled to the hearing rights, if any, provided by the LLP/AHP Manual then in effect.

9. Medical Review.

The Medical Executive Committee, each Medical Staff Department, the Professional Qualifications Committee, the Quality Management Committee and the Medical Staff Support Committee are each responsible in part for evaluating and improving the quality of care rendered at the Hospital and for determining that health services rendered were performed in compliance with applicable standards of care. All actions, reports and proceedings of such committees in connection with this procedure shall be made and conducted in furtherance of those responsibilities. All information furnished to any of these committees, their chairmen or other representatives are given in that context and shall be entitled to the maximum confidentiality and protection afforded by law.

POLICY HISTORY

Original Adoption Date: 04/17/02

Review/Revise History:

Reviewed: 10/08
Reviewed and format updated: 04/17
Revised: 06/20, 03/23

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Emergency Medical Treatment and Active Labor Act (EMTALA)	**FACILITIES:**	**MEDICAL STAFF POLICY NUMBER:** 5
APPROVALS: **Approved by the Medical Staff:** 12/24 **Approved by Hospital Authority:** 12/24 **Effective Date:** 12/18/2024	☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to establish the obligations of physicians who provide on-call coverage to the South Georgia Medical Center ("SGMC") Emergency Department, to comply with the requirements of the Emergency Medical Treatment and Labor Act ("EMTALA"), and to ensure that SGMC meets the emergency needs of its patients in accordance with acceptable standards of practice.

APPLICATION

This Policy is applicable to SGMC.

DEFINITIONS

Capabilities means physical space, equipment, supplies and services (including ancillary services) that are available. The capabilities of staff mean the level of care that personnel can provide within the training and scope of their professional licenses.

Capacity means the ability to accommodate the individual requesting a medical screening examination or to provide necessary stabilizing treatment of an individual who is diagnosed with an emergency medical condition (including transferred individuals). Capacity encompasses such things as numbers and availability of qualified staff, beds and equipmen,t and past practices of accommodating additional patients in excess of SGMC's occupancy limits.

E*mergency Medical Condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part; or

4. With respect to a woman who is having contractions:

   a. That there is inadequate time to effect a safe Transfer to another hospital before delivery; or

   b. That the Transfer may pose a threat to the health or safety of the woman or the unborn child.

A woman who is having contractions but has been determined to be in false labor pursuant to SGMC policy, *Emergency Medical Treatment and Patient Transfer*, is not in an Emergency Medical Condition.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless the woman is determined to be in false labor pursuant to SGMC policy, *Emergency Medical Treatment and Patient Transfer.*

Patient means (1) an individual who has begun to receive outpatient services resulting from direct personal contact between the individual and physician or other authorized person in order to furnish hospital services for diagnosis and treatment (other than treatment required under this Policy); and (2) an individual who has been admitted as an inpatient.

Stabilize means to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur during the Transfer of the individual from the Hospital, or, with respect to a pregnant woman who is having contractions, that she has delivered a child (including the placenta).

Transfer means the movement, including discharge, of an individual outside SGMC at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) SGMC, but does not include such movement of an individual who has been declared dead or leaves the facility without the permission of said person.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

Emergency Department:

1. Pursuant to SGMC *Emergency Medical Treatment and Patient Transfer Policy* ("SGMC Policy") and in n furtherance of SGMC's efforts to comply with EMTALA and ED.1 of the National Integrated Accreditation of Healthcare Organizations ("NIAHO") Accreditation Requirements, it is the policy of SGMC to provide an appropriate Medical Screening Examination of any individual who comes to the Emergency Department and requests examination and treatment for a medical condition, or what may be an Emergency Medical Condition.

2. Upon presentation to the Emergency Department, a qualified registered nurse shall perform patient triage pursuant to NIAHO Accreditation Requirement ED.2, SR.2.

3. If necessary, SGMC will provide, within its capabilities, such further examination and treatment as may be required to Stabilize the individual's condition or to provide, in accordance with the procedures set forth in such SGMC Policy, an appropriate Transfer of the individual to another medical facility.

4. In accordance with ED.2 of the NIAHO Accreditation Requirements SGMC maintains an on-call list of physicians on the SGMC shall have adequate medical and nursing staff qualified in emergency care. To ensure adequate staffing, SGMC maintains an on-call list of physicians on the SGMC Active Medical Staff in a manner that best meets the needs of those receiving the medical services required under the SGMC Policy, in accordance with the resources available to SGMC, including the availability of the on-call physicians.

Members of the Active Medical Staff are required to take Emergency Department call, as determined by the individual Medical Staff clinical departments taking into account the needs of the community and the number of Active Staff Members available in that specialty, with an annual review of the minimum requirements to reflect any changes in the needs of the community and/or number of providers. All call requirements determined by the individual departments must be approved by the Medical Executive Committee and the Hospital Authority if the call schedule does not provide for Emergency Department coverage in a particular specialty twenty-four (24) hours per day seven (7) days per week.

5. The Emergency Department physician is responsible for determining whether the on-call physician must physically assess a patient in the Emergency Department.

If the Emergency Department physician determines that the on-call physician is needed in the Emergency Department to provide a Medical Screening Examination or treatment, the on-call physician is required to appropriately respond to the Emergency Department within thirty (30) minutes of being called by the Emergency Department.

If the Emergency Department physician determines that the patient is not in an Emergency Medical Condition:

a. The on-call physician is required to appropriately respond by coming to the Emergency Department within the time frame stated by the Emergency Department physician; or

b. If the Emergency Department physician concludes that the patient could safely be admitted without the on-call physician's physical assessment of the patient, the on-call physician is required to appropriately complete the admission and assume care and treatment of the patient.

The Emergency Department physician is required to document the above determinations in the patient'smedical record.

6. In the event a physician with a particular specialty is needed, but is either not on-call at the time or is on-call but cannot respond because of circumstances beyond their control, the Emergency Department physician will:

a. Contact the group with which the unavailable, on-call physician is associated and request another physician in that group with the same specialty to appropriately respond; and

b. If the group has no other physician with the same specialty available, the Emergency Department physician will attempt to locate another physician with the same or different specialty, with capability and appropriate Clinical Privileges at SGMC, sufficient to stabilize and/or manage the patient's medical needs.

If both of these efforts are unsuccessful, SGMC will screen, stabilize, and provide for an appropriate transfer of the individual to another facility with adequate space and capability of providing the necessary specialty and care in accordance with ED.3, SR.1.

7. When a physician has agreed to be on-call at a particular hospital during a particular period of time but also has scheduled elective surgery or an elective diagnostic or therapeutic procedure during that time as permitted by SGMC policy, that physician must have arranged back-up call in the event the physician is called while performing elective surgery and is unable to respond to an on-call request in a reasonable time.

Receiving Facility Responsibilities:

1. SGMC is required to accept appropriate transfers of individuals with Emergency Medical Conditions if SGMC has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals.
2. SGMC's Transfer Center should coordinate all calls from outlying facilities requesting hospital to hospital transfers.
3. The on-call specialty provider will accept the transfer from another facility, anywhere in the United States, if SGMC has the capacity and capabilities.
4. The obligations of the Receiving Facility do not apply to inpatients.

POLICY HISTORY

Original Adoption Date: 09/17/08

Review/Revision History:
Reviewed: 02/09, 12/24
Reviewed and format updated: 04/17, 10/22
Revised: 06/20, 10/22

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Official Order of Call APPROVALS: Approved by Medical Staff: 12/24 Approved by Hospital Authority: 12/24 Effective Date: 12/18/2024	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 6

PURPOSE

The purpose of this Policy is to establish the official order of call for the South Georgia Medical Center ("SGMC") Medical Staff.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITION

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

Officers of the SGMC Medical Staff provide coverage for official duties at all times. This will include days, nights and weekends. It is recognized that individuals are not expected to be available all the time. However, in the event that a Medical Staff Officer is needed for official duty when unavailable, another Officer will be available.

PROCEDURE

A. Officers have the option of designating an alternate to cover during absence. However, certain Officers may on occasion, be needed at unexpected times when an alternate is not available. For this reason, lists are maintained designating other Officers who may be contacted to act in place of certain key Officials. These lists will be revised annually or more frequently as needed, published and made available in locations where needed. These will

include the Emergency Department, Nursing Units, Operating Room, and Administrative Offices.

B. A list (Pecking Order) will be published for each of the following:
1. Chief of Staff
2. Chairman, Department of Medicine
3. Chairman, Department of Surgery
4. Chief, Emergency Medicine Service

C. In the event the need to contact one of these Officers arises during his/her absence and an alternate is not available, the list will be followed in order until the first available Officer is reached. This individual is authorized to act in the absence of the Officer needed until that Officer returns to duty.

POLICY HISTORY

Original Adoption Date: 04/17/02

Review/Revision History:
Reviewed: 01/03, 01/04, 01/05, 01/07, 01/08, 10/08, 01/09, 01/10, 07/10, 03/16
Reviewed and format updated: 04/17
Reviewed: 06/20, 10/22, 12/24

PROFESSIONAL SERVICES AGREEMENT
(SGMC Berrien – Vice Chief of Staff)

THIS PROFESSIONAL SERVICES AGREEMENT ("Agreement") is made and entered into by and between DHAVAL PATEL, D.O. ("Physician") and SOUTH GEORGIA MEDICAL CENTER, INC. d/b/a SGMC HEALTH ("SGMC").

1. BACKGROUND.

1.1. SGMC owns and operates SGMC Health Berrien ("SGMC Berrien").

1.2. Physician is a member of the Medical Executive Committee of the Medical Staff of SGMC Berrien (the "MEC") and Vice Chief of Staff of SGMC Berrien's Medical Staff.

1.3. SGMC and Physician desire Physician to provide professional and administrative services pursuant to the terms of this Agreement.

1.4. In consideration of the premises and the promises and covenants contained in this Agreement, the parties agree to the following terms and conditions.

2. PHYSICIAN'S OBLIGATIONS.

2.1. Services. Physician will perform the duties as a member of the MEC and the Vice Chief of Staff the SGMC Berrien Medical Staff, as such duties are defined in the SGMC Berrien Medical Staff Bylaws.

2.2. Documentation of Services. Physician will keep an accurate and complete record of all time spent performing services under this Agreement and provide the SGMC Chief Executive Officer ("CEO") or his designee with a copy of the same on a monthly basis in the form of Exhibit A attached hereto and incorporated herein by reference, or other form acceptable to SGMC, as a condition of receiving payment for services hereunder.

2.3. Conflict of Interest. Physician shall comply with the then-current SGMC Policy and Procedure entitled *Conflict of Interest,* as required for Medical Executive Committee members. Physician acknowledges receipt of a copy of such Policy.

3. SGMC'S OBLIGATIONS.

3.1. Compensation. Compensation for the services provided pursuant to this Agreement must at all times be consistent with the principles under which SGMC must conduct its operations, including, among others, the applicable Federal and State laws and regulations that regulate or limit referral and payment for healthcare and related services. The level of compensation must, therefore, be established at a level that is reasonable for the services that Physician renders to SGMC. SGMC therefore agrees to pay Physician Two Hundred Dollars ($200.00) per hour, payable upon presentation of documentation of the services provided pursuant to this Agreement acceptable to the CEO of SGMC, provided, however, SGMC shall not be obligated to pay

Physician more than Five Hundred Dollars ($500.00) per month hereunder. SGMC will not withhold or deduct any taxes or other amounts in connection with payments to Physician pursuant to this Agreement, and Physician will be responsible for paying the same. The parties acknowledge and agree that the compensation paid hereunder is intended to reflect fair market value for the services rendered by Physician under this Agreement, is negotiated at arms-length, is reasonable and necessary for the legitimate business purpose of the Agreement and is given in return only for the services provided by Physician hereunder. No compensation contemplated herein or paid hereunder is tied to referrals or any other business generated between the parties.

3.2. Reimbursement. SGMC will reimburse Physician for reasonable pre-approved out-of-pocket expenses incurred by Physician when performing his/her duties under this Agreement, and will also pay for training and education related to the performance of his/her duties, as approved by the CEO or his designee. Payment of expenses for attending SGMC training and educational events may also be paid directly by SGMC to the applicable vendor to the extent such training and educational session is related to training Physician to perform the professional and administrative services required herein. Any consideration or payment of expenses shall be tracked and documented to ensure the consideration is consistent with the obligations of this Agreement. As a condition precedent to SGMC's obligation to reimburse Physician pursuant to this Agreement, Physician shall fully comply with all policies and procedures of SGMC relating to the reimbursement of expenses.

3.3. Insurance and Indemnity. With regard to services provided pursuant to this Agreement, SGMC will indemnify Physician or provide insurance coverage on Physician's behalf in accordance with the Medical Staff Bylaws.

4. PHYSICIAN WARRANTIES AND COVENANTS.

4.1. Perform Duties in Good Faith. Physician hereby represents, warrants and covenants that he/she will perform his/her duties in good faith and with due care, in a manner that is in the best interest of SGMC.

4.2. Non-Exclusion. Physician hereby represents, warrants and covenants that he/she is not and has never been excluded, debarred, restricted or suspended from participation in any federal or state healthcare payor program, including Medicare and Medicaid.

4.3. Compliance with Bylaws, Policies and Procedures. Physician shall at all times perform hereunder in compliance the bylaws, policies and procedures of SGMC and the SGMC Berrien Medical Staff.

4.4. Regulatory Restrictions. The services contemplated under the provisions of this Agreement shall at all times be rendered by Physician in compliance with the applicable statutes, regulations, rules and directives of Federal, State and other governmental and regulatory bodies having jurisdiction over SGMC and the applicable standards of The Joint Commission.

4.5. Electronic Medical Records System.

4.5.1. Physician shall complete education and training regarding utilization of SGMC's electronic medical records system as required by SGMC, including achieving the proficiency and competency in utilization of such electronic medical records system as required by SGMC.

4.5.2. Physician will utilize SGMC's electronic medical records systems, including Computerized Physician Order Entry ("CPOE").

5. TERM AND TERMINATION.

5.1. Term. The term of this Agreement commences on January 1, 2026 and shall continue until such time that Physician is no longer a member of the Medical Executive Committee.

5.2. Immediate Termination. SGMC may terminate this Agreement immediately upon the occurrence of any of the following:

5.2.1. Termination, suspension, or non-renewal of Physician's SGMC Berrien Active Medical Staff Membership or involuntary termination or suspension of any Clinical Privileges held by Physician at SGMC Berrien;

5.2.2. Termination, expiration or suspension of Physician's status as a member of the MEC and Vice Chief of Staff;

5.2.3. Exclusion, debarment, restriction or suspension of Physician from participation in any federal or state healthcare payor program, including, without limitation, Medicare and Medicaid; or

5.2.4. Physician's failure, on a recurring basis, to faithfully or diligently perform his/her obligations hereunder.

5.3. Termination With Notice. This Agreement may be terminated by either party upon thirty (30) days' prior written notice to the other party.

5.4. Similar Agreement. If this Agreement is terminated prior to the expiration of the initial twelve (12) months of the Term, the parties may not enter into another agreement for the subject matter hereof prior to January 1, 2026.

5.5. Bylaws And Handbook Procedures Not Applicable To Termination. The parties expressly agree that neither the SGMC Berrien Medical Staff Bylaws nor any Bylaws, rules, regulations, or employee handbook issued by SGMC Berrien shall create an employment relationship or create any rights in favor of Physician not created pursuant to this Agreement. Physician agrees and understands that the termination of this Agreement does not entitle him/her to any procedural rights or remedies provided for in the SGMC Berrien Medical Staff Bylaws or SGMC Bylaws.

6. GENERAL PROVISIONS.

6.1. Assignment. Physician shall not assign or transfer his rights or obligations under this Agreement. SGMC may assign this agreement to any affiliate or related entity without the prior consent of the Physician.

6.2. Entire Agreement; Amendment. This Agreement constitutes the entire agreement between SGMC and Physician with respect to the subject matter hereof. This Agreement shall not be amended or modified except by a subsequent written agreement between Physician and duly authorized representatives of SGMC.

6.3. Compliance With Laws. The parties hereto shall comply with all applicable federal, state, and local laws, regulations and restrictions in the conduct of their obligations under this Agreement. This arrangement for the provision of personal services is intended by the parties to comply fully with the exception under the illegal remuneration provision, relating to compensation payable to independent contractors for such services, as set forth in 42 U.S.C. § 1320a-7b and as set forth in the "Safe Harbor" regulations promulgated thereto, and the relevant provisions and exception for personal services as set forth in the Omnibus Budget Reconciliation Act of 1993, 42 U.S.C. §1395nn, and the related regulations. Notwithstanding any unanticipated effect of any of the provisions herein, neither party will intentionally conduct itself/himself/herself under the terms of this Agreement in a manner that constitutes a violation of the Medicare and Medicaid fraud and abuse provisions.

6.4. Agreement Controls. In the event of a conflict between the provisions of this Agreement and the Bylaws, policies or rules and regulations of the SGMC Berrien Medical Staff, the provisions of this Agreement shall control.

6.5. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be governed by, and construed and interpreted in accordance with, the laws of the State of Georgia.

6.6. Physician Records. Until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, Physician shall make available, upon written request, to the Secretary of the Center of Health and Human Services, or upon request, to the Comptroller General, or any of their duly authorized representatives, this Agreement and all books, documents and records of Physician that are necessary to certify the nature and extent of costs incurred with respect to any services furnished for which payments may be made under the Medicare or Medicaid programs. This Section 6.6 shall survive expiration or termination of this Agreement.

6.7. Other Agreements With SGMC. SGMC maintains a master list(s) of physician contracts that is/are maintained and updated centrally, which include(s) this Agreement and any other agreement(s) entered into by and between Physician and SGMC. Such list(s) are subject to review by the Secretary of Health and Human Services upon request.

6.8. Notices. All notices related to this Agreement will be in writing and will be deemed to have been given when delivered personally or at the time sent, if sent by registered or certified United States mail, return receipt requested, postage prepaid, or by FedEx or similar delivery service for overnight delivery, and addressed to the other party as follows or at such address as such party from time to time may indicate by written notice to the other party:

If to Physician:
Address reflected in Physician's then-current Medical Staff file.

If to SGMC Berrien:
South Georgia Medical Center, Inc. d/b/a SGMC Health
2501 North Patterson Street
Valdosta, GA 31602-1785
Attention: Chief Executive Officer

6.9. Education About False Claims Recovery. Physician acknowledges that SGMC has adopted policies and procedures concerning Education About False Claims Recovery and that access to these policies and procedures is available through the SGMC website, www.sgmc.org, by selecting "Education About False Claims Recovery" under the Vendor option.

IN WITNESS WHEREOF, this Agreement has been executed by the Physician and on behalf of SGMC.

_____ _____*(LS)*
Date Dhaval Patel, D.O.

"Physician"

South Georgia Medical Center, Inc.
d/b/a SGMC Health

_____ By: _____
Date Ronald E. Dean
President and Chief Executive Officer

"SGMC"

EXHIBIT A

Time Log

[Form Attached]

Time Log

SOUTH GEORGIA MEDICAL CENTER, INC.

Medical Executive Committee - SGMC Berrien
For the Month Ending _____

Dhaval Patel, D.O. (Vice Chief of Staff)

For a complete listing of duties please reference the Professional Services Agreement
Please indicate time in half hour increments.

DUTIES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
a. Meeting with CEO or SGMC staff																															
b. MEC meeting Preparation/Attendance/Minutes -Preparation and Review																															
c. Other Medical Staff meeting attendance and/or preparation including meetings with other leaders (circle) Quality Management, Professional Qualifications, Bylaws, Dept/Service, Other (specify)																															
d. Board Meeting Preparation / Attendance																															
e. Collegial intervention/Peer Review/Counseling. Preparation and Participation.																															
f. Education (e.g. seminars)																															
g. Bylaws, Rules & Regulations, Policies - Review, Preparation																															
h. Miscellaneous Activities (specify)																															
TOTAL HOURS																															

I certify that the above information is true and complete.

_____ _____
Dhaval Patel, D.O. *Date*

Approved by:

_____ _____
Date

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Locum Tenens	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 7
APPROVALS: **Approved by Medical Staff:** 8/2025 **Approved by Hospital Authority:** 8/2025 **Effective Date:** 8/20/2025	☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to define the procedures for Physicians to apply for Temporary Clinical Privileges pursuant to Article V of the Medical Staff Bylaws as a *locum tenens* for a member of the South Georgia Medical Staff ("SGMC") Medical Staff ("Staff Member") or a Practitioner with Clinical Privileges at SGMC and to define the responsibilities of Staff Members or Practitioners who have *locum tenens* coverage.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

LLP means a Limited Licensed Professional.

Locum Tenens means a Practitioner who temporarily works in the place of a Staff Member or LLP with Clinical Privileges when the Staff Member or LLP is absent.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

Locum Tenens Practitioners may apply for Temporary Clinical Privileges by following the procedures below.

PROCEDURE

1. Request by a Staff Member or LLP for *Locum Tenens* Coverage

A Staff Member or LLP who seeks to have a *locum tenens* exercise Temporary Clinical Privileges at SGMC in his/her absence must submit a written request for *locum tenens* coverage to the Office of Medical Affairs, utilizing the form provided by the Office of Medical Affairs from time to time.

The Staff Member or LLP for whom the *locum tenens* is covering is responsible for assuring the Medical Staff that the *locum tenens* is qualified to exercise the Clinical Privileges for which the application is made.

The Staff Member or LLP is responsible for determining whether his/her professional liability insurance covers the *locum tenens* during his/her absence or whether a separate policy is required for coverage if both he/she and the *locum tenens* are actively engaged in practice. Primary source verification of insurance is required.

2. Timely Application for Temporary *Locum Tenens* Clinical Privileges

Practitioners seeking Temporary Clinical Privileges as a *locum tenens* must submit a completed Georgia Uniform Healthcare Practitioner Credentialing Application Form with required supporting documentation to the Office of Medical Affairs at least thirty (30) days prior to the requested coverage dates for initial *locum tenens* applicants and at least fifteen (15) days prior to the requested coverage dates for returning applicants. References submitted should reflect recent activity over five (5) years. With the approval of two (2) of the following, the time frame for submitting an application for Temporary Clinical Privileges as a *locum tenens* may be waived: Chief Medical Officer, Chief of Staff, Chief Elect, Chief of Staff or Chief Executive Officer.

3. Criteria for Granting Temporary Privileges

When dictated by urgent patient care need or when an application is complete without any negative or adverse information before action by the medical staff or governing body, the chief executive officer, or designee, may grant temporary clinical privileges: (1) On the recommendation of a member of the medical executive committee, president of the medical staff, or medical director and (2) for a period of time note to exceed 120 days. See DNV NIAHO Accreditation Requirements (Rev, 20-1) at MS.13, SR.1 & SR.2)

Additional criteria for granting temporary privileges include: (1) Primary verification of education (AMA/AOA Profile is acceptable); (2) Demonstration of current competence; (3) Primary verification of state professional licenses; (4) Receipt of professional references (including current competence); and (5) Receipt of database profiles from AMA, AOA, NPDB, and OIG Medicare/Medicaid Exclusions. See DNV NIAHO Accreditation Requirements (Rev, 20-1) at MS.13, SR.3.

SGMC Medical Staff Bylaws include a process for approving practitioners for care of patients in the event of an emergency or disaster. *See* DNV NIAHO Accreditation Requirements (Rev, 20-1) at MS.13, SR 4.

4. Additional Temporary *Locum Tenens* Clinical Privileges Within Twelve (12) Months

Subject to the restrictions of Section 4 below, within twelve (12) months from the beginning date of a Practitioner's Temporary Clinical Privileges as a *locum tenens*, a Practitioner may request Temporary Clinical Privileges for additional periods of time up to sixty (60) days by submitting a signed attestation

statement that the information submitted in his/her initial application remains accurate and complete and a current CV including recent *locum tenens* assignments.

4. Ineligibility for Recurring Appointments

If a Physician holds Temporary *Locum Tenens* Clinical Privileges more than seventy-five (75) days during any one (1) calendar year or if the Practitioner has been granted Temporary *Locum Tenens* Clinical Privileges two (2) times during any one (1) calendar year, the Practitioner is not eligible to apply for additional Temporary *Locum Tenens* Clinical Privileges until the expiration of two (2) years from Practitioner's first Temporary *Locum Tenens* Clinical Privileges appointment within such calendar year. The Physician may be eligible to apply for membership and Clinical Privileges as a member of the Coverage Staff.

POLICY HISTORY

Original Adoption Date: 5/15/02

Review/Revision History:
Revised: 07/11
Reviewed and format updated: 04/17
Reviewed: 06/20, 8/25
Revised: 10/22

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff, LLP and AHP Complaint Management and Physician/Provider Behavior APPROVALS: Approved by Medical Staff: 12/2025 Approved by Hospital Authority: 12/25 Effective Date: 12/17/2025	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 8

PURPOSE

The purpose of this Policy is to provide a consistent process for receiving and evaluating complaints regarding Medical Staff Members, Limited License Professionals and Allied Health Professionals and to promote a safe, cooperative and professional healthcare environment by setting forth the institution's expectations for positive interaction between physicians, other providers and the public that South Georgia Medical Center ("SGMC") serves. This Policy outlines a mechanism to recognize, address and correct behavior that fails to meet those objectives or that disrupts the operation of SGMC affects the ability of others to do their jobs to practice competently, or creates a hostile work environment for SGMC employees, patients, or other individuals.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITION

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the Medical Staff Bylaws.

Chief Executive Officer or CEO means the Chief Executive Officer of South Georgia Medical Center.

Practitioner means an individual who is licensed or otherwise authorized by the State of Georgia to provide certain health care services.

POLICY

1. In conjunction with the Medical Staff Bylaws, this Policy provides a mechanism for management of Medical Staff through corrective or rehabilitative action pursuant to MS 14, SR 1 of the National Integrated Accreditation for Healthcare Organizations ("NIAHO") Accreditation Requirements. Such action may result from unprofessional demeanor and conduct, behavior that is likely to be

detrimental to patient safety or the delivery of quality care, and/or other conduct disruptive to SGMC operations. Any officer of the Medical Staff, the CEO, or any officer of the board may initiate this corrective or rehabilitative action.

2. All Practitioners, Limited Licensed Practitioners ("LLPs") and Allied Health Professionals ("AHPs") practicing at SGMC must conduct themselves in a professional and cooperative manner and must treat others with respect, courtesy, and dignity. As defined in this Policy, disruptive conduct toward or in the presence of employees, patients, other members of the Medical Staff, will not be tolerated.

3. Each Practitioner, upon submission of an application for appointment or reappointment for Medical Staff Membership and/or Clinical Privileges or Clinical Functions, shall acknowledge their understanding of an agreement to abide by this Policy.

4. Application and enforcement of this Policy shall be conducted as part of SGMC's medical review and professional and peer review activities.

5. Generally, to the extent that corrective action is required regarding this Policy, such action shall be taken in progressive steps, including, but not limited to counseling, warnings, and meetings with a Practitioner, that can be taken to address complaints about behavior which fails to meet the requirements of this Policy by Practitioners and AHPs. However, a single incident of disruptive conduct or a pattern of disruptive conduct may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee, the elimination of any particular step in the Policy, or a request for initiation of investigation for corrective action.

PHYSICIAN CONDUCT POLICY

The practice of medicine is deemed to be a profession and individuals providing care to patients are expected to behave professionally, as well as clinically proficiently. The aspirational goal of professional conduct is as simple as the Golden Rule: treat each individual, whether colleague, support staff or patients, as you would want to be treated.

Georgia law does not specifically define professional conduct, but does specify in its regulations (the relevant portion of which is attached hereto as "Attachment A" and incorporated herein as it may be amended from time to time), a definition of unprofessional conduct, along with various examples of unprofessional conduct, in the following generalized areas:

1. Prohibited conduct regarding the prescribing of medication;
2. Prohibiting treatment without appropriate documentation;
3. Failing to obtain proper consents;
4. Committing acts of sexual intimacy or abuse related to the practice;
5. Conducting a physical exam of the breast or genitalia of the opposite sex without a chaperone;
6. Practicing medicine when impaired; and/or

7. Failing to use diagnostic routines, tests, and modalities to diagnose, treat and record the care provided.

DISRUPTIVE CONDUCT

Examples of "disruptive conduct" include, but are not limited to:

1. Rude, vulgar, or abusive conduct toward, or in the presence of, patients, nurses, hospital employees, AHPs, Practitioners or visitors;

2. Nonfactual comments spoken, or written, in patient records or other official documents; attacking or impugning the quality of care in the hospital, other Practitioners, SGMC personnel, or hospital policy (other than as part of the confidential peer review or quality improvement process);

3. Breach of confidentiality, such as unauthorized disclosure of committee proceedings, medical records, and privacy of patients;

4. Deliberate destruction or stealing of hospital property, including medical records;

5. Disrupting hospital case management, committee, or peer review functions, as opposed to thoughtful and/or meaningful concerns which are raised in an appropriate professional way;

6. Disrupting hospital personnel's ability to perform their assigned functions;

7. Engaging in discrimination or unwelcome harassment of any SGMC employee, patient, Practitioner, AHP, or visitor at SGMC on the basis of the individual's race, color, national origin, sex, age, religion, disability, sexual orientation, or any other status protected by law. Unwelcome harassment is defined as verbal or physical contact by any individual that denigrates or shows hostility or aversion toward the other. As part of this prohibition of harassment, no Practitioner or AHP may sexually harass any SGMC employee, patient, visitor, resident physician, Practitioner, or other individual performing services at or for SGMC. SGMC's Personnel Policy on sexual harassment includes, but is not limited to unwelcome sexual advances, sexual jokes or comments, requests for sexual favors, or other unwelcome verbal or physical conduct of a sexual nature when:

    a. Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment or professional advancement;
    b. Submission to or rejection of such conduct by an individual is used as a basis for employment decisions or professional advancement decisions affecting that individual; or
    c. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, demeaning or offensive environment.

8. Degrading or demeaning comments in public regarding the following individuals or directly to the following individuals: patients, families, nurses, physicians, hospital personnel, or SGMC; and

9. Derogatory comments about the quality of care being provided by SGMC, another Practitioner, or any other individual outside of appropriate Medical Staff and/or administrative channels.

10. Conduct that causes an arrest or indictment against the Practitioner.

REPORTING COMPLAINTS, QUALITY CONCERNS AND DISRUPTIVE CONDUCT

1. Legitimate complaints, quality concerns and legitimate concerns should be reported immediately, using appropriate hospital reporting mechanisms.

2. Any person may provide information or submit a complaint to the Chief of Staff, the Chief-Elect of the Medical Staff, the Chief Medical Officer, and/or through the hospital confidential compliance reporting mechanism (RL Solutions) about a Practitioner who, based on the reasonable belief of the reporting individual, who:

    a. Fails to comply with the ethics of the profession, the Medical Staff Bylaws, SGMC Policies, the Medical Staff, or the LLP/AHP Manual;
    b. Exhibits personal or professional behavior or conduct which appears to be lower than the standards of the hospital, Medical Staff, and/or generally accepted Standard of Care; or
    c. Is unable to work harmoniously with others to the extent that it affects the orderly operation of SGMC or Medical Staff organization.

3. Written or verbal complaints, quality concerns, and reports of disruptive behavior are forwarded to the Hospital Quality Improvement/Patient Safety Department. Complaints received by the Quality Improvement/Patient Safety Department regarding Medical Staff Members, LLPs or AHPs are forwarded to the Office of Medical Affairs (to the attention of the Chief of Staff). To the extent that such complaint describes behavior that fails to comply with the Policy and/or disruptive conduct, the complaint is considered pursuant to this Policy. To the extent the complaint contains quality concerns, such complaint may also be referred to the applicable Section Chief, Department Chair, the Quality Assurance Committee, and/or the MEC.

4. The implicated individual will be notified immediately of any complaint in writing. However, depending upon a specific request from the complainant, the complaint committee may elect to protect the identity of the complainant.

5. Documentation of disruptive conduct shall include:
    a. Names of all parties involved;
    b. Date, time, and circumstances surrounding the situation;
    c. A description of the conduct limited to factual, objective language;
    d. Any known consequences of the conduct; and
    e. Any witnesses to the event

6. Practitioners shall self-report to the Chief of Staff or Chief Medical Officer conduct that causes an arrest, or indictment against the Practitioner within three (3) days of knowledge of such arrest or indictment. To the extent the conduct occurs on the Hospital campus or poses a risk to the safety of the Hospital for the patients, staff or other practitioners or adversely impacts the Practitioners ability to safely exercise his or her privileges, the self-report shall be submitted to the complaint committee for review.

PROCEDURE

1. Pursuant to SGMC policies and procedures, written or verbal complaints received by or submitted to SGMC employees are forwarded to the SGMC Office of Quality Improvement/Patient Safety. Complaints received by the Office of Quality Improvement/Patient Safety regarding Practitioners, Limited License Professionals or Allied Health Professionals are forwarded to the Office of Medical Staff Services, to the attention of the Chief of Staff.

2. Acting at the express direction of the Medical Executive Committee, the Chief Medical Officer, Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, Department of Surgery chairman, and Department of Medicine chairman shall serve as a committee (the "Complaint Committee") formed for the purpose of performing peer review and medical review functions and subject to the confidentiality protections and privileges and the discovery prohibitions of the Georgia Medical Review and Peer Review Statutes, O.C.G.A. §§ 31-7-130, et seq., and 31-7-140 et seq.

3. The Complaint Committee will review the complaint and may determine after initial review and investigation that the complaint cannot be substantiated or lacks merit, in which case, further investigation is not warranted. After such determination, no further action with regard to the complaint will be taken, other than if required by a Hospital medical review or patient grievance process, the Chief of Staff will report such determination back to the appropriate Hospital medical review or peer review committee.

4. The Complaint Committee may request the subject physician/provider come and discuss the matter collegially with the Complaint Committee, solicit statements, and/or conduct a witness interview.

5. After such initial review and investigation, the Complaint Committee may also determine that the complaint should be referred for review under the procedures of MS 1 (Medical Staff Review of Practitioner Performance), MS 8 (Complaint Management & Disruptive Behavior Policy), MS 4 (Medical Staff, LLP and AHP Support Policy) or the Medical Staff Bylaws (Article XI, Corrective Action). After such referral of the complaint, the processes and procedures of the applicable policy or Bylaws provisions will apply to the evaluation and review of the complaint.

6. Notice of a substantiated complaint with a summary of the nature of the complaint regarding a Practitioner, Limited License Professional or Allied Health Professional will be forwarded promptly to the affected person.

7. An individual who files repeated complaints against a Practitioner, LLP, or AHP that are found to be without merit may be subject to disciplinary or corrective action.

8. After reviewing the complaint and the clinical information, if any, relevant to the complaint, the Complaint Committee will recommend the appropriate disposition of the complaint as soon as practical. This review may include, but is not required to include, discussion with the individual Practitioner, LLP or

AHP, discussion with the appropriate Department Chairman, or Service Chief and/or review by the Quality Management Committee. A report found to be credible or of merit will warrant a discussion with the individual and, in the case of an AHP, the Sponsoring Medical Staff member, and may include discussion with the appropriate Department Chairman, or Service Chief, and/or review by the Quality Management Committee.

9. The Complaint Committee, after consideration of clinical information and any further information provided by the affected Practitioner, LLP or AHP will prepare a summary of its assessment and recommendations. A copy will be forwarded, if appropriate, to the affected Practitioner, LLP or AHP the Medical Executive Committee, Chief of Staff, and Department Chairman. The notification to the Medical Executive Committee referred to above may constitute a request for corrective action under the appropriate section of the Medical Staff Bylaws or LLP/AHP Manual.

10. Precautionary suspension, as outlined in the Medical Staff Bylaws or LLP/AHP Manual, may be appropriate during the investigation, subject to the due process provisions contained therein.

11. At any time, the matter may be referred to the Medical Staff Support Committee for review, as provided in the Medical Staff Bylaws.

12. All meetings with the Practitioner, LLP or AHP shall be documented, including any rebuttal. The Office of Medical Staff Services will maintain a complaints file for such records, together with the assessment of the Complaint Committee, to be available for review by the Chairmen of the Departments of Medicine and Surgery in furtherance of their duties and responsibilities as Chairmen.

13. Complaints and outcomes will be maintained as CONFIDENTIAL and privileged Medical Review and Peer Review documents.

14. A summary report of complaints, without specific physician identifiers, will be forwarded to the Medical Executive Committee quarterly.

POLICY HISTORY

Original Adoption Date: 03/19/03

Review/Revision History:

Reviewed: 10/08,
Revised: 04/10, 06/17, 02/19, 04/21, 10/23, 04/25,12/25

Consolidated with MS2 (Physician/Provider Disruptive Behavior): 10/23

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Staff Member, LLP & AHP Orientation APPROVALS: Approved by Medical Staff: 4/2024 Approved by Hospital Authority: 4/2024 Effective Date: 4/17/2024	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 9

PURPOSE

The purpose of this Policy is to ensure that all new Medical Staff Members, Limited License Professionals ("LLPs") and Allied Health Professionals ("AHPs") are made aware of the Medical Staff Bylaws, Rules, Regulations and Policies, the Hospital Policies and the structure of South Georgia Medical Center ("SGMC").

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITION

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

A. New Medical Staff Members, LLPs and AHPs are provided with orientation materials which address the following:

1. What Medical Staff membership and/or Clinical Privileges or Clinical Functions means and requires.

2. How quality of care is monitored, measured and ensured.

3. Obligation to ensure accurate, timely and legible medical records.

4. Coverage of the Emergency Room and unattached patients.

5. Clear expectations regarding disruptive behavior.

6. Importance and requirement for attending meetings and Medical Staff activities.

7. Invitation to consider Medical Staff leadership in the future.

8. Introduction to organization and operation of SGMC, including SGMC's applicable policies and procedures.

9. Patient rights and responsibilities.

10. Fire safety, handling of hazardous material, and disaster preparedness.

11. Process for completion and maintenance of patient medical records.

12. Explanation of the SGMC infection control program.

13. Regulatory required education including but not limited to the following topics:
    - i. Information Management
    - ii. Hospital Leadership
    - iii. Medication Management
    - iv. Medical Staff
    - v. National Patient Safety Goals
    - vi. Provision of Care, Treatment, & Services
    - vii. Transplant Safety
    - viii. Waived Testing

B. New Medical Staff Members, LLPs and AHPs are provided with an electronic copy of the Medical Staff Bylaws, LLP/AHP Manual, Rules and Regulations and Policies or a link to access such documents through the SGMC website.

PROCEDURE

New Medical Staff Members, LLPs and AHPs receive the orientation materials during training on use of the electronic medical record systems.

POLICY HISTORY

Original Adoption Date: 11/20/02

Review/Revision History:
Reviewed: 10/08, 04/21, 04/24
Revised: 06/17; 02/19

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Organized Healthcare Arrangement APPROVALS: Approved by Medical Staff: 10/2022 Approved by Hospital Authority: 10/2022 Effective Date: 10/19/2022	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 10

PURPOSE

The purpose of this Policy is to establish guidelines for sharing health care information within an Organized Health Care Arrangement.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS:

Covered Entity means a health plan, health care clearing house or health care provider who transmits any health information in electronic form.

Disclose(s) or Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside SGMC.

Health Care Provider means a provider of services (as defined in section 1861(u) of the Act 42, U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act 42, U.S.C. 1395x(s)) and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Health Care Operations means any of the following activities of a SGHS Facility:

1. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; Patient safety activities; population-based activities relating to improving health or reducing health care costs, protocol development, case

management and care coordination, contacting of health care providers and Patients with information about treatment alternatives; and related functions that do not include Treatment;

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
4. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the SGHS Facility; and
5. Business management and general administrative activities of the SGHS Facility, including, but not limited to:

    a. Management activities relating to implementation of and compliance with HIPAA;
    b. Resolution of internal grievances;
    c. The sale, transfer, merger, or consolidation of all or part of the SGHS Facility with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
    d. Creating de-identified health information or a Limited Data Set, and fundraising for the benefit of a SGHS Facility.

Organized Health Care Arrangement or OHCA means:

1. A clinically integrated setting in which individuals typically receive health care from more than one health care provider; or
2. An organized system of health care in which more than one covered entity participates and in which the participating covered entities:

    a. Hold themselves out to the public as participating in a joint arrangement; and
    b. Participate in joint activities that include at least one of the following:

        i. Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;
        ii. Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or
        iii. Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if PHI created or received by a covered entity is

reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

Payment means activities undertaken to obtain or provide reimbursement for the provision of health care.

PHI means Protected Health Information.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including: the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Use means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of such PHI.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

SGMC is a clinically integrated setting in which patients receive care from more than one provider. In order to facilitate patient care, an Organized Health Care Arrangement exists allowing the sharing of PHI between legally separate entities. This arrangement involves the sharing of PHI for the purpose of Treatment, Payment, and Health Care Operations (including assisting in the scheduling and registration for patient services at SGMC).

PROCEDURE

I. SGMC's Notice of Privacy Practices is acknowledged by the patient at time of admission. This notice explains how SGMC Uses, Discloses and releases PHI. In addition, this notice explains that physicians with Clinical Privileges and SGMC share PHI for Treatment, Payment, and operations. This agreement is considered a "joint notice" and adopts a single notice of privacy practices to cover Use and Disclosure of PHI obtained during the course of Treatment at SGMC. Therefore, physicians and other authorized Practitioners (non-SGMC employees) are not required to obtain individual acknowledgment from a patient.

II. SGMC employees, Medical Staff members and authorized Practitioners will abide by the terms of the notice with respect to PHI, created or received by the Covered Entity as part of its/his/her participation in the Organized Health Care Arrangement or be subject to sanctions according to SGMC Policy SPP, *Sanctions for Non-Compliance*. Terms of this notice will include PHI which is obtained:

A) during the course of Treatment on the premises of SGMC; or

B) when a patient receives services remotely (such as when blood is drawn in the doctor's office and the blood is analyzed in a hospital lab).

Patient Treatment outside of SGMC premises and not utilizing SGMC services, such as a follow-up visit with a physician after discharge, is outside the context of the arrangement. In such Treatment situations, a patient should acknowledge the physician's own privacy notice at that time.

III. SGMC does not have the responsibility to track Disclosures of PHI released by Medical Staff members, Practitioners, Allied Health Professionals or their staff.

IV. Organized Health Care Arrangement participants are responsible for their own HIPAA compliance efforts (transactions, security and privacy). This Policy does not state or infer that all Organized Health Care Arrangement participants join together in one another's HIPAA compliance, nor does it mean that any participant is responsible for the violations of another participant.

V. Participants of the OHCA may disclose PHI to another Covered Entity for Health Care Operation activities of the OHCA.

POLICY HISTORY

Original Adoption Date: 11/20/02

Review/Revision History:
Reviewed: 10/08
Reviewed and format updated: 04/17
Reviewed: 06/20
Reviewed and Revised: 10/22

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Students: Shadowing & Applied Learning Experience/Clinical Rotations APPROVALS: Approved by Medical Staff: 12/2025 Approved by South Georgia Medical Center Inc.: 12/2025 Effective Date: 12/17/2025	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 11

PURPOSE

The purpose of this policy is to define the method by which individuals are allowed to enter South Georgia Medical Center ("SGMC") to Shadow Practitioners and Allied Health Professionals and to define the method by which Students are allowed to participate in an applied learning experience or a clinical rotation in SGMC.

APPLICATION

This Policy applies to Students applying to Shadow Practitioners and Allied Health Professionals ("AHPs") and Students applying to accompany a Practitioner or AHP as part of an applied learning experience or clinical rotation.

DEFINITIONS

Authorized Activity means a specific examination, care or treatment activity approved pursuant to Section V.B.2. of this Policy.

Preceptor means a Practitioner or AHP who has a contract, memorandum of understanding or affiliation agreement with a medical, dental, podiatry or AHP school to direct and supervise specific Student's(s') applied learning experience or clinical rotation in SGMC; and has been authorized pursuant to this Policy to allow the Preceptor to direct and supervise specific Student(s) in SGMC.

Shadow means to accompany and observe a Supervising Practitioner or AHP in SGMC.

Shadowing Individual means an individual who has been authorized to accompany and observe a Supervising Practitioner or AHP in SGMC pursuant to this Policy.

Student means an individual who is enrolled in a medical, dental, podiatry or AHP school.

Supervising Practitioner or AHP means a Practitioner or AHP who has been authorized pursuant to this Policy to allow an individual to Shadow the Practitioner or AHP in SGMC.

POLICY

I. ELIGIBILITY TO SHADOW OR PARTICIPATE IN AN APPLIED LEARNING EXPERIENCE/CLINICAL ROTATION

A. Shadowing

1. An individual must be at least sixteen (16) years old to be eligible to apply to Shadow in SGMC.

2. At least seven (7) days prior to the requested Shadowing start date, an individual must submit the following documents to the Medical Education Office:

   i. An Application to Shadow and all agreements required by such Application, signed by the individual and the Supervising Practitioner(s) or AHP(s); and
   ii. Evidence of tuberculosis screening, immunizations, and Hepatitis B screening or declination of Hepatitis B, as required by SGMC policy depending on the nature of the intended Shadowing.

3. At least forty-eight (48) hours prior to the requested Shadowing start date, the individual must complete training regarding HIPAA, infection prevention, sterile practices, and safety training as required by SGMC policy, depending on the proposed length of the Shadowing experience and areas of SGMC in which the individual will Shadow. For instance, if the individual intends to Shadow in a sterile area, he or she must complete sterile training.

B. Applied Learning Experience/Clinical Rotation (Student)

1. A Student meeting the following qualifications is eligible to request permission to complete an applied learning experience or clinical rotation in SGMC:

   a. Affiliation Agreement: SGMC must have a current Affiliation Agreement with the individual's medical, dental, podiatry or AHP school whereby SGMC agrees to allow Students of such school to complete a portion of an applied learning experience/clinical rotation in SGMC under the direction and supervision of a Preceptor.

2. At least seven (7) days prior to the requested applied learning experience/clinical rotation start date:

   a. The student must submit the following documents to the Medical Education Office:

      i. An Applied Learning Experience/Clinical Rotation Application and all agreements required by such Application signed by the individual and the Practitioner(s) or AHP(s) who will serve as the Student's Preceptor(s); and
      ii. Evidence of tuberculosis screening, immunizations, Hepatitis B screening or declination of Hepatitis B, as required by SGMC policy depending on the nature of the intended applied learning experience/clinical rotation.
      iii.

b. The Student must complete a drug screening examination as instructed in the Applied Learning Experience/Clinical Rotation Application.

3. At least forty-eight (48) hours prior to the first date of the Student's applied learning experience/clinical rotation, the Student must complete training regarding HIPAA, infection prevention, sterile practices and safety training as required by SGMC policy depending on the proposed length of the applied learning experience/clinical rotation and the areas of SGMC in which the Student will enter.

II. ELIGIBILITY TO SERVE AS A SUPERVISING PRACTITIONER OR AHP OR TO SERVE AS A PRECEPTOR

A. Supervising a Shadowing Individual

1. A Practitioner or AHP is eligible to serve as a Supervising Practitioners or AHP for a Shadowing Individual provided such Practitioner or AHP complies with this Policy during the Shadowing experience and is not ineligible to supervise as pursuant to Section II.A.2. below.

2. In the event that a Supervising Practitioner or AHP fails to comply with this Policy: (i) the Chief of Staff or his/her designee and the Chief Executive Officer or his/her designee may terminate a Shadowing experience; and (ii) the Supervising Practitioner or AHP is then ineligible to supervise a Shadowing Individual in SGMC for the remainder of his/her then-current Medical Staff or AHP appointment term and his/her next full Medical Staff or AHP appointment term.

3. Serving as a Supervising Practitioner or AHP is not a Clinical Privilege or Clinical Function and the loss of eligibility to supervise Shadowing Individuals is not a "denial" of Medical Staff or AHP appointment or Clinical Privileges or Clinical Functions. Such loss of eligibility is not reportable to the National Practitioner Data Bank and does not entitle the Practitioner or AHP to a hearing or review pursuant to the Medical Staff Bylaws or the Limited License Professionals/Allied Health Professionals Manual ("LLP/AHP Manual").

B. Serving as a Preceptor for a Student

1. A Practitioner or AHP is eligible to serve as a Preceptor pursuant to this Policy provided such Practitioner or AHP complies with this Policy as a Preceptor and is not ineligible as pursuant to Section II.B.2. below.

3. In the event that a Practitioner or AHP serving as a Preceptor fails to comply with this Policy: (i) the Chief of Staff or his/her designee and the Chief Executive Officer or his/her designee may terminate the Preceptor's eligibility to continue to serve as a Preceptor and will communicate with the Student's school as provided in the applicable Affiliation Agreement with regard to the Student's ability to continue his/her applied learning experience/clinical rotation in SGMC; and (ii) the Practitioner or AHP is then ineligible to serve as a Preceptor in SGMC for the remainder of his/her then-current Medical Staff or AHP appointment term and his/her next full Medical Staff or AHP appointment term.

3. Serving as a Preceptor in SGMC is not a Clinical Privilege or Clinical Function and the loss of eligibility to serve as a Preceptor is not a "denial" of Medical Staff or AHP appointment or Clinical Privileges or Clinical Functions. Such loss of eligibility is not reportable to the National Practitioner Data Bank and does not entitle the Practitioner or AHP to a hearing or review pursuant to the Medical Staff Bylaws or LLP/AHP Manual.

III. APPROVAL

A. Shadowing

Upon an individual's completion of all steps and submission of all documentation required by Section I.A.2. of this Policy, the Director of Medical Education will determine if the individual is eligible to Shadow and the requested Supervising Practitioner or AHP is eligible to serve as a Supervising Practitioner or AHP, and will notify the individual of the approval or denial or his/her request to Shadow in SGMC. Provided, however, the individual may not begin to Shadow in SGMC until he/she also completes the training required by Section I.A.3. of this Policy.

B. Applied Learning Experience/Clinical Rotation (Student)

Upon a Student's completion of all steps and submission of all documentation required by Section I.B.2. of this Policy, the Director of Medical Education will determine if the Student is eligible to request to complete an allied learning experience/clinical rotation in SGMC and the Practitioner or AHP requested to serve as the Student's Preceptor is eligible to serve as a Preceptor in SGMC, and will notify the Student of the approval or denial or his/her request. Provided, however, the Student may not begin an approved applied learning experience/clinical rotation until he/she also completes the training required by Section I.B.3. of this Policy.

IV. RESPONSIBILITIES & PREROGATIVES

A. Shadowing

1. Responsibilities & Prerogatives

   a. A Shadowing Individual:
      i. Shall remain with his/her Supervising Practitioner or AHP or with other Practitioner(s) or AHP(s) as directed by his/her Supervising Practitioner or AHP at all times while in SGMC;
      ii. May observe as authorized by his/her Supervising Practitioner or AHP only, i.e., Shadowing Individuals may not participate in examination, care, or treatment in any way;
      iii. Shall wear a SGMC issued badge identifying the individual as a Shadowing Individual at all times when in SGMC; and
      iv. Shall comply with SGMC policies and procedures, including, but not limited to, policies protecting patients' privacy and confidentiality.

   b. The Supervising Practitioner or AHP is responsible for ensuring that Shadowing Individuals under his/her supervision:
      i. Except as provided in Section IV. A.1.c. below, remain with the Supervising Practitioner or AHP at all times when in SGMC;

ii. Observe only, i.e., Shadowing Individuals may not participate in examination, care, or treatment in any way; and
iii. Comply with SGMC policies and procedures.

c. The Supervising Practitioner or AHP may arrange for a Shadowing Individual under his/her supervision to accompany and observe another Practitioner or AHP in SGMC provided that the Supervising Practitioner or AHP ensures that such Practitioner or AHP understands that the Shadowing Individual must remain with such Practitioner or AHP at all times and that the Shadowing Individual may only observe, i.e., the Shadowing Individual shall not participate in examination, care or treatment of any patient.

d. The Supervising Practitioner or AHP is responsible for the activities of Shadowing Individuals for whom he/she has agreed to serve as Supervising Practitioner or AHP.

B. Applied Learning Experience/Clinical Rotation (Student)

1. Responsibilities & Prerogatives

a. A Student participating in an applied learning experience/clinical rotation at SGMC:
i. Shall remain with his/her Preceptor or such other Practitioners or AHPs as directed by his/her Preceptor at all times when in SGMC;
ii. May observe examination, care and treatment as authorized by his/her Preceptor;
iii. May participate in examination, care, and treatment IF:
(1) The specific activity is an Authorized Activity for the Student's specific Student type and level of education; and
(2) The specific activity is directed by the Preceptor;
iv. Shall wear a SGMC issued badge identifying the individual as a Student at all times when in SGMC; and
v. Shall comply with SGMC policies and procedures, including but not limited to policies protecting patients' privacy and confidentiality.

b. The Preceptor is responsible for:
i. Ensuring that Students under his/her supervision:
(1) Except as provided Section IV.B.c. below, remain with the Preceptor at all times when in SGMC;
(2) Comply with SGMC policies and procedures; and
(3) Only participate in examination, care and treatment as directed by the Preceptor pursuant to sub-section ii. below.

ii. Directing Students under his/her supervision to participate in examination, care, or treatment to the extent that the specific activity is:
(1) An Authorized Activity for the Student's specific Student type and level of education (see Section V below);
(2) Consistent with the Student's prior education and training as provided in SGMC's applicable Affiliation Agreement with the Student's school; and
(3) Consistent with the Preceptor's Agreement with the Student's school.

c. The Preceptor may arrange for a Student under his/her supervision to accompany and observe another Practitioner or AHP in SGMC provided that the Preceptor ensures that such Practitioner or AHP understands that the Student must remain with the Practitioner or AHP at all times and that the Student may only observe the Practitioner or AHP, i.e., the Student shall not participate in examination, care or treatment of any patient.

d. The Preceptor is responsible for the activities of Students for whom he/she serves as the Preceptor.

V. AUTHORIZED ACTIVITIES: SPECIFIC EXAMINATION, CARE & TREATMENT ACTIVITIES

A. Shadowing Individuals

Shadowing Individuals may only observe. Shadowing Individuals are not authorized to participate in examination, care, or treatment in any way.

B. Students

1. Specific examination, care and treatment activities that may be performed by a Student under the direct supervision of a Preceptor are developed by the applicable Medical Staff and must be approved by the Medical Executive Committee and the South Georgia Medical Center Inc., Board of Trustees.

2. In the event that a Student applies to complete an applied learning experience/clinical rotation and there are no Authorized Activities approved for his/her Student type, if the Student is allowed to begin his/her applied learning experience/clinical rotation prior to the approval of such Authorized Activities, the Student may only observe and shall not participate in examination, care or treatment in any way.

POLICY HISTORY

Original Adoption Date: 11/19/03

Review/Revise History:

Reviewed: 10/08
Revised: 08/06, 11/09, 12/17, 2/20, 12/2025
Reviewed: 12/22

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Clinical Privilege Criteria APPROVALS: Approved by Medical Staff 12/2025 Approved by Hospital Authority: 12/2025 Effective Date: 12/17/2025	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 13

PURPOSE

The purpose of this Policy is intended to provide guidance for establishing criteria by which Clinical Privileges may be granted.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

Criteria for Clinical Privileges are developed pursuant to the procedures below.

PROCEDURE

1. Criteria for Clinical Privileges will be developed for Services and Sections with collaborative effort of affected Services and Sections, with guidance from the Professional Qualifications Committee and Department Chairmen, using available documents published by specialty organizations and recognized National Medical Organizations. Criteria will be submitted for approval by the Medical Executive Committee and the Hospital Authority. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS. 6, SR. 6.

2. It is recommended that Services and Sections develop a defined core of Clinical Privileges with appropriate minimum criteria for eligibility. All individuals who are permitted by SGMC and by law to provide patient care services independently at SGMC shall have delineated Clinical Privileges, *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.6.

3. All individuals with clinical privileges provide services only within the scope of privileges granted. Additionally, Qualified Licensed Practitioners are authorized to order outpatient services that are within their scope of service to order. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.8.

4. All individuals who are permitted by law to provide patient care services independently in the Hospital shall have delineated privileges. As part of the process for determining privileges to be granted the Medical Staff and Governing Body consider whether the activity/task/procedure is one that the Hospital can support when it is conducted within the Hospital. This review may occur through the Joint Conference Committee for new technologies or new services lines as described below. Privileges shall not be granted for tasks/procedures/activities that are not conducted within the Hospital, regardless of the individual's ability to perform them. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) M.S. 6. S.R. 7.

5. Privileges to perform additional and/or more complex procedures require definition of minimum criteria.

6. Services and Sections will submit, through the appropriate Department Chairman, the criteria as developed and amended from time to time, to be reviewed by the Professional Qualifications Committee, forwarded to the Medical Executive Committee and will become attachments to this Policy after approval by the Hospital Authority.

7. Whenever a privileging question arises for which there is no policy or privileging criteria, the Professional Qualifications Committee will follow these steps to develop a policy and acceptable criteria:

    a. The burden of obtaining appropriate information will rest with the Practitioner making application for the privilege.

    b. New technology and/or new treatment protocol should be reviewed with information regarding the development and indications for the use of new technology or new treatment protocol as well as any peer reviewed research demonstrating efficacy, risks and anticipated outcomes of the proposed new technology and treatment protocol versus established or conventional technology and treatment protocols. Specific product literature and educational materials should not be the sole basis for the information provided. The names and contact information of individuals with established expertise in the new technology.

    c. The Professional Qualifications Committee will review the issue and will recommend whether the technology will be permitted within the institution at all. The Professional Qualifications Committee, after reviewing the information provided, may seek additional information or opinion from the Departments, Services and Sections at South Georgia Medical Center involved in the delivery of this new technology or treatment.

    d. The Professional Qualifications Committee will submit the results of their findings and their recommendations to the Medical Executive Committee.

    e. The Medical Executive Committee may seek additional information and guidance from external sources as well as guidance from such internal committees and task forces as

deemed necessary to make an informed decision and recommendation to the Hospital Authority.

f. In the event an informed decision requires further collaboration between the Medical Executive Committee and the Hospital Authority, the matter will be reported to the Joint Conference Committee as described in Medical Staff Bylaws.

g. As criteria are developed and approved for specific new technologies and procedures, they should be submitted for attachments to this Policy as in paragraph 4 above.

8. Initial applications for Medical Staff membership and/or Clinical Privileges shall have sufficient documentation of current competency, including age-specific competency where applicable, to be provided by residency or fellowship director and/or practitioners in the institution from which the applicant is transferring who are knowledgeable of his/her professional ethic, ability and work.

9. Appointment or reappointments to the Medical Staff and the granting, renewal, or revision of Clinical Privileges are made usually biannually, and, at time of re-application shall have sufficient documentation of current competency, including individual performance data review, in order for Service Chiefs, Section Chiefs and Department Chairmen to certify that the Practitioner is capable of performing the Clinical Privileges requested. See DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.6.

10. Reappraisal of clinical privileges shall also occur when the practitioner seeks to perform procedures outside the scope of those originally granted. See DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.10.

11. SGMC reviews individual performance data variation from criteria determined by the Medical Staff to identify need for training or proctoring, that may be required. See DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.6b(2).

12. SGMC Medical Staff Bylaws provides a mechanism for consideration of automatic suspension of Clinical Privileges in any of the following instances, among others: (1) Revocation/restriction of professional license; (2) Revocation/suspension/probation of Federal Narcotics Registration Certificate (DEA); (3) Failure to maintain the specified amount of professional liability insurance; or (4) Non-compliance with written medical record delinquency or deficiency requirements. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.12, SR.6.

13. SGMC Medical Staff Bylaws provide a mechanism for immediate and automatic suspension of Clinical Privileges due to (1) revocation/restriction of professional license; (2) revocation/suspension/probation of federal narcotics registration certificate/ (3) the termination or revocation of the practitioner's Medicare or Medicaid status; (4) failure to maintain the specified amount of professional liability insurance; or (5) noncompliance with written medical record delinquency or deficiency requirements. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.11.

14. The recommendations provided for initial appointments, reappointments and privileging shall be in writing and include the supporting rationale. If the governing body appoints a candidate or makes a privileging decision contrary to the recommendation of the medical staff, the rationale for doing so shall be documented. See DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.9.

15. SGMC Medical Staff Bylaws contain fair hearing and appeal provisions for any adverse actions regarding the appointment, reappointment, suspension, reduction, or revocation of privileges of any individual who has applied for or has been granted Clinical Pprivileges. *See* DNV NIAHO Accreditation Requirements (Rev, 25-1) at MS.6, SR.12.

POLICY HISTORY

Original Adoption Date: 10/20/04

Review/Revision History:
Reviewed: 10/08
Reviewed and format updated: 04/17
Reviewed: 06/20
Revised: 12/22, 12/25

ATTACHMENT A

SOUTH GEORGIA MEDICAL CENTER
New Technology/Procedure Briefing

Physician Name:_____
Date:_____
What new technology/procedure do you wish to use?

_____
_____
_____
_____

Will the nursing and other staffs need any special or additional education?

_____
_____
_____

Will use of this technology/procedure require an OR set-up that is different from the norm?

_____
_____
_____

Please give us the names of three (3) hospitals where this technology/procedure is used:

_____
_____
_____

When would you like to begin using this new technology/procedure?

_____
_____

Are there any continuing medical education courses which must be attended prior to using this technology/procedure?

_____
_____
_____
_____

Please outline the qualification needed by a physician to use this technology/ procedure safety:

_____
_____
_____

If you have any of the following, please submit:

a) research concerning the proposed technology/procedure;
b) course materials;
c) manufacturer's materials;
d) FDA approvals (if any).

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Credentialing and Peer Review Files APPROVALS: Approved by Medical Staff: 08/26 Approved by Hospital Authority: 08/26 Effective Date: 08/19/2026	FACILITIES: ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 14

PURPOSE

The purpose of this Policy is to establish guidelines regarding the content and confidentiality of Credentialing Files and Peer Review Files.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITION

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws, O.C.G.A. § 31-7-140, *et. seq.*, and O.C.G.A. § 31-7-130, *et. seq.*

POLICY

1. SGMC maintains files on its Medical Staff members and others who exercise Clinical Privileges or Clinical Functions at SGMC.

2. SGMC maintains two (2) separate files for each Medical Staff member, LLP and AHP who maintains SGMC Clinical Privileges or Clinical Functions, a Credentialing File and a Peer Review File.

3. The content of the SGMC Credentialing File is described in Attachment A to this Policy.

4. The content of the SGMC Peer Review File is described in Attachment B to this Policy.
5. Some of the files' contents are subject to the medical review and peer review privileges found at O.C.G.A. § 31-7-140, et. seq. and O.C.G.A. § 31-7-130, et. seq., respectively. SGMC takes

steps to ensure these protections are maintained. All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101, *et. seq*.

6. Files subject to the medical review and peer review privileges are strictly confidential. Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the medical review or peer review privilege.

POLICY HISTORY

Original Adoption Date: 06/21/17
Review: 06/20,08/26
Revised: 12/22

ATTACHMENT A
(Credentialing File)

The SGMC Credentialing File contains the following:

a. **Background Ground Information**
   i. Picture
   ii. CV
   iii. Biography

b. **Insurance Information**
   i. Memorandum of Insurance (or similar correspondence from the carrier)
   ii. Certificate of liability insurance or other similar proof of insurance

c. **CME/Education**
   i. CME Log
   ii. Education certificates

d. **Correspondence**
   i. Administrative correspondence
   ii. Letters of Commendation

e. **State Licensure/DEA**
   i. Copy of Georgia license
   ii. DEA registration
   iii. ACLS, CPR and other similar certifications
   iv. National Provider Identifier (NPI)
   v. Copy(ies) of other state licenses
   vi. Information related to allied health professionals, including Physician Assistant Job Descriptions and Nurse Protocol Agreements

f. **Board Certification**
   i. AMA Profile Verification Page
   ii. Board Certification Certificates
   iii. ECFMG Certification, if applicable

g. **SGMC Specific/Archive**
   i. Helpstar request documents
   ii. Physician acknowledgement statement
   iii. Physician information sheet
   iv. HIPAA Acknowledgement
   v. Physician personal ID form
   vi. Statement of Intent
   vii. Government issued ID
   viii. Social Security Card
   ix. Remote Access Contract

h. Reappointment

i. Correspondence from Hospital Authority
ii. Redacted reappointment application (Health Status, Attestation questions, Schedule B, and Part Two are redacted)
iii. State licensure verification
iv. AMA Profile
v. Board certification verification
vi. OIG/Verisys Printout

*** Note: This section only contains applications for reappointment on/after September 1, 2010.

i. Application

i. Application for initial appointment (Subsection C (Reason for Leaving), Subsection D (Reason for Leaving), Peer References, Health Status, Attestation Questions, and Schedule B (liability claims information) are redacted)
ii. Residency Case Logs
iii. Pre-Application
iv. Pre-Application Letter

j. Initial Appointment

i. Correspondence from the Hospital Authority re: appointment to Medical Staff/LLP or AHP status and clinical privileges or clinical functions
ii. Service/Department/PQC/MEC/Hospital Authority Signatures
iii. Temporary privileges signature form
iv. AMA Profile
v. OIG Inquiry Printout

ATTACHMENT B
(Peer Review File)

The SGMC Peer Review file contains the following:

a. **OPPE**

   i. OPPE Physician Profile Reports
   ii. Documents supporting the report other than Complaints
   iii. Documents supporting evaluation of Quality Management measures listed on the report.

b. **PPD Screens**

c. **Signed Privilege Forms**

d. **NPDB Reports**

e. **Internal Appraisals & Recommendations**
   i. Appraisals & recommendations generated by SGMC physicians/staff
   ii. Reappointment appraisal records
   iii. Reappointment peer evaluations

f. **External Peer References**
   i. Initial appointment references (correspondence to/from external professional peer references including professors/program directors)
   ii. Verification letters from medical schools, residency programs, and fellowships
   iii. Previous and current hospital/work affiliation verifications
   iv. Character letters
   v. Credentialing checklist
   vi. Letters of recommendations

g. **Complaints – CMO/Chief of Staff Review**

h. **Medical Records Documentation Issues**

i. **MEC/LLP AHP Committee Review/FPPE**

   i. MEC peer review/action
   ii. Focused Professional Practice Evaluations

j. **Complete Application and Attestations**
   i. Initial Applications
   ii. Reappointment Applications

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Procedural Sedation (Non-Anesthesiologist)	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 15
APPROVALS: **Approved by the Medical Staff** 4/2024 **Approved by Hospital Authority** 4/2024 **Effective Date:** 4/17/2024	☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to provide a consistent process for the provision of sedation for patients undergoing medical/surgical or diagnostic procedures.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

Procedure means Procedural Sedation, formerly known as "Conscious Sedation" is a drug induced technique used to produce a depressed level of consciousness and applies to sedation/analgesia given by any route of administration.

POLICY

A. Oversight:
Medical Staff Departments, Services and Sections and Patient Care Service.

B. Levels of Sedation:

1. Minimal sedation (anxiolysis) – A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. Moderate sedation/analgesia ("conscious sedation") – A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep sedation/analgesia – A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

C. Qualifications:

1. Professional Education- MD, DO, DDS or DMD.

2. Postgraduate Education- Successful completion of a postgraduate residency or clinical fellowship in medicine or surgery approved by the AMA or successful completion of a postgraduate dental residency in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation of the ADA.

3. Board Certification- For new applicants after January 1, 1999, certification or meet the training and experience and any time limit requirements for certification by the appropriate specialty board recognized by the American Board of Medical Specialists or the American Board of Oral and Maxillofacial Surgery.

4. Previous Experience - Except for Practitioners that are privileged to provide services in the emergency department that maintain board certification with ABEM or ABOEM, applicants must demonstrate evidence of competence for such requested procedural privileges as set forth below:

   a. The applicant must demonstrate evidence of competence in administration and monitoring of pharmacologic agents appropriate to procedural privileges requested by:

      1) Evidence of completion of a residency or fellowship in which procedural sedation was taught, with verification,
         or
      2) Successful completion of a training module approved by the Medical Staff CME Committee and certification in ACLS, ATLS, NRP or PALS,
         or

3) Successful performance of twelve (12) procedures using procedural sedation at this hospital with appropriate documentation in the past twelve (12) months and certification in ACLS, ATLS, NRP or PALS.

b. The applicant must demonstrate evidence of capability of evaluating patients prior to performance of sedation including airway evaluation, assignment of classification and documentation by:

1) Successful completion of a residency or fellowship in which procedural sedation was taught, with verification,
or
2) Successful completion of a training module approved by the Medical Staff CME Committee and certification in ACLS, ATLS, NRP or PALS.
or
3) Successful performance of twelve (12) procedures using procedural sedation at this hospital with appropriate documentation in the past twelve (12) months and certification in ACLS, ATLS, NRP or PALS.

c. The applicant must have capability to manage patients under sedation, including management of airway of patients reaching a deeper level of sedation either intentionally or unintentionally by:

1) Successful completion of a residency or fellowship in which procedural sedation was taught, with verification,
or
2) Successful completion a learning module approved by the Medical Staff CME Committee and certification in ACLS, ATLS, NRP or PALS,
or
3) Successful performance of twelve (12) procedures using procedural sedation at this hospital with appropriate documentation in the past twelve (12) months and certification in ACLS, ATLS, NRP or PALS.

D. Renewal of Privileges:

1. Continued granting of these privileges will be based on the successful performance of procedures using sedation/analgesia with good outcomes, evaluated by the Chief of the appropriate Section and Service and Chairman of Department at time of reappointment and/or renewal of other privileges.

2. For applicants after January 1, 2005, certification will be required in ACLS, ATLS, NRP or PALS within the previous 30 months, unless granted exemption by the Credentials Committee and approved by the Medical Executive Committee.

E. Privileges and exemptions will only become effective upon final approval by the Hospital Authority.

F. This policy would not apply to procedures deemed "Emergent" by the provider caring for the patient during that time, provided this has been documented in the patients' medical record.

POLICY HISTORY

Original Adoption Date: 5/6/2008

Review/Revision History:
Reviewed: 02/11, 07/19, 04/21, 04/24
Reviewed and reformatted: 04/2019

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medication Therapy Management **APPROVALS:** **Approved by the Medical Staff** 08/26 **Approved by Hospital Authority** 08/26 **Effective Date:** 08/19/2026	**FACILITIES:** ☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	**MEDICAL STAFF POLICY NUMBER:** 16

PURPOSE

The purpose of this policy is to provide guidance for when Physicians collaborate with Pharmacists providing Medication Therapy Management.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

POLICY

Pharmacists employed by South Georgia Medical Center may practice in a collaborative manner (Medication Therapy Management) with members of the Medical Staff in the following ways:

A. A member of the Medical staff requests the Medication Therapy Management through an individual order
B. The Pharmacy and Therapeutics and Medical Executive Committees approves a Medication Therapy Management protocol/ guideline that is applicable to the entire Medical Staff

(Pursuant to O.C.G.A Section 26-4-210 to 26-4-214 and Georgia Pharmacy Board Rule 480-35-08)

POLICY HISTORY

Original Adoption Date: 10/18/2023
Review Date: 08/26
Revised Date: