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: 03/14/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 03/21/18	☐ SGMC Lanier Campus	
Effective Date: 03/21/18	☐ 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 a Practitioner's performance may require further action to improve such 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 measure, assess and improve Practitioner's performance not to establish procedures which must be followed prior to the initiation of corrective action proceedings pursuant to the Medical Staff Bylaws.

APPLICATION

This Policy is applicable to SGMC Berrien Campus.

DEFINITIONS

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

"Hospital" means SGMC Berrien Campus.

"MEC" means Medical Executive Committee.

"QM Committee" means Quality Management Committee.

POLICY

I. Evaluation & Review of Performance

The QM Committee, assisted by the Quality Improvement/Patient Safety staff, will undertake activities necessary to measure, assess, and improve performance by the Medical Staff, including:

a. Focused professional practice evaluation and reviews: (i) following the appointment of initial Clinical Privileges to a Practitioner; (ii) following 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 and reviews, including: (i) identification of core indicators which 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, nursing and administrative personnel.

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

2. Core Indicators

The QM Committees will, at least annually, submit proposed core indicators which 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, to identify opportunities for performance improvement and is made available for consideration by the Department Chairmen and the MEC, to assist them in performing their responsibilities relating to assessment of the 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

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

6. Review by the Medical Executive Committee

a. A Department Chairman may report case(s) identified through the evaluation and reviews described above, in his or her discretion, to the MEC for review and consideration.

b. In the event that a Department Chairman, 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 his/her 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, i.e., the 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 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 prepares 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 submits 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 assigns cases for review to a member(s) of the QM Committee or, 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, when the procedure is not currently performed by another member of the Medical Staff and 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 shall not be present during any personal presentation and 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, 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.

- ***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.

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 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 and maintained and information made available for consideration by the appropriate Department Chairman and the MEC as necessary to support their responsibilities for assessing the appropriateness of professional services.

POLICY HISTORY

Original Adoption Date: 03/21/18

Review/Revision History:
Reviewed: 02/21
Reviewed and reformatted:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Disruptive Behavior	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 2
APPROVALS: **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	☐ SGMC ☒ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to promote a safe, cooperative and professional healthcare environment by preventing or eliminating conduct which disrupts the operation of SGMC Berrien Campus ("SGMC"),or affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for SGMC employees, patients or other individuals.

APPLICATION

This Policy is applicable to SGMC Berrien Campus.

DEFINITIONS

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

"Practitioner" means:

(a) Any Physician or Oral or Maxillofacial Surgeon applying for or exercising Clinical Privileges under these Bylaws;

(b) Such a person who does not exercise Clinical Privileges but who is a Staff Member assigned to the Honorary Staff; or

(c) A Limited License Professional where the Board has authorized the application for and the exercise of Clinical Privileges by such Limited License Professionals.

POLICY

A. All Practitioners and Allied Health Professionals ("AHPs") practicing in SGMC must conduct themselves in a professional and cooperative manner and must treat others with respect, courtesy, and dignity in the facilities of SGMC. Disruptive Conduct toward or in the presence of employees, patients, other members of the Medical Staff, or others, will not be tolerated.

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

C. All efforts undertaken pursuant to this Policy shall be part of SGMC's medical review and professional and peer review activities.

D. This Policy outlines collegial steps, i.e., counseling, warnings, and meetings with a Practitioner, that can be taken to address complaints about Disruptive Conduct by Practitioners. 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 being addressed through this Policy to the Medical Executive Committee, the elimination of any particular step in the Policy or a request for initiation of investigation for corrective action.

E. 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, SGMC employees, AHPs, Practitioners or visitors. However, constructive criticism to help improve patient care should not be construed as harassment.

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

3. Breach of confidentiality, such as confidentiality of committee proceedings, medical records, or privacy of patients.

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

5. Disrupting SGMC case management, committee or peer review functions.

6. Disrupting SGMC 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, AHP 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, request 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 regarding patients, families, nurses, Practitioners, AHPs, SGMC personnel, or SGMC.

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

10. Any person may provide information to the Chief of Staff or the Chief-Elect of the Medical Staff about a Practitioner who, based on the reasonable belief of the reporting individual fails to comply with the ethics of the profession or the Bylaws and Policies of SGMC, the Bylaws, Policies, Rules and Regulations of the Medical Staff or the LLP/AHP Manual pertaining to any aspect of the individual's behavior or conduct in SGMC, or where such behavior or conduct is considered to be lower than the standards of SGMC, or where the Practitioner or AHP is unable to work harmoniously with others to the extent that it affects the orderly operation of SGMC or the Medical Staff organization.

F. Reporting Disruptive Conduct Procedure

1. Disruptive Conduct should be reported immediately.

2. Pursuant to SGMC policies and procedures, written or verbal complaints received by or submitted to SGMC employees are forwarded to the SGMC Quality Improvement/Patient Safety Department. Complaints received by the Quality Improvement/Patient Safety Department regarding Practitioners Members or AHPs are forwarded to Medical Staff Services, to the attention of the Chief of Staff. To the extent that such complaint describes Disruptive Conduct, the complaint is considered pursuant to this Policy.

3. Any person may also submit a complaint of Disruptive Conduct of a Practitioner or AHP to the Chief of the Medical Staff.

4. The implicated individual will be notified immediately of any complaint in writing.

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.

G. Investigation of Disruptive Conduct

1. Upon receipt of a complaint or report documenting Disruptive Conduct as described above, any two (2) members of the Medical Executive Committee appointed by the Chief of Staff shall serve as a committee (the "Complaint Committee") acting at the express direction of the Medical Executive 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.

2. Others involved in the investigation may include the appropriate Department Chairman and Committee Chairpersons and, as appropriate, SGMC administrative personnel.

3. The Complaint Committee will review the complaint or report 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 SGMC medical review or patient grievance process, the Chief of Staff will report such determination back to the appropriate SGMC medical review or peer review committee.

4. After such initial review and investigation, the Complaint Committee may also determine that the complaint should be referred for review (by the Medical Executive Committee or as otherwise provided in the applicable Policy) under the procedures of MS 1 (Medical Staff Review of Practitioner Performance), MS 8 (Medical Staff, LLP and AHP Complaint Management), 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.

5. Notice of a complaint with a summary of the nature of the complaint regarding a Practitioner or AHP will be forwarded promptly to the implicated Practitioner or AHP.

6. An individual who files repeated complaints against a Practitioner or AHP that are found to be without merit may be subject to disciplinary or corrective action. A Practitioner or AHP shall be governed by this Policy and a SGMC employee or agent shall be governed by the appropriate SGMC Policy.

H. Interventions and Actions

1. 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. 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, but is not required to include, discussion with the appropriate Department Chairman and/or review by the Quality Management Committee.

2. The Complaint Committee, after consideration of the complaint or report and supporting documentation, clinical information and any further information provided by affected Practitioner, or AHP and discussions as provided above, as applicable, will prepare a summary of its assessment and recommendations. A copy will be forwarded to the affected Practitioner or AHP, the Medical Executive Committee, the Chief of Staff, and the Department Chairman.

I. Procedure Thereafter

1. Referred to the Medical Executive Committee pursuant to Section G above shall constitute a request for corrective action under the appropriate section of the Medical Staff Bylaws or LLP/AHP Manual.

2. 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.

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

4. All meetings with the Practitioner or AHP shall be documented, including any rebuttal, and such records, together with the assessment of the Complaint Committee, shall be maintained in a file for complaints by Medical Staff Services. Complaints and outcomes will be maintained as CONFIDENTIAL and privileged pursuant to Medical Review and Peer Review protection. Such file is available for review by Department Chairs in furtherance of his/her duties and responsibilities as Chairman.

POLICY HISTORY

Original Adoption Date: **3/21/18**

Review/Revision History:

Reviewed: 02/21
Revised:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff, LLP & AHP Support	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 4
APPROVALS:	☐ SGMC	
Approved by Medical Staff: 3/14/18, 5/9/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 3/21/18, 5/16/18	☐ SGMC Lanier Campus	
Effective Date: 3/21/18, 5/16/18	☐ SGMC Lakeland Villa	

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. This Policy, therefore, 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 SGMC Berrien Campus ("SGMC Berrien Campus" or "Hospital").

DEFINITIONS

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

"Approved treatment program" is a program for alcoholism or substance abuse treatment that is approved by the Medical Association of Georgia's Medical Director and Committee on Physician Impairment.

"Chief Executive Officer" means the Chief Executive Officer of SGMC Berrien Campus.

"Designated Chairmen" are the Chief of Staff or his/her designee, 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 which 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 Hospital personnel.

"Positive result" of an alcohol or other drug test means the detection of alcohol or another drug in concentrations deemed significant by the United States Department of Health and Human Resources 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, an agency of the U.S. Department of Health and Human Services.

POLICY

1. 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.

2. 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 Hospital 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 Hospital 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 reports directly to the Designated Chairman. The Designated Chairman receiving the report shall be responsible for taking the appropriate action under this Policy, including notifying the Chairman of the Medical Staff Support Committee.

2) Other Reports. All other reports of suspected impairment shall be submitted to Medical Staff Services for distribution to the Chief of Staff, Chairman of the appropriate Medical Staff Department and Chairman of the Medical Staff Support Committee.

3) Notifications following Receipt of Reports. The Chief of Staff will notify the person making a report that the report has been received, reviewed and appropriately acted upon. Such notification shall be made orally and shall generally not specify the action taken. The Chief of Staff shall also notify the Chief Executive Officer when a substantiated report has been received and shall apprise him of the progress of assessment, treatment and recovery. The Chief Executive Officer will be entitled to review substantiated reports of possible impairment as well as follow-up reports of treatment, recovery and wellness.

b. Self-reporting. All Providers must submit a written report to Medical Staff Services of any change in the Provider's psychiatric or other medical status which might possibly affect the quality of patient care rendered by the Provider within the limits of his or her 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 the Hospital, he or she must comply with the evaluation, reporting and follow-up procedures set forth in this Policy.

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 in question 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, as appropriate.

b. Post-incident testing. A Provider whose performance either is reasonably believed to have contributed to an accident or incident at a Hospital-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.

i. Substance Abuse. Specimen collected shall comply with applicable procedures established from time to time by the Hospital, 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 or urine. 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 Berrien Campus 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 Chief of Staff and the Designated Chairman who requested the testing. Such refusal shall be documented in the medical staff file and may be rounds 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 from time to time by SAMHSA. Test results shall be reported in writing to the Chief of Staff 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 Medical Review Officer who is a physician who is trained and certified by SAMHSA in interpretation of drug tests, who reviews the positive test results along with the Provider's 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 the Chief of Staff or his or her designee 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 test results shall be retained for at least one (1) 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 Chief Executive Officer. Test results and related reports with respect to an AHP or LLP 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.

ii. Psychiatric Disorders. Psychiatric evaluation must be performed by a psychiatrist approved by the Chief of Staff, who may be an independent psychiatrist unassociated with SGMC. The evaluating psychiatrist will report to the Chief of Staff and the Designated Chairman requesting the evaluation the Provider's failure to cooperate with the evaluation or refusal to consent to release of reports. Such action 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 and the Chief of the Provider's Department in determining the appropriate level of restrictions on the Provider's Clinical Privileges or Clinical Functions.

iii. 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 Chief of Staff and the Designated Chairman 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.

5. Intervention.

   a. Substance Abuse. Upon receipt of a positive test result, the Chief of Staff, Chairman of the Medical Staff Support Committee and Chairman of the Impaired Provider's Department shall select a group of physicians or other Providers to contact the Impaired Provider and attempt intervention.

      If the intervention is successful, the Impaired Provider shall enter an approved treatment program for assessment and such treatment or other follow-up as may be recommended by such program. The Provider's Clinical Privileges or Clinical Functions will be temporarily suspended and he or she will be relieved of any SGMC responsibilities or duties while receiving assessment and treatment.

      The treating physician(s) at the approved treatment program shall submit a written report of successful completion of treatment to Medical Staff Services.

      Such report shall be made available to the Designated Chairmen, the Chairman of the Provider's Department and the Chief Executive Officer. Upon receipt of the report and execution of a "Relapse Contract" by the treated Provider, the Provider's Clinical Privileges or Clinical Functions may be reinstated.

   b. Psychiatric Disorders. Following evaluation and diagnosis of a psychiatric disorder resulting in impairment, an approved psychiatrist shall determine the frequency and nature of continuing psychiatric care. The approved psychiatrist shall report to Medical Staff Services 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, an approved physician shall provide ongoing evaluation and management of the disorder. The approved physician shall report to Medical Staff Services 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. The number and type of proctored cases may be revised at any time by the Department Chairman, following recommendation of the proctors.

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. A written, non-restricted report of assessment must be submitted by the treatment program at least every four (4) months to Medical Staff Services. Such report shall be available to the Designated Chairmen, the Chief Executive Officer, and the Chairman of the individual's Department. The assessments and reports required by this paragraph may be discontinued after a minimum of two (2) years of recovery and with the written release of the approved physician. 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 Medical Staff Services at least every four (4) months while follow-up care continues. Such reports will be available for review by the Designated Chairmen, the Chief Executive Officer, and Chairman of the Provider's Department. If the Provider's condition remains stable for two (2) 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/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 Limited License Professional or Allied Health Professional 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 Berrien Campus Medical Staff Bylaws. Limited License Professionals who do not maintain Clinical Privileges and Allied Health Professionals 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 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, and all information furnished to any of these Committees or 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: 3/21/18

Review/Revise History: 5/16/18

Reviewed: 02/21
Reviewed and format updated:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Emergency Medical Treatment and Active Labor Act (EMTALA)	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 5
APPROVALS:	☐ SGMC	
Approved by Medical Staff: 3/14/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 3/21/18	☐ SGMC Lanier Campus	
Effective Date: 3/21/18	☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to establish the obligations of physicians who provide on-call coverage to the SGMC Berrien Campus Emergency Department.

APPLICATION

This Policy is applicable to SGMC Berrien Campus.

DEFINITIONS

Emergency 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 the System Policy and Procedure ("SPP") *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 SPP, *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 Berrien Campus at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) SGMC Berrien Campus, 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 Berrien Campus Medical Staff Bylaws.

POLICY

1. Pursuant to SGMC Berrien Campus *Emergency Medical Treatment and Patient Transfer Policy* ("SGMC Berrien Campus Policy") in furtherance of its efforts to comply with the Emergency Medical Treatment Act ("EMTALA"), it is the policy of SGMC Berrien Campus 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. If necessary, SGMC Berrien Campus will provide, within the capabilities of SGMC Berrien Campus, 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 Berrien Campus Policy, an appropriate Transfer of the individual to another medical facility. SGMC Berrien Campus maintains an on-call list of physicians on the SGMC Berrien Campus Active Medical Staff in a manner that best meets the needs of those receiving the medical services required under the SGMC Berrien Campus Policy, in accordance with the resources available to SGMC Berrien Campus, including the availability of the on-call physicians.

2. 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.

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

4. 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 by coming to the Emergency Department in less than forty-five (45) minutes of being called to the Emergency Department.

5. 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.

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

7. 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 his/her 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 Berrien Campus, sufficient to stabilize and/or manage the patient's medical needs and request him/her to appropriately respond. If both of these efforts are unsuccessful, SGMC Berrien Campus 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.

POLICY HISTORY

Original Adoption Date: 3/21/18

Review/Revision History:
Reviewed: 02/21
Reviewed and format updated:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Official Order of Call	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 6
APPROVALS: **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	☐ SGMC ☒ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

PURPOSE

The purpose of this Policy is to establish the official order of call for the SGMC Berrien Campus Medical Staff.

APPLICATION

This Policy is applicable to SGMC Berrien Campus.

DEFINITION

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

POLICY

Officers of the SGMC Berrien Campus 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 Officers. 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 and Administrative Offices.

B. A list (Pecking Order) will be published for each of the following:
1. Chief of Staff
2. 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: **3/21/18**

Review/Revision History:
Reviewed: 02/21
Reviewed and format updated:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Locum Tenens	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 7
APPROVALS: **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	☐ 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 SGMC Berrien Campus Medical Staff ("Staff Member") or a LLP with Clinical Privileges at SGMC Berrien Campus and to define the responsibilities of Staff Members or LLPs who have *locum tenens* coverage.

APPLICATION

This Policy is applicable to SGMC Berrien Campus ("SGMC").

DEFINITIONS

LLP means a Limited License 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 Berrien Campus 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 Medical Staff Services, utilizing the form provided by Medical Staff Services 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 Medical Staff Services 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. The time frame for submitting an application for Temporary Clinical Privileges as a *Locum Tenens* may be waived with the approval of two (2) of the following: Chief Medical Officer, Chief of Staff, Chief Elect or Chief Executive Officer.

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

POLICY HISTORY

Original Adoption Date: **3/21/18**

Review/Revision History:
Revised:
Reviewed: 02/21

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff, LLP and AHP Complaint Management	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 8
APPROVALS: **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	☐ SGMC ☒ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	

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.

APPLICATION

This Policy is applicable to SGMC Berrien Campus ("SGMC").

Policy Not Applicable to Corrective Action

Requests to the Medical Executive Committee for initiation of investigation for possible corrective action pursuant to the Medical Staff Bylaws are not governed by this Policy.

DEFINITION

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

POLICY

Complaints regarding Practitioners, Limited License Professionals ("LLPs") and Allied Health Professionals ("AHPs") are addressed pursuant to the Procedure below.

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, LLPs or AHPs are forwarded to Medical Staff Services to the attention of the Chief of Staff.

2. Acting at the express direction of the Medical Executive Committee, two (2) members of the Medical Executive Committee appointed by the Chief of Staff 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. 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 2 (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.

5. Notice of a complaint with a summary of the nature of the complaint regarding a Practitioner, LLP or AHP will be forwarded promptly to the affected Practitioner, LLP, or AHP.

6. After reviewing the complaint and the clinical information relevant to the complaint, if any, 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 and/or review by the Quality Management Committee.

7. 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, the Chief of Staff, and the Department Chairman.

8. Medical Staff Services will maintain a file for complaints, together with the assessment of the Complaint Committee, to be available for review by the Chairmen of the Departments of Medicine and Surgery.

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

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

POLICY HISTORY

Original Adoption Date: 3/21/18
Review/Revision History:

Reviewed: 02/21
Revised:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Staff Member, LLP & AHP Orientation	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 9
APPROVALS:	☐ SGMC	
Approved by Medical Staff: 3/14/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 3/21/18	☐SGMC Lanier Campus	
Effective Date: 3/21/18	☐ SGMC Lakeland Villa	

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 SGMC Berrien Campus ("SGMC").

APPLICATION

This Policy is applicable to SGMC Berrien Campus.

DEFINITION

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Berrien Campus 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: **3/21/18**

Review/Revision History:
Reviewed: 02/21
Revised:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Organized Health Care Arrangement APPROVALS: **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	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 SGMC Berrien Campus ("SGMC").

DEFINITIONS:

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

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.

Organized Health Care Arrangement (OHCA) means (1) A clinically integrated care 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:

(i) Hold themselves out to the public as participating in a joint arrangement, and
(ii) Participates in joint activities that include at least one of the following:
  a) Utilization Review
  b) Quality assessment
  c) Payment Activities

PHI means Protected Health Information.

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Berrien Campus 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 protected health information 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 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 who are not employed by SGMC.

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: **3/21/18**

Review/Revision History:
Reviewed: 02/21
Reviewed and format updated:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Students: Shadowing & Applied Learning Experience/Clinical Rotations **APPROVALS:** **Approved by Medical Staff:** 3/14/18 **Approved by Hospital Authority:** 3/21/18 **Effective Date:** 3/21/18	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 SGMC Berrien Campus ("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 eighteen (18) 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 Medical Staff Services:

   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 Medical Staff Services:

      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.

   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.

2. 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 Staff Services 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 Staff Services 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 Service and must be approved by the Medical Executive Committee and the Hospital Authority 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: 3/21/18

Review/Revise History:

Reviewed: 02/21
Revised:

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Clinical Privileges Criteria	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 13
APPROVALS:	☐ SGMC	
Approved by Medical Staff: 3/14/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 3/21/18	☐ SGMC Lanier Campus	
Effective Date: 3/21/18	☐ SGMC Lakeland Villa	

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 SGMC Berrien Campus ("SGMC").

DEFINITIONS

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

POLICY

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

PROCEDURE

1. Criteria for Clinical Privileges will be developed with collaborative effort of the Professional Qualifications Committee and the Medical Executive Committee, 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.

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

3. 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 should be provided as part of the review.

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 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.

4. 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.

5. Applications for renewal of Medical Staff membership and/or Clinical Privileges at time of re-application (usually biannually) shall have sufficient documentation of current competency, including age-specific competency where applicable, sufficient to certify that the Practitioner is capable of performing the Clinical Privileges requested.

POLICY HISTORY

Original Adoption Date 3/21/18

Review/Revision History:
Reviewed: 02/21
Reviewed and format updated:

ATTACHMENT A
SGMC Berrien Campus
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	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 14
APPROVALS:	☐ SGMC	
Approved by Medical Staff: 3/14/18	☒ SGMC Berrien Campus	
Approved by Hospital Authority: 3/21/18	☐ SGMC Lanier Campus	
Effective Date: 3/21/18	☐ SGMC Lakeland Villa	

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 SGMC Berrien Campus ("SGMC").

DEFINITION

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

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, Limited License Professional ("LLP") and Allied Health Professional ("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.

POLICY HISTORY

Original Adoption Date: 3/21/18
Reviewed: 02/21
Revision History:

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/LLP/AHP acknowledgement statement
iii. Physician/LLP/AHP information sheet
iv. HIPAA Acknowledgement
v. Physician/LLP/AHP 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

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) APPROVALS: **Approved by Medical Staff:** 6/13/2018 **Approved by Hospital Authority:** 6/20/2018 **Effective Date:** 6/20/2018	FACILITIES: ☐ SGMC ☒ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa	MEDICAL STAFF POLICY NUMBER: 15

Definition of procedure:

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.

Oversight:

Medical Staff Departments, Services and Sections and Patient Care Service.

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.

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.

4. Previous Experience-
   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 SGMC 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 SGMC 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 of 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 SGMC 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.

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 Staff 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 and approved exemption by the Medical Executive Committee.

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

POLICY HISTORY

Original Adoption Date: **6/20/2018**

Review/Revision History:

Reviewed: 02/21

Revised: