**Document #5177**

**CMA Legal Counsel and California Public Protection and Physician Health**

**September 2013**

# Guidelines for Physician Well-Being Committees Policies and Procedures

## INTRODUCTION

These Guidelines[1] are intended to aid hospitals, medical groups, medical societies, specialty societies and any other physician entities to create and operate a committee which assists physicians with matters related to prevention of impairment and maintenance of health, with particular attention to substance abuse or addiction, mental illness, or behavior. Commonly referred to as "Physician Well-Being Committees," these committees assist medical staff in a variety of ways and play several important roles.[2] They act as educational resources for medical and other organization staff in matters related to maintenance of health and prevention of impairment. The Well-Being Committee (or the "Committee") provides an informal, confidential access point for persons who voluntarily seek their counsel and assistance. It also provides a source of expertise whereby the medical staff may identify health factors underlying a clinical performance problem for which corrective action is under consideration. In the context of a formal investigation regarding clinical performance being conducted by the Medical Executive Committee or similar entity within the organization, the Well-Being Committee may be called upon to determine the presence, and the nature, of an underlying problem and make recommendations related to such problems.

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[1] These Guidelines have been amended to incorporate changes that reflect revisions to Joint Commission standards and law.

[2] Other CMA ON-CALL documents referenced in this document include CMA ON-CALL document #5101, "Disruptive Behavior Involving Medical Staff Members," CMA ON-CALL document #5204, "Documentation of Peer Review Activities," CMA ON-CALL document #5202, "Credentialing: Liability Releases, Indemnification," CMA ON-CALL document #5213, "State Agency Requests for Peer Review Information," CMA ON-CALL document #4250, "Confidentiality of Sensitive Medical Information," CMA ON-CALL document #6001, "Disabled Physicians and Employees," CMA ON-CALL document #2055, "Reporting Incompetent, Impaired or Unethical Colleagues," CMA ON-CALL document #2052, "NPDB & HIPDB Overview," and CMA ON-CALL document #2051, "MBC & NPDB: Reporting Disciplinary Actions" on Medical Board and National Practitioner Data Bank Reports.

An "individual health" or well-being function is mandated by the Joint Commission and is implemented by a committee of the medical staff. According to Standard MS.11.01.01, a medical staff must implement "a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes." This process must include all of the following nine elements:

1. Education of the licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to practitioners;

2. Self-referral by a licensed independent practitioner;

3. Referral by others and maintaining informant confidentiality;

4. Referral of the licensed independent practitioner to the appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition or concern;

5. Maintenance of the confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened;

6. Evaluation of the credibility of a compliant, allegation, or concern;

7. Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required;

8. Reporting to the organized medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment; and

9. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The purpose of this process is to support personal health and to facilitate rehabilitation rather than discipline. However, if it is determined that a physician is unable to exercise safely the privileges that he or she has been granted, the matter should be reported to the medical staff leadership for appropriate corrective action.

**APPLICATION BEYOND THE HOSPITAL SETTING**

The Well-Being Committee function is an essential element of medical staff activity in the hospital setting, as well as for physician organizations outside of hospitals. While the term "medical staff" typically refers to the organized medical staff found in the hospital setting, these Guidelines use the term to refer to any aggregate of physicians or other health care providers. Therefore, as used in these Guidelines, and unless otherwise noted, the term "medical staff" also refers, for example, to the physicians who are members of a medical group, an IPA, a medical specialty society, or a component society of the CMA that maintains a Well-Being Committee for the benefit of its members. In any context, the Well-Being Committee serves as one of an array of mechanisms physicians should utilize to assure patient safety. A general summary of its actions should be reported to the Medical Executive Committee and/or other organizational governing body at least quarterly.

Well-Being Committees formerly operated almost exclusively in the hospital medical staff and county medical society setting*s*, and are still a vital part of the hospital medical staff structure. With changes brought on, however, by the growth of managed care in California and a more complicated physician

practice environment, physician Well-Being Committees are now found in numerous other settings. In certain practice situations, some committees have assisted other health professionals.

## SUGGESTED NAMES FOR THE COMMITTEE

Committee on Physician Health

Committee on the Well-Being of Physicians

Medical Staff Health Committee

Medical Staff Well-Being Committee

Practitioner Well-Being Committee

Professional Staff Well-Being Committee

The Well-Being Committee

## BYLAWS

### Designation of Committee

The Committee and its charges should be described in the controlling bylaws or rules of the medical staff within which the Committee is formed. California Title 22 Regulations require each hospital medical staff to include a provision in its bylaws for the assistance of "medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services." Inclusion of a standing Well-Being Committee in the hospital bylaws not only satisfies Title 22 Regulations and Joint Commission standards, but also assures that the Committee will receive the same confidentiality protections for its records under Evidence Code §1157 as any other medical staff committee. Inclusion of the Well-Being Committee in non-hospital governing rules or bylaws may also assure the protections of Section 1157. A copy of the portion of the CMA Model Medical Staff Bylaws addressing "Medical Staff Aid Committees" may be found in Attachment A at the end of this document.

### Assuring Access to Relevant Information

To assure that the Committee has timely access to information that may indicate a practitioner is a danger to him/herself or to patients, the medical staff bylaws [can][should] include the following provisions:

1) A requirement that a medical staff member must promptly notify the medical staff of any arrest or conviction for driving under the influence of alcohol or driving with a blood alcohol level in excess of the legal limit (which are separate offenses under state law); and

2) A requirement that a medical staff member must cooperate fully and promptly whenever requested by the Committee or the Medical Executive Committee to undergo a drug or alcohol test or other physical or mental examination for cause.

**Reporting Relationship**

In a hospital setting, the Committee should be advisory to the Medical Executive Committee ("MEC") and such other appropriate hospital medical staff committees, as the MEC shall designate. In other settings, such as medical societies and medical groups, the Committee should be advisory to the appropriate governing committee.

**MEETINGS**

Consistent with Department of Public Health (DPH) Title 22 regulations, the hospital Well-Being Committee should be a standing committee of the medical staff. The hospital Well-Being Committee should meet no less than quarterly, and as frequently as required to fulfill its charges in accordance with its policies and procedures. 22 C.C.R. §70703(d) requires reports of activities and recommendations relating to the functions of hospital Well-Being Committees to be made to the medical executive committee and the governing body "as frequently as necessary *and at least quarterly*." Thus, hospital-based Well-Being Committees must meet at least quarterly to comply with this DPH Title 22 regulation.

The nonhospital Well-Being Committee should also be a standing committee, and should meet regularly.

Regular meetings help preserve and assure the Committee's preparedness and efficiency in responding to problems as they arise. Regular meetings also enhance acceptance of Well-Being Committee's role as an integral part of the medical staff structure. As a consequence, access to the Committee's services by individuals is thereby facilitated. (See Attachment B, Making a Well-Being Committee Effective.)

**CHARGES**

In order to maintain and improve the quality of care and assist staff members in the maintenance of appropriate standards of personal performance, the medical staff is responsible to take note of and to evaluate issues related to the health, well being or impairment of medical staff members.

It is important to identify the role of the Committee as advisory in nature, and not a substitute for a personal physician or a disciplinary body.

The Committee should be charged to:

a) Be an effective resource to the medical staff and others as the point where information and concern about the health of an individual physician can be delivered for confidential consideration and evaluation;

b) Receive and assess information; seek corroboration and additional information;

c) Respond to the person, including the physician in question, or group who contacted the Committee (the referring source);

d) Provide advice, recommendations and assistance to the physician in question and to the referring source; provide recommendations for treatment and/or education; provide assistance in obtaining what is recommended, including referral to the appropriate professional internal or external resources for the diagnosis and treatment of the condition or concern; be an advocate for the physician;

e) Monitor physicians for compliance with the terms of monitoring agreements;

f) Assist physicians with reentry issues;

g) Educate its members and the members of the medical staff about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, monitoring, and recovery; about the responsibilities of the medical staff in response to concerns about a physician's health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and reentry; and

h) Maintain confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

## MEMBERSHIP ON THE WELL-BEING COMMITTEE

### Expertise; Diverse Specialties

Members should be selected for specific expertise, experience and willingness to serve. An effort should be made to appoint members from several specialties. This includes, but is not limited to, involvement of:

- Physicians with expertise in addiction medicine;
- Physicians with expertise in psychiatry;
- Qualified persons recovering from alcoholism or other chemical dependence.

### Number of Members

The number of members should be no fewer than three.

### Appointment

Each member should be formally appointed to the Committee using the appointment process designated in the medical staff bylaws or other governing rules.

### Membership Composition

**Medical Staff Membership.** Membership may be restricted to members of the medical staff. Individuals who are not members of the medical staff (including non-physicians) may be appointed when such appointment will materially increase the effectiveness of the work of the Committee. Physician members of the medical staff should comprise the majority of the members of the Committee.

**Medical Staff Leaders as Members.** The Committee may wish to recruit medical staff members who formerly served on the medical staff governing committee (e.g., in the hospital setting, the medical executive committee), peer review committees and/or as department heads. Such individuals can bring a wealth of knowledge regarding how the organization and its medical staff served by the Committee work both procedurally and politically. Additionally, such individuals may be able to facilitate institutional support for the Committee's purposes given their prior leadership roles in the institution. It is important, however, that no Committee member currently hold any discipline-related position within the institution, e.g., active membership on the Medical Executive Committee or peer review committee. (See paragraph below "Membership on Other Committees; Restrictions" regarding the dangers of "dual roles" for Committee members.)

**House Staff.** Where there is house staff, there should be house staff members on the Committee.

**Duration of Service on Committee**

To provide for continuity and development of expertise, the policy of the Committee should be to encourage membership terms lasting several years.

**Confidentiality; Evidence Code Section 1157**

This Committee will maintain strictest confidentiality in its proceedings and shall be considered a Peer Review Committee for purposes of claiming the confidentiality protections afforded by Evidence Code §1157. Notwithstanding this protected status, there may be times when sharing of Committee information is desired or required. See Sections on "Confidentiality of Records and Record Sharing" and "Communications in Response to a Subpoena or Other Demand," below.

**Membership on Other Committees; Restrictions**

A physician should not serve on both the physician Well-Being Committee and a committee that has review or authority over members of the medical staff. Particularly, members of the physician Well-Being Committee should not also serve on the hospital Medical Executive Committee or a Judicial Review Committee, or any other Committee considering disciplinary issues relating to conduct previously dealt with by the Well-Being Committee.

Not only would such dual membership tend to inhibit a physician seeking the services of the Committee, but also it would place the physician serving on both committees in a precarious position in the event of discipline and a subsequent lawsuit. Further, Joint Commission standards require that the process be separate from the medical staff disciplinary function. (Standard MS.11.01.01.)

WHEN IT IS NOT FEASIBLE TO MAINTAIN THIS SEPARATION, it may be preferable to establish an agreement with the county medical society or with a consortium of local hospital medical staffs to provide the function. See the section below, "ALTERNATIVES TO FORMATION AND OPERATION OF COMMITTEE AT EACH HOSPITAL OR EACH ENTITY."

**POLICIES AND PROCEDURES**

**Purposes of the Committee**

The Committee's purpose is two-pronged: The Committee should focus on the needs of the physician (and other licensed independent practitioners) in question, while at the same time considering patient safety. According to the Joint Commission, "the purpose of the process is to facilitate rehabilitation, rather than discipline, by assisting a practitioner to retain and regain optimal professional functioning that is consistent with protection of patients." (Joint Commission Intent of Standard MS.11.01.01.) While the Committee should have no authority to take disciplinary action, it should serve as an advisor to the bodies within the medical staff that do take disciplinary action. The primary purpose of the Committee is to be a candid advisor to both the referral source and to the physician in question, with the understanding that, in that role, it should make appropriate recommendations to assure patient safety and to avoid damage to the health and career of the physician.

**Objectives of the Committee**

The Committee's focus is on the needs of the physician and the safety of patients treated by the physician, as well as on the responsibilities of the medical staff.

Committee members should be mindful of their role as advocate for the physician and the appropriate limits on that advocacy which may be imposed by a need to protect patients from harm.

**Action in Matters Affecting Patient Safety**

The Committee's first task is to evaluate information and concerns brought to them and to seek corroboration and sufficient additional information. All contacts by and with the Committee should be confidential to the fullest extent permitted by law.

In the event information received by the Committee clearly demonstrates that the health or known impairment of a medical staff member creates a likelihood of harm to patients or others in the organization, that information shall be conveyed to those individuals or committees within the medical staff responsible for assuring that appropriate follow-up action is taken, including, if necessary, adherence to state or federally mandated reporting requirements. However, laws protecting the confidentiality of substance abuse treatment and disabled individuals must be complied with. *See* CMA ON-CALL document #4250, "Confidentiality of Sensitive Medical Information" and CMA ON-CALL document #6001, "Disabled Physicians and Employees."Should the Well-Being Committee have questions regarding the ability of the physician to practice, appropriate expert opinion should be obtained. See Guidelines for Physician Health Committees: Evaluations of Health Care Professionals from California Public Protection and Physician Health (2013). Following the receipt and evaluation of such opinion, the committee should determine if it would recommend that some limitation of practice is indicated.

**Committee Recommendations Made Only To Referral Source and Subject Physician**

Except in an instance where there is a serious risk of harm to patients (see prior section), the Committee should report only to the referral source and to the physician in question. Many times the person or group which brings its concerns to the Committee and asks for the advice and services of the Committee will be a person or group with disciplinary authority, such as chief of staff, department head, Medical Executive Committee. In such cases, where the referral source has disciplinary authority, the same policy and procedure apply: the Committee should make recommendations only to the referral source and to the physician in question.

**Treatment and Monitoring**

The Committee or committee members should not provide treatment or supervision of clinical practice for a physician. The Committee should refer the physician to appropriate resources for treatment.

The Committee should advise on the appropriateness of aftercare, and on a monitoring plan and its provisions. The monitoring plan is the basis for a monitoring agreement between the physician and the designated medical staff committee.

Alternatively, if a physician enters a physician health program, or treatment or monitoring program with a provider of physician health services without involvement of the Committee, and the institution receives a notification of entry into the program, this communication should trigger the development of an institution-specific monitoring agreement between the Well-Being Committee or the appropriate medical staff committee or entity and the physician.

In either case, the Committee should be responsible to see that the physician is monitored for compliance with the provisions of the monitoring agreement. The Committee should insure that appropriate monitoring procedures are established and carried out. (See Attachment C for specific guidelines for monitoring, including using a qualified third party to provide the monitoring and report to the Committee and including a discussion of the Committee's response if the physician does not comply with the monitoring plan.)

A Committee member should be the coordinator of monitoring. The Committee should review and re-evaluate the physician and the monitoring agreement at regular intervals to be sure that the agreement fits the current needs and situations.

**The Disruptive Physician**

Evaluating and making recommendations regarding physicians who exhibit disruptive behavior patterns is also an appropriate charge to this Committee. *See* CMA ON-CALL document #5101, "Disruptive Behavior Involving Medical Staff Members."

**Committee Reports to Governing Committee; Identity of Physician**

Title 22 requires that hospital-based Well-Being Committees shall provide a quarterly report to the Medical Executive Committee. Non-hospital Well-Being Committees should regularly report their activities to the governing body as well. The identity of a physician who voluntarily seeks assistance from the Committee and who continues to cooperate with the Committee's recommendations and comply with the elements in a monitoring agreement shall not be disclosed in the report.

Where the physician has experienced some clinical performance failure and has been referred to the Well-Being Committee by the MEC or other governing body for evaluation, the identity of the physician may be disclosed in the report.

**ALTERNATIVES TO FORMATION AND OPERATION OF COMMITTEE AT EACH HOSPITAL OR EACH ENTITY**

There are certain circumstances in which it may not be feasible or practical to create a standing Well-Being Committee. Medical staffs falling under this category should provide for appropriate alternatives to a standing committee. Alternatives may include a working agreement with the local county medical society and/or specialty societies for the services of their Well-Being Committees. It may also be possible for medical societies, or smaller medical staffs or groups of physicians from several institutions to create a consortium Well-Being Committee to serve where creation of a formalized committee in one organization may not be possible.

**REPORTS TO THE MEDICAL BOARD OF CALIFORNIA, NATIONAL PRACTITIONER DATA BANK**

The law requires that, under specified circumstances, reports must be made of physicians to the Medical Board and/or National Practitioner Data Bank. When such instances arise, the reporting responsibility should vest in the hospital Medical Executive Committee or equivalent governing body for the organization served by the Well-Being Committee. The Well-Being Committee should serve only as an advisory and monitoring body, conducting inquiries and evaluations, and making reports to the governing committee as necessary. The Committee is charged to provide support and advocacy for physicians, and should not assume responsibility to report to government agencies. The fact that reporting is done by the governing committee rather than the Well-Being Committee indicates a clear separation of the mission and

activities of Well-Being Committees from those of the medical staff committees responsible for credentialing, corrective action and other disciplinary matters. For information on reporting requirements applicable to investigations of impaired physicians, *see* CMA ON-CALL document #2055, "Reporting Incompetent, Impaired or Unethical Colleagues." For information on Medical Board Reports, *see* CMA ON-CALL document #2051, "MBC & NPDB: Reporting Disciplinary Actions." For information on NPDB/HIPDB reports, *see* CMA ON-CALL document #2052, "NPDB & HIPDB Overview."

**RECORD KEEPING**

The records kept should be only those which are appropriate to the charges given to the Committee by the medical staff. Detailed records of the deliberations about an individual physician, beyond what is current or historic information important to the Committee's charge, would not be appropriate. *See* CMA ON-CALL document #5204, "Documentation of Peer Review Activities."

**CONFIDENTIALITY OF RECORDS & RECORD SHARING**

Hospital medical staffs and other peer review bodies *should* guard their peer review records carefully. All records of the physician Well-Being Committee should be maintained in the strictest confidence, preferably in locked files to which only certain key Committee members and staff have access or, if electronically maintained, with passwords that are available only to certain key Committee members and staff. Indiscriminate sharing of those records, particularly if the information were to be leaked outside the legitimate peer review context, can severely compromise the confidentiality of the records. This is because California Evidence Code §1157, which protects such records from compelled or involuntary disclosure (e.g., when a malpractice attorney tries to subpoena them) applies only as long as the information is *utilized* for peer review and quality assurance purposes. However, peer review bodies need not be unduly hesitant to share information with other peer review bodies when the other peer review bodies provide reliable assurances that they will use this information only in furtherance of legitimate peer review activities and that the records will remain confidential.

Conversely, there is no general legal *duty* to share peer review information between hospital or non-hospital peer review bodies (such as hospital medical staffs, ambulatory surgical center staffs, HMOs, medical societies, medical schools, medical groups, and other bona fide peer review bodies). There is, however, significant public policy that favors the voluntary sharing of information between legitimate peer review bodies in order to assist in maintaining physician competence and protecting the public health. The issue of whether and to what extent a peer review body should share information with another peer review body, therefore, is a matter solely within the first peer review body's discretion. The decision of whether and to what extent the physician Well-Being Committee shares information should be made in accordance with any existing medical staff bylaws, policies and procedures, and after consideration of all relevant laws regulating disclosure of otherwise confidential information, and protections for communicating such information.

**Factors to Consider When Deciding Whether to Share Protected Information**

A key factor to evaluate in determining if information should be shared is whether the Committee wishes to share information in furtherance of its patient protection and physician rehabilitation goals (e.g., with another Well-Being Committee) or instead contemplates disclosing information only in response to a subpoena or other demand. Another factor of importance is that, while the Committee's records as a whole will generally be considered peer review records for purposes of legal protections, some of the records may be patient treatment records which are subject to special protections and may not be disclosed or shared

voluntarily without meeting certain other requirements. *See* CMA ON-CALL document #4250, "Confidentiality of Sensitive Medical Information," and CMA ON-CALL document #6001, "Disabled Physicians and Employees." It must be emphasized that CMA supports a clear separation of the mission and activities of physician Well-Being Committees from those of medical staff committees responsible for credentialing, corrective action and other disciplinary matters. Therefore, CMA policy encourages the sharing of information *only* with the physician Well-Being Committees of other medical staffs. Nonetheless, it is advisable to inform physicians that information may be shared in furtherance of the Committee's goals and to seek each physician's written acknowledgment of and authorization for such disclosures. See also section on Communications in Response to a Subpoena or Other Demand, below.

Note that approval of the chief of staff should be secured for the sharing of information but the request for approval does not need to identify the physician about whom information is to be shared. Although the immunity protections discussed below will often apply even without physician authorization, obtaining a signed authorization from a physician may avoid subsequent questions or disputes regarding the disclosures. Moreover, a carefully worded authorization may also avoid charges regarding disclosures in this and other contexts that the Committee, either knowingly or inadvertently, violated the special confidentiality laws that protect special patient treatment information which the Committee may have in its possession.

**Protections Against Liability In Sharing Peer Review Information**

Under Civil Code §43.8 there can be no monetary liability against any person arising from the communication of information to any medical peer review committee, *so long as the communication is intended to aid in the evaluation of the qualifications, fitness, character or insurability of a medical practitioner.* A communication of information not known to be false is also protected from liability under federal laws by the Health Care Quality Improvement Act (42 U.S.C. §11111(b)). Additionally, California law now expressly provides for peer review information sharing, and states that "[t]he responding peer review body acting on good faith is not subject to civil or criminal liability for providing information to the requesting peer review body pursuant to this section." (California Business & Professions Code §809.08 (c).) Thus, official communications related to a physician's competence, from (or to) a peer review committee or anyone on it to (or from) another peer review committee or anyone on it should not give rise to liability.

Sometimes medical staffs and other peer review bodies do not understand that they have discretion to share this information. Others are worried that, if they do share this information, they might be exposing themselves to liability or compromising the confidentiality of the information shared. In order to encourage the voluntary sharing of this information, the California Legislature has provided: (1) numerous statutory immunities for individuals who communicate peer review information, and (2) broad confidentiality protections for such information even after it has been shared with another peer review body. A thorough understanding of the available protections and some important practical concerns should go a long way toward protecting peer review bodies which might otherwise be hesitant to share this information.

**Confidentiality Agreement Advised Before Sharing Information**

While the communication of information between physician Well-Being Committees of various medical staffs will not jeopardize the protection from discovery afforded by Evidence Code §1157 or confidentiality protections afforded by other laws, legal protections of this nature are only effective if they are asserted. Accordingly, CMA suggests there be a written agreement on the part of the receiving committee: 1) that the records will be used strictly for quality assurance activities, 2) that the records will be maintained exclusively as part of the peer review committee records, 3) that the peer review committee

will assert the protections available under Evidence Code §1157 and other confidentiality laws to the fullest extent permitted by law in the event that any outside party attempts to obtain discovery or disclosure of these documents. For more information on sharing peer review, including] a sample confidentiality agreement, *see* CMA ON-CALL document #5202, "Credentialing: Liability Releases, Indemnification."

**Consult With Legal Counsel; Develop Protocols**

Because of the complexity of these laws, each Committee, with consultation from legal counsel, should develop a protocol and procedure governing the release of Committee information, to be approved by the medical staff.

**COMMUNICATIONS IN RESPONSE TO A SUBPOENA OR OTHER DEMAND**

Voluntary disclosure of information by the Committee in furtherance of the goals of protecting patients and rehabilitating physicians as discussed above must be distinguished from disclosure in response to a subpoena or other demand, which is generally discouraged by the laws. Generally, Evidence Code §1157 protects peer review records from compelled or involuntary disclosure except under certain narrowly defined circumstances. In 1996, the California Supreme Court created a new exception, namely that the Medical Board may obtain documents and information otherwise protected by Evidence Code §1157 upon issuance of an investigative subpoena. Records of this nature should be produced to the Medical Board only when requested in an investigative subpoena which is specific as to the records requested, and that meets all requirements of applicable federal and state laws. All such subpoenas should be reviewed by legal counsel to assure that disclosure, if forthcoming, will be limited to only those items appropriate for discovery. For more information, *see* CMA ON-CALL document #5213, "State Agency Requests for Peer Review Information." In any case, patient medical records or patient medical information generally may not be released *without a signed patient authorization specifically permitting release of such records.* Vigilance is of prime importance in protecting the confidentiality of medical staff and patient records.

**ADDITIONAL RESOURCES**

Information from a number of organizations may be of assistance to Well-Being Committees. These include:

**Federation of State Physician Health Programs (FSPHP)**

Federation of State Physician Health Programs (FSPHP)
c/o American Medical Association
515 North State Street - Room 8584
Chicago, IL 60654
Tel: (518) 439-0626
Fax: (518) 439-0769
Website: www.fsphp.org

The Federation of State Physician Health Programs, Inc. (FSPHP), publishes guidelines for physician health programs which can be informative even though they are targeted to the statewide physician health programs that exist in many states and not to well-being committers. FSPHP is a nonprofit corporation whose purpose is to provide a forum for education and exchange of information among state physician health programs, to develop common objectives and goals, to develop standards, to enhance awareness of issues related to physician health and impairment, to provide advocacy for physicians and their health issues at local, state, and national levels, and to assist state programs in their quest to protect the public.

**Federation of State Medical Boards**

Federation of State Medical Boards of the United States, Inc.
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855
(817) 868-4000

The Federation of State Medical Boards published its "Policy on Physician Impairment" in 2011 (www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf).

**CMA Physicians' and Dentists' Confidential Line**

Tel: (650) 756-7787 (Northern California) or
(213) 383-2691 (Southern California)
Website: http://www.cmanet.org/resources/confidential-assistance/confidential-assistance

The Physicians' & Dentists' Confidential Assistance Line is a name given to a phone line service for physicians, dentists and their family members who request help with problems of alcoholism, drug dependence or mental illness.

When you call the Confidential Assistance Line, you reach an answering service that relays the message (name and phone number) to the on-call physician, who then returns the call. Physicians and dentists staffing the line are selected because of their experience with alcoholism, drug dependence and mental health and their ability to work with doctors as patients. They speak with the caller and gather enough information to make the best referral to an appropriate consultant. They may also, if appropriate, refer calls from spouses to trained counselors who are also members of the CMA Alliance.

**California Public Protection and Physician Health**

*Making Informed Choices: Guidelines for Selecting Physician Health Services* CPPPH 2012

*Guidelines for Physician Health Committees: Evaluations of Health Care Professionals* CPPPH 2013

The website www.CPPPH.org includes guidelines, examples of documents such as monitoring agreements, and relevant articles.

CPPPH offers regularly scheduled workshops designed for committees on physician health or well-being committees every four months in four regions of California: San Francisco Bay Area, Sierra Sacramento Valley, Los Angeles, San Diego (http://cppph.org/regional-networks/).

**American Society of Addiction Medicine**

4601 North Park Avenue, Suite 101
Chevy Chase, MD 20815
Tel: (301) 656-3920
Fax: (301) 656-3815
Publications Center: (800) 844-8948
Website: www.asam.org
email@asam.org

ASAM is a national medical society that works to educate physicians and the public about addiction medicine, improve the quality of addictions treatment and promote research and prevention. ASAM sponsors several CME programs each year, and publishes a journal, a newsletter and a textbook, among other publications. Call the toll-free publications number to order materials or get information on a specific course.

ASAM Public Policy Statement on Healthcare and Other Licensed Professionals with Addictive Illness (2011) is a 10-part document covering topics from "Illness versus Impairment" to "Medical Licensure Boards, Specialty Board Certification and Professional Society Membership," (www.csam-asam.org/sites/default/files/pdf/misc/ASAM_Policy_Statement_1.pdf).

**American Board of Addiction Medicine**

ABAM offers certification and maintenance of certification for specialists in Addiction Medicine. www.ABAM.net.

**California Society of Addiction Medicine**

575 Market Street, Suite 2125
San Francisco, CA 94105
Tel: (415) 764-4855
Fax: (415) 764-4915
Website: www.csam-asam.org
E-mail: csam@csam-asam.org

CSAM is the state specialty society in the field of addiction medicine and a chapter of the American Society of Addiction Medicine. The CSAM website includes a section with selected and annotated articles on physician health and well-being committees. CSAM can provide speakers to medical entities to educate members on Well-Being committee functions. However, groups must provide a site and reimburse for travel expenses. CSAM also sponsors and conducts conferences in California on addiction medicine and on physician Well-Being committee functions.

**Hazelden Publishing and Educational Services**

(Learning Resources on Alcohol and Drugs)

15251 Pleasant Valley Road
P.O. Box 176
Center City, MN 55012
Tel: (800) 328-9000
Fax: (651) 213-4590
Website: www.hazelden.org

Hazelden offers a wide variety of educational materials on alcoholism, drug addiction, and mental illnesses. Their publications and videos are directed to both patients and clinicians by age, gender, and ethnicity. The materials offered address all aspects of treatment for chemical dependency: identification, intervention, recovery, relapse, family relationships and spirituality.

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 40,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA's online health law library, CMA ON-CALL, or refer to the *California Physician's Legal Handbook* (CPLH). CPLH is a comprehensive health law and medical practice resource containing legal information, including current laws, regulations and court decisions that affect the practice of medicine in California. Written and updated by CMA's Center for Legal Affairs, CPLH is available in an eight-volume, softbound print format or through an online subscription to www.cplh.org. To order your copy, call (800) 882-1262 or visit CMA's website at www.cmanet.org.

**ATTACHMENT A - CMA MODEL MEDICAL STAFF BYLAWS**

ARTICLE XI - COMMITTEES

11.1 DESIGNATION

Medical staff committees shall include but not be limited to, the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under this Article, and meetings of special or ad hoc committees created by the medical executive committee (pursuant to this Article) or by departments (pursuant to Sections 9.4(i) and (l)). The committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with and approval by the medical executive committee. Medical staff committees shall be responsible to the medical executive committee. Under hospital regulations, while a medical staff must perform certain functions, the medical staff retains discretion as to whether such functions will be performed by separate committees or whether an individual committee will perform some or all of the functions. So long as each of the mandated functions is performed, the requirements will be satisfied. *See* 22 C.C.R. §70703, requiring executive review of credentialing, medical records review, tissue review, utilization review, infection control, pharmacy and therapeutics and medical staff assistance regarding chemical dependency and mental illness.

11.2 PROVISIONS

11.21 TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed for a term of [ ], and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

11.22 REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the medical executive committee.

11.23 VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the medical executive committee.

## ATTACHMENT B - MAKING A WELL-BEING COMMITTEE EFFECTIVE

The Committee is only as valuable as it is effective. The following discusses steps Well-Being Committees should take to increase the likelihood they fulfill their promise.

### ACTIVITIES

The charge to the Committee should emphasize the education of medical staff members of the medical staff. The measures of Committee effectiveness should relate to elements including (but not limited to) the frequency and regularity of activities such as grand rounds presentations and Department meetings, information articles placed in hospital publications, etc.

### EDUCATING THE MEDICAL STAFF

If the leadership and the members of the medical staff or in the medical group are unaware of the Committee's existence, or how to access it, it won't be used. The Committee should be assertive and creative in efforts to make the committee known throughout the whole community of the hospital, to all staff and to family of medical staff members. There are several ways in which committees can increase their visibility.

- Ask to be included in medical staff programs and plans, such as retreats for the medical staff.
- If there is a medical staff auxiliary, ask to be included in its publications and/or in one of its programs.
- Apply to do medical grand rounds on the subjects related to physician health and impairment on a regular schedule
- Take the initiative in informing and educating the nursing and other allied health staff.
- Submit brief articles and notices to hospital publications.

To the extent the committee makes presentations on physician health and impairment, it has the dual benefit of increasing the sensitivity to these issues and the likelihood that early and timely intervention will be sought.

### EDUCATING COMMITTEE MEMBERS

The Committee is charged to educate its members and the members of the organization about physician health, wellbeing and impairment; about appropriate responses to different levels and kinds of distress and impairment; about treatment, monitoring, and recovery; about the responsibilities of the medical staff in response to concerns about a physician's health; about the importance of early intervention; and about appropriate resources for prevention, treatment, rehabilitation, monitoring and recovery. (See Guidelines, Section IV, "Charges" of the Committee.)

Every regular meeting of the Committee should have an educational component. It should vary from meeting to meeting, with different activities being chosen because of an identified "need."

The following methods have proven helpful in educating Committee members and are recommended:

- A brief presentation by a Committee member on a topic selected by the member or by the Committee;
- A brief presentation by an invited speaker;
- Concurrent or retrospective review of a specific case that has been prepared for presentation and discussion. All the information needed to have a meaningful discussion should be gathered and presented to the Committee.
- Retrospective case review, as described above, with a consultant invited to discuss it with the Committee; and
- Review/discussion of an article or book that has been distributed to each member of the Committee in advance.

The Committee's educational activities should follow these principles or guidelines:

- Needs assessment should be an assigned responsibility within the Committee. Needs assessment should be an on-going function to identify the areas of information which the Committee "needs to know."
- Preparing for and carrying out the educational activity at each regular meeting should be an assigned responsibility within the Committee.
- Every case or situation in which the outcome was not what the Committee would have liked should be prepared for presentation and retrospective case review and discussion.

In addition to these activities, Committee members should be encouraged to attend conferences or workshops on the subjects related to physician health/impairment and to the responsibilities of physician organizations. It is recommended that more than one Committee member attend each conference.

**ENGENDERING TRUST**

Another crucial attribute of an effective Well-Being Committee is trustworthiness. If physicians don't believe the Committee will deal with them or their colleagues appropriately, its counsel will not be sought. There are three areas of particular importance to developing and maintaining that trust:

- For the Committee to be effective, it must be the advocate, not the judge.
- The Committee has to be a confidential one.
- Committee members should have appropriate expertise and experience in interacting with and treating physicians as patients.
- Involvement of qualified physicians recovering from alcoholism and other chemical dependence is desirable and deserves special consideration.

Finally, consideration should be given to establishing ways to encourage access to the Committee from all members of the relevant medical community and to facilitate the flow of communication to the Committee from those who might be reluctant to approach a Committee member with sensitive information. Early intervention can save physicians' careers and patients' lives. An effective committee will do what it can to increase the likelihood that such interventions occur where necessary.

## ATTACHMENT C - MONITORING

### Introduction

A medical staff must be satisfied that the physician's current physical and mental health meet the medical staff's standards for appointment, re-appointment or resumption of patient care. When a physician's illness or behavior has raised a concern about his/her ability to practice safely, the medical staff is expected to respond with actions designed to carry out its responsibility for patient safety. The Well-Being Committee (or the "Committee") can provide the medical staff's most effective first response.

The Committee, acting for the medical staff, can assess the situation and identify the most appropriate response and the requirements to be made of the physician.

Examples are participation in initial and ongoing treatment, maintenance of abstinence from alcohol and any drugs or non-prescribed medications, maintenance of appropriate behaviors in interacting with patients and with the treatment team and hospital personnel. The physician is required to comply, and the medical staff monitors the physician for compliance with those requirements for a specific length of time.

In the context of the role and function of the physician health committee, monitoring means the process of gathering, compiling and evaluating different kinds of information over time to document whether the physician is complying with the elements of an agreement. Monitoring assists the physician to comply with the requirements. Monitoring can provide indications that will assist with early detection of relapse, reemergence of signs and symptoms, or resumption of unacceptable behavior. Monitoring records document the actions of the medical staff to carry out its responsibilities.

Effective monitoring is time-consuming; it is a lengthy and complex process involving paperwork, record keeping, receiving and evaluating reports, and meetings with the physician being monitored.

The medical staff's own activities and information should document that the physician meets and continues to meet its standards for the exercise of privileges. However, the medical staff can engage the services of qualified providers of monitoring services to carry out the necessary elements and report to the Committee. The Committee receives and evaluates reports from those service providers and provides the necessary oversight. Sufficient time and resources should be allocated for carrying out that oversight role effectively.

Care should be taken in the selection of the qualified provider of the monitoring services [see Guidelines for Selecting Physician Health Services, adopted by CPPPH on 5-31-12, cppphdotorg.files.wordpress.com/2013/10/guideline-for-selecting-oct-2013.pdf] and the provider should be required to provide certain elements to the medical staff physician health committee. [See the section "CONTRACTING WITH A SERVICE TO CONDUCT THE MONITORING."]

The Committee should choose providers that meet criteria and meet the Committee's needs as well as the physician's needs: those who have demonstrated ability to provide services appropriate to the clinical situation, who have demonstrated ability to treat physicians as patients and to provide the Committee with substantive and timely reports.

## PURPOSE OF MONITORING

The purpose is most commonly but not always related to documenting compliance with elements of ongoing treatment and recovery from substance use disorders. Monitoring is also required when the issues are related to compliance with agreements for changes related to disruptive behavior, anger management, treatment related to psychiatric diagnoses, changes in privileging, or other situations.

## MONITORING RELATED TO SUBSTANCE USE DISORDERS OR OTHER ADDICTION

The purpose of monitoring described here is to assure the medical staff committee that the physician is in recovery, continues in recovery and is participating in an appropriate recovery program. Monitoring is designed to document the status of the physician's recovery. Monitoring is a service to the physician as well as to the medical staff. Monitoring serves to document status in recovery (to facilitate advocacy), increase accountability (to decrease likelihood of relapse), and increase the likelihood of early detection of problems (to increase safety and decrease consequences if there is a recurrence.) [Skipper 6-18-12] For the physician, a comprehensive monitoring program establishes a history of performance, with documentation, which can be invaluable in vouching for a physician's current status in recovery. For the medical staff, a record is established over time, showing that the medical staff is acting in a knowledgeable, timely, thorough and responsible way to assure that the physician continues to deliver safe care.

## MONITORING RELATED TO CONDITIONS OTHER THAN A SUBSTANCE USE DISORDER

When monitoring for a situation or condition other than a substance use disorder is required, all principles of monitoring described here should be adapted and applied. For example, the committee should satisfy itself that the physician receives appropriate treatment or other intervention such as psychiatric care, educational experiences, anger management counseling, and such. Initial interventions should be sufficient to assure that the problem is being addressed effectively and should be followed by ongoing care and monitoring as indicated by the situation. All elements should be specified in an agreement with the physician and monitoring for compliance with the agreement should follow the principles described.

## CONTRACTING WITH A THIRD PARTY TO CARRY OUT THE MONITORING

When ongoing monitoring is performed by a third party, the Committee's responsibilities include these elements. The Committee should:

- Have in place an agreement between the Committee, on behalf of the medical staff, and the provider of the monitoring service, or "contractor." The agreement should require the contractor to:
    - provide regular reports, on the frequency schedule set by the Committee, specific enough to serve as the basis of the Committee's decisions
    - make sure the physician meets and continues to meet the Committee's established criteria for documenting recovery, which are situation- and site-specific.
- Have in place a long-term agreement among the three parties: the Committee, the physician and the provider of monitoring services.
- Assure that there is an evaluation of the physician specific enough to serve as the basis of the monitoring program.

- Secure all necessary authorizations for releases of information. See "Authorization for Use or Disclosure of Health Information"

- Review the proposed monitoring plan that defines what elements are required of the physician to be sure that the requirements are appropriately tailored to the physician's clinical situation, practice setting and privileges.

- Have in place a worksite monitor so that there is a point of contact between and among the medical staff and the physician and the contractor

- Receive, review and evaluate, and keep the reports

- Address any situation in which any monitor or the contractor does not meet the Committee's needs for reliable, substantive and timely reporting. (Ask the monitor or the contractor to meet requirements or change monitors or contractors if necessary.)

- Periodically review the monitoring agreement with the physician to determine if any changes are indicated as the physician's clinical situation changes. (Requirements may be reduced or increased.)

- Involve the Committee so that more than one person (e.g., someone in addition to the Chair) knows the details of the situation.

On behalf of the medical staff, the MEC should:

- Expect regular reports from the Committee. Note that reports from the committee to the MEC do not identify physicians, but they do inform the MEC that the Committee is working with x number of members of the medical staff and carrying out the responsibilities of the Committee.

- Take action when the Committee reports information that requires action.

**MONITORING PLAN AND MONITORING AGREEMENT RELATED TO SUBSTANCE USE DISORDERS OR OTHER ADDICTION**

A monitoring plan should be drawn up and it should serve as the basis of a monitoring agreement between the designated medical staff committee and the physician. A detailed written agreement should be prepared and signed. It should be an agreement between the physician and the appropriate representative of the medical staff. Circumstances should determine whether the appropriate representative is the Well-being Committee, other committee or an officer. Examples include a Department Head, the Chief of Services, Chief of Staff, Medical Executive Committee. In any case, it should be the Well-Being Committee (because of its charge and its role within the medical staff) that coordinates the monitoring activities, insures that they are implemented, gathers information and assesses compliance with the different elements of the agreement.

A monitoring plan usually includes these elements:

- Evaluation as requested

- Completion of initial treatment

- On-going treatment/counseling

- Facilitated monitoring groups
- Drug testing
- Regular face-to-face contact with a knowledgeable and approved observer
- Reports made to the coordinator of monitoring
- Regular conferences

The following elements should be addressed as the monitoring plan is designed.

**Treatment**

The committee should satisfy itself that the physician receives appropriate treatment sufficient to assure that the problem is being addressed effectively. An initial course of treatment appropriate to the situation should be instituted and completed.

The Committee should choose qualified treatment programs based on appropriate criteria. [See *Guidelines for Selecting Physician Health Services*, California Public Protection and Physician Health 2012, cppphdotorg.files.wordpress.com/2013/10/guideline-for-selecting-oct-2013.pdf. See also *Physician Health Program Guidelines,* Federation of State Physician Health Programs 2005, www.fsphp.org/2005FSPHP_Guidelines.pdf.]

Regular reports from the treatment provider--including projected length of stay, fitness-for-duty assessment, and continuing participation in treatment--should be provided from the treatment program to the committee.

If there has been a course of initial treatment, the treatment provider or treatment facility should be expected to make recommendations for aftercare and for monitoring. The monitoring plan should incorporate the elements of an aftercare plan and recovery plan that have been recommended by those responsible for the initial treatment.

**Release of Information.** The medical staff should require that the physician authorize the treatment provider to communicate information to the Committee. Information should come from those responsible for initial treatment as well as aftercare and/or ongoing care.

**Recovery Plan.** When the problem is alcoholism, substance use disorder or addiction, the physician should have a specific, ongoing recovery or continuing care plan sufficient for the situation and to the physician's status in recovery. The monitoring plan should be designed to accumulate the information that will, over time, provide adequate documentation of the physician's compliance with the recovery and monitoring plan.

The Committee should satisfy itself that the physician's current physical and mental health care sufficient to allow him/her to practice safely.

**Groups.** When the problem is a substance use disorder, regular participation in a self-help group of persons recovering from substance use disorder (where appropriate, a facilitated group of recovering physicians or health professionals) is usually recommended.

**Workplace Monitor.** The plan should include a requirement for observation and regular reporting by someone who is present to witness the physician's behavior in the practice setting and who agrees to

interact with the physician as a monitor and provide information about his/her behavior to the coordinator of monitoring. The Committee should describe the expected obligations and limitations of the role of the worksite monitor and establish criteria for selecting worksite monitors. The Committee should identify any specific qualifications needed for a worksite monitor in each case/situation.

**Information to Be Gathered and Reviewed.** Information about the health status of the physician in recovery and about his/her behavior should be gathered and reviewed regularly and consistently for a specified period of time.

Information should come from several sources appropriate to the physician's situation. Examples are:

- from the hospital or other physician work place
- from a workplace monitor
- from the results of testing for drug/alcohol use
- from an aftercare coordinator
- from treating physicians and/or other treatment providers
- from family members

**FROM COLLEAGUES**

The Committee should designate those who are in a position to gather and submit to the coordinator of monitoring the different kinds of information appropriate to the case. These monitors should be appointed as members of the Committee for the purpose of carrying out this activity so that the peer review protections will be applicable.

**Regular Contact with a Knowledgeable Observer.** There should be regular, face-to-face contact between the physician and a monitor or monitors knowledgeable about the condition being monitored. The time and place of the contact should vary. The frequency and length of contact should be determined for each case. For some, daily or even more than once-a-day contact may be indicated, especially in the first days/weeks of the monitoring process. Usually, three times a week would be considered a minimum for the initial period. The frequency will vary with the particular physician's status in recovery. The length of contact must be sufficient to make an observation of the physician's behavior. The record should include periodic notes based on this observation.

The monitors should be able to create a relationship of mutual trust, support, helpfulness and respect. Monitors, however, should maintain objectivity and diligence throughout the monitoring process.

**Coordinator of Monitoring.** All who serve as sources of information, including a qualified third party that is conducting monitoring, should report to one coordinator of monitoring for the case, and that person should be a member of the Well-Being Committee. The function of the coordinator is to assemble all the information and to review, interpret, evaluate and respond to the comprehensive picture.

**Drug/Alcohol Testing**. Drug/alcohol testing alone does not comprise a sufficient monitoring plan; it is one element of a monitoring plan. The tests should be conducted on a random schedule and should follow guidelines and standards for such testing.

The monitoring agreement should specify what role testing will have in the overall monitoring plan. The agreement should describe how positive results and missed tests will be interpreted and what will be the response of the medical staff committee to positive results. The monitoring agreement should specify the costs of testing and who pays the costs. The results should be sent to the coordinator of monitoring.

The test(s) performed must be able to detect the drug(s) that the physician might use.

**Regular Conferences.** There should be regular face-to-face conferences, with the frequency of conferences specified in the monitoring plan, and a mechanism for adjusting the frequency according to need. The conference should include the monitors, the physician monitored, the coordinator of monitoring and the medical staff committee responsible for the monitoring. These conferences are important to be sure everyone has the same information. These conferences may include the re-evaluation of the recovery plan and the monitoring plan.

**Re-Evaluation of the Recovery Plan and the Monitoring Plan.** The monitoring plan should be re-evaluated regularly, e.g., every six months, by the Well-Being Committee or its designee. This permits modifications of the plan as needed to keep it tailored to current circumstances while the monitoring period progresses.

It may be appropriate to have this evaluation made by an acknowledged expert outside of the medical staff who will provide a written report. The monitoring agreement should specify the costs of such evaluation and who pays the costs.

**Record Keeping.** For each case where there is monitoring, there must be a record. The record should include a copy of the signed monitoring agreement and copies of all signed forms authorizing disclosure of information to the committee. The medical staff committee or its designate must have adequate information to assess the physician's status in recovery and compliance with the elements in the agreement. This information must be accumulated in the record and must be kept in strict confidence, preferably in a locked file or other secure storage that may be accessed only by Well-Being Committee members. This information should be retained indefinitely, preferably as long as the physician practices in the hospital or other institution plus five (5) years. Disclosure of this information outside of the Well-Being Committee should be made only to a qualified third party with whom the Committee has an agreement, or another medical staff committee in order to assist that committee with its physician evaluation activities, and at the written request of the individual involved or with the advice of legal counsel.

**Responses to Lapse or Relapse when the Diagnosis Is Substance Use Disorder.** The monitoring plan should take into consideration the fact that a lapse or relapse or resumption of use of alcohol or drugs is not uncommon for those recovering from a substance use disorder.

Some distinguish a lapse from a relapse because a lapse is defined as a short period of time, or a single use, with immediate return to abstinence. A lapse may or may not, but frequently does, include self- reporting. Statistics show that lapses or relapses occur in a significant percent of cases (approximately 10-20%), usually within the first year of sobriety. The response should be the same as the handling of the initial complaint; that is, the lapse/relapse should be assessed by a knowledgeable, experienced evaluator and the response should be tailored to the situation. A lapse or relapse alone should not be considered cause for termination of privileges or loss of employment or position. The customary response is to consider the need for additional treatment for the primary and/or co-occurring disorder, and intensify the treatment plan and intensify the monitoring for a period of time appropriate to the case. It may or may not be appropriate to require that the physician take a leave from patient care for a period of time. Consideration should be given to the physician's health and to patient safety in reaching a decision about whether a leave is appropriate.

**Medical Staff Privileges.** The medical staff's own activities and information, including information from outside specialists and qualified third-party monitoring programs, should document that the physician meets and continues to meet the standards of that medical staff for the exercise of privileges.

For more information on the physician health programs, *see* CMA ON-CALL document #0701, "Physician Health Programs (Plus CMA Policy on Impairment Among Physicians)."

**PROCTORING**

The medical staff must also satisfy itself that the physician's clinical skills are intact. To that end, the monitoring plan should contain provisions for proctoring appropriate to each case, especially if erosion of clinical skills is a concern. In some situations, proctoring may not be indicated. There should be concurrent peer review and regular record review for all monitored physicians, for a period of time to be determined in each case. For those with surgical privileges, or those who perform other procedures in a hospital, there should be a proctor for a period of time to be determined in each case.

**WHEN THE PHYSICIAN HAS PRIVILEGES AT MORE THAN ONE HOSPITAL**

The monitoring agreement should provide for notifying the appropriate medical staff committee(s) of the other hospital(s) (and medical groups where conditions make it appropriate) where the physician has privileges or is applying for privileges. In an optimal situation, monitoring activities will be integrated in a way that meets the responsibilities of each medical staff without unnecessary duplication. At a minimum, each medical staff should have a monitoring agreement (or each medical staff/medical group should be a party to one monitoring agreement) and there should be regular contact with a knowledgeable observer at each hospital or patient care setting whose reports are submitted to one coordinator of monitoring.

**PROTECTION OF THE PHYSICIAN'S IDENTITY**

It is possible to carry out every element of monitoring described here and still protect the identity of the physician. The physician's identity and information about the situation needs to be known only to the signers of the monitoring agreement, the monitors and the medical staff committee responsible for the monitoring. Disclosure of this information may be required if it becomes relevant in a staff privileges dispute.

**DISCLOSURE FORMS**

There are broad protections under both California and federal law for the confidentiality of medical information. As a general rule, *medical information may not be disclosed absent the patient's consent* documented in writing by a special authorization form signed by the patient or the patient's legal representative. Generally speaking, the only exceptions to this rule involve disclosures pursuant to subpoena, search warrant, court order, certain mandatory reporting obligations, and certain circumstances where the law expressly allows for disclosure within the physician's discretion. A sample authorization form meeting the requirements of California's Confidentiality of Medical Information Act and the HIPAA Privacy Rule follows this summary.

**SAMPLE LETTERS AND FORMS: INSTRUCTIONS**

The information provided in the following sample form does not constitute, and is not a substitute for legal or other professional advice. Users should consult their own legal or other professional advisors as necessary for individualized guidance with respect to each particular situation.

1. Authorization for Use or Disclosure of Health Information – Form 16-1 California Hospital Association

2. Authorization for Use or Disclosure of Health Information - Sample Form

To use this document, replace all text that appears in brackets ("["and"]") with correct information and make sure all blank spaces are filled correctly.

**Authorization for Use or Disclosure of Health Information – Form 16-1 California Hospital Association**

From "California Health Information Privacy Manual" June 2009 4th Edition

**FORM 16-1**

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient name: _____

## *USE AND DISCLOSURE OF HEALTH INFORMATION*

I hereby authorize: _____ to release to:

_____

*(Persons/Organizations authorized to receive the information)*

_____

*(Address — street, city, state, zip code)*

the following information:

a. ❑ All health information pertaining to my medical history, mental or physical condition and treatment received; OR

❑ Only the following records or types of health information (including any dates):

_____

b. I specifically authorize release of the following information (check as appropriate):

❑ Mental health treatment information[1]

❑ HIV test results

❑ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

## *PURPOSE*

Purpose of requested use or disclosure: ❑ Patient request; OR ❑ Other:

_____

_____

_____

## *EXPIRATION*

This authorization expires on *(date)*: _____

[1] If the patient requests that mental health information covered by the Lanterman-Petris-Short Act be released to a third party, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist who is in charge of the patient must approve the release. If the release is not approved, the reasons therefore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party, however.

## MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.[2]

I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing[3] and submit it to the following address: _____.

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.[4]

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

If this box ☐ is checked, the Requestor will receive compensation for the use or disclosure of my information.[5]

## SIGNATURE

Date: _____ Time: _____ AM / PM

Signature: _____
*(patient/legal representative)*

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____
*(legal representative)*

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[2] If any of the HIPAA recognized exceptions to this statement applies, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.

[3] Patients of federally-assisted substance abuse programs and patients whose records are covered by LPS may revoke an authorization verbally.

[4] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 C.F.R. Section 164.508(d)(1), (e)(2))*.

[5] The requestor is to complete this section of the form.

**Authorization For Use Or Disclosure of PHI - Sample Form**

**Authorization For Use or Disclosure of Protected Health Information**

[Physician Letterhead]
[Name, Title and Telephone Number of Privacy Officer]

***As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.***

I hereby authorize this medical practice to use and disclose health information concerning _____

_____

(patient name and address) as follows:

**Health information to be used or disclosed (check *only one box*): ***

[ ] Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

_____

[ ] All psychotherapy notes may be released, except as specifically provided below:

_____

_____

**This health information may be disclosed to:**

_____

_____

(*Name and address of person to use or receive the health information*)

**The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual":**

_____

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

**Effect of Refusal to Sign Authorization [Note: Physician Practice must include one of the following, as appropriate:]**

[I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.] ***or***

[I understand that if I do not sign this form:]

[I cannot participate in this research-related treatment.]

[A health plan may not enroll me or make me eligible for benefits.]

[My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.]

This authorization is effective now and will remain in effect until _____(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)

[ ] guardian or conservator of an incompetent patient

[ ] beneficiary or personal representative of deceased patient **

[ ] spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

[*Signed: _____ Dated: _____]
Treating Physician

* For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health information (except other psychotherapy notes).

** *It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*