UC DAVIS MEDICAL STAFF
MEDICAL STAFF WELL-BEING COMMITTEE MONITORING AGREEMENT

The Medical Staff Well-Being Committee (Committee) of the UC Davis Medical Center (UCDMC) has developed a supportive program for Medical Staff members working at UCDMC that is designed to protect the safety and welfare of our patients while aiding Medical Staff members who are exhibiting disruptive behaviors that impair their ability to work and function at their best. The success of the program is dependent upon a commitment by the Medical Staff member to participate in all aspects of the program, and the ability of UCDMC to monitor the Medical Staff member's progress.

The following serves to memorialize the terms and conditions of the monitoring agreement between XXX, M.D. and the UCDMC Medical Staff.

Background: The UCDMC Chief Medical Officer conducted a fact-finding review regarding concerns about Dr. XXX's professional conduct and (insert specific disruptive behaviors) . Based on the findings of that review sent to Dr. XXX on (date), s/he was referred to the Committee for counseling and monitoring.

A. Description of assessment conducted by (Name of person(s) performing assessment) on (date):
   - (Insert details of assessment)
   -

B. Description of expected behaviors:
   - Dr. XXX will uphold the UC Davis Health System Code of Conduct and the UC Davis Principles of Community in his/her interactions with all members of the UC Davis community, including patients, staff, colleagues trainees, students and administrators, so that s/he is seen to be acting in a professional and respectful manner at all times.
   - Dr. XXX will attend any training courses at the recommendation of the Medical Staff Well-being Committee.
   - (Insert specific descriptions of expected behaviors)
   -

C. Description of monitoring program:
   - Workplace monitor. A Workplace Monitor will be appointed by the Committee to observe Dr. XXX on a regular basis to assess whether s/he may be continuing to exhibit disruptive behavior. The Workplace Monitor will immediately inform the Committee if s/he observes any unusual or concerning behavior. Dr. XXX has proposed XXX serve as the Workplace Monitor, subject to the approval of the Committee Chair. (The workplace monitor will typically be a faculty member from a similar Department, with regular professional contact with the physician, and at a similar academic level.)
   - Medical care. Dr.XXX will continue to consult with his/her primary care physician and other treating providers, as applicable, and will follow their recommendations for continuing treatment of his/her medical and/or psychiatric conditions, as applicable.
   - Authorization to release medical information. Dr. XXX will complete the attached "Authorization to Release Medical Information" authorizing his/her primary care physician and psychiatrist to communicate regularly with the Committee and share information relating to his/her participation and progress in the monitoring program, and to allow the Committee Chair access to all medical records. This information will include, but is not limited to, Dr.XXX's protected health information (PHI).
   - Workplace assignment. If at any time Dr. XXX's Department Chair or academic/professional supervisor and/or Committee determine that Dr. XXX is unable to safely practice medicine,

some or all of his/her responsibilities will be immediately reassigned until the Committee feels that Dr. XXX is able to return to work. S/he will agree to perform whatever work assignments are determined by his/her Department Chair to be appropriate and to allow his/her Department Chair to communicate with Committee representatives.

- Self-prescribing. Dr. XXX will not self-prescribe any medications while under this monitoring agreement.
- Duration of monitoring agreement. Dr. XXX's participation in the monitoring program begins (Date) and ends (Date), assuming satisfactory progress and absence of relapse. This agreement will be reviewed every six months by the Committee, with the right to make modifications as needed.
- Confidentiality. The confidentiality of Dr. XXX's PHI and his/her participation in the monitoring program will be protected at all times. Committee records will be maintained separately from Medical Staff credentials files. The Committee will inform the CMO and the Department Chair of general information about his/her condition as necessary, including his/her status related to participation in the monitoring program as well as ability to work safely, but will not otherwise share his/her PHI. The CMO may share information about the monitoring agreement with the Peer Review Committee.
- Committee Chair rights. At all times, the Committee Chair will have the right to act on behalf of the Committee on any matter until such time as the Committee has had an opportunity to vote on that matter.

D. Description of consequences of disruptive behavior:
The response to a relapse into disruptive behavior or noncompliance with this agreement may vary depending upon the circumstances surrounding the relapse.

- In the event of a reported relapse, Dr. XXX will be asked to stop clinical practice and the Committee or CMO will be notified. Dr. XXX will not return to clinical practice until the circumstances of the relapse have been reviewed by the Committee and an action plan is developed.
- In the event of non-compliance with the requirements of this agreement or termination of participation in the monitoring program against the advice of the Committee, the Committee Chair will report this to the CMO and Dr. XXX, Department Chair. The CMO and Department Chair will determine what action to take, including whether the matter will be referred to the Medical Staff Executive Committee for corrective action.

By signing below, you have read and understand the above information and agree to comply with its terms.

_____ Print Name: _____

Signature of Medical Staff member

Date: _____

_____ Print Name: _____

Signature of Treating Psychiatrist

Date: _____

_____ Print Name: _____

Signature of Committee Chair

Date: _____

_____ Print Name: _____

Signature of Chief Medical Officer

Date: _____

_____ Print Name: _____

Signature of Department Chair

Date: _____

_____ Print Name: _____

Signature of Workplace Monitor

Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, authorize the following persons:
Print name of Medical Staff member

Primary care physician: _____

Psychiatrist: _____

To release my medical information to:

UCDMC Medical Staff Well-Being Committee Chair:_____

Please specify the health information you authorize to be released:

☒ MEDICAL ☒ MENTAL HEALTH

Type(s) of health information: Medical information obtained in the course of and for the purpose of the above-referenced person's participation in the UCDMC Medical Staff Well-Being Committee's monitoring program.
Date(s) of treatment: _____

☒ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. §§2.34 and 2.35).

NOTICE: UCDMC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. You are entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION: Until revoked by you, this authorization will expire ten years from the date identified below.

_____ _____
Print Name of Medical Staff Member Signature of Medical Staff Member

_____
Date