SAMPLE POLICY HANDBOOK

INSOURCE PROGRAM MODEL

NAME OF MEDICAL SOCIETY

NAME OF PROGRAM

* The NAME OF PROGRAM offers private, confidential to address a variety of personal and professional concerns including work overload, difficulties in relationships with family and friends, managing the threat of impending litigation, burnout, depression, and navigating the uncertainty of the current health care climate.
* Up to NUMBER (X) sessions annually free of charge with a seasoned therapist.
* Sessions offered in a private suite, on-site at the NAME OF MEDICAL SOCIETY/ABBREVIATION offices, or the option to be seen at the therapist’s private office.
* No diagnosis, no billing of insurance, and no electronic medical record of sessions.
* No role in disciplinary or fitness-for-duty evaluation.
* Physician initiated, separate and independent from 3rd parties.
* Accessible by all physicians, NAME OTHER CATEGORIES IF ANY.
* Counseling is quickly and easily available at physician convenient hours.

**APPOINTMENTS**

Medical Society pays for up to NUMBER counseling appointments. If sessions are expected to run past NUMBER visits, therapist encourages client to continue visits at their private practice through insurance, therefore disconnecting them from the NAME OF PROGRAM. Medical Society will not turn away clients in need of more than NUMBER visits through the NAME OF PROGRAM.

Society staff are on site and available at initial appointments in case any situations or concerns arise.

If appointments are back to back, physicians use separate waiting rooms.

**RECORDS**

Notes taken by your therapist during counseling appointments are kept on site at the Medical Society in a locked file cabinet accessed by the therapist only, or at the therapist private practice depending on where the appointments take place. Notes are to be maintained in a safe and confidential manner for a minimum of 7 years from the date of last session.

**WELLNESS PHONE LINE**

**Hours:** Executive Director carries the wellness line cell phone, and responds to calls during business hours, 7:30-4:30. The wellness line has a designated phone number. After hours calls are answered by XXXX answering service. XXXX answering service agreed to donate their services valued at $50 per month to operate after hours call line for NAME OF MEDICAL SOCIETY/ABBREVIATION.

**Protocol for answering wellness line:** When a client calls, answer the phone; *Thank you for calling the Medical Society’s confidential wellness line, how may I help you*?

* Ask if their need is urgent.
* Gather dates and times they may be available.
* Gather confidential contact information from the client including, first name, last name, email, and phone.
* Verify they are a physician or PA thought the medical society website.
* If non-urgent, let the client know they will hear back from you by the next morning. Email therapist with the client’s availability.
* If urgent, call therapist right away to schedule appointment.
* Email the client confirmation and instructions.

**Email:** Dr. \*\*\*:

This confirms your appointment through the NAME OF PROGRAM on DATE/TIME. Please arrive 5 minutes early to complete appropriate forms.

Your appointment will be located at:

Address

Please call the wellness number line at 555-555-5555 if any issues arise.

Please let me know if you have any questions.

**Voicemail on Wellness Line:** *Thank you for calling the Confidential NAME OF MEDICAL SOCIETY NAME OF PROGRAM wellness line.*

*If this is an emergency, please hang up and dial 911. If this is urgent, please call your county mental health crisis intervention hotline.*

*We are sorry that we missed your call.*

*Please leave your confidential message, and if possible, times you may be available to see one of our wellness counselors.*

*We will return your call within 24 hours.*

*For additional information about our wellness program please visit WEBSITE.org*

*We look forward to speaking with you soon.*

**AFTER HOURS ANSWERING SERVICE**

Wellness Line phone number is 555-555-5555

Office hours are 8:30am-4:30pm

Main Contact is; NAME OFFICE PHONE CELL PHONE

**PAS Voice Mail Verbiage:***You have reached the NAME OF MEDICAL SOCIETY’s confidential wellness line. If this is an emergency, please hang up and dial 911. For after-hours needs, we have partnered with the XXX answering service who is able to connect you with the medical society’s wellness therapist if your need is urgent. If you would prefer to connect with our wellness representative directly, please call back Monday thru Friday between 8:30-4:30. For more information regarding the NAME OF PROGRAM, visit WEBSITE.org. A representative of XXX answering service will be with you very shortly.*

**PAS Representative:**

*Thank you for calling the NAME OF MEDICAL SOCIETY wellness line. Is your need urgent?*

**If urgent;**

*Can I please get a name, and a confidential email and phone number? Thank you. Can you provide me with a few dates and times you are available? Thank you. A Wellness Representative will get back to you within 24 hours*.

**If non-urgent;**

*Can I please get a name, and a confidential email and phone number? Thank you. Can you provide me with a few dates and times you are available?*

*Thank you. A Wellness Representative will get back to you by the next business day.*

**THERAPISTS**

**Criteria**

* Seasoned therapists who have experience providing care for physicians.
* Veteran, experienced XXXX level therapists.
* Veteran integrating brief therapy strategies/practices.
* Experience and familiarity working with health care professionals .(physicians, nurses, technicians) and health care organizations (hospitals, clinics, medical office practices).
* Knowledge of physician issues, including burnout and impairment, experience working with grief and loss of a physician losing a patient, an understanding of the STATE statutes pertaining to the Medical Practice Act.
* Therapists are separated from the medical community to reduce the potential of social networking contacts. Goal: place high priority on privacy and confidentiality.
* Knowledgeable about substance abuse diagnosis and treatment options.
* Familiar with medical board guidelines regarding mental health and substance abuse.
* Working knowledge and practical experience integrating ethical issues and interpersonal workplace dynamics to resolve workplace conflicts.
* Experienced integrating anger management strategies.
* Experience selecting motivational interviewing and/or problem solving strategies when clinically appropriate.
* Dedicated to this work and would adjust or extend their schedules to quickly accommodate physician appointments.

**Professional Liability Insurance** - Therapists are required to name NAME OF MEDICAL SOCIETY on their professional liability insurance and provide the medical society with certificate of insurance. NAME OF MEDICAL SOCIETY incurs the cost for the added insurance.

**WEBSITE**

NAME OF PROGRAM website includes the following information; framework of the program, how to schedule an appointment, bios on therapists, donation access, downloadable brochures, and a wellness library containing articles, studies and videos discussing physician burnout, stress, depression and general wellness.

**FUNDING SOURCES**

The NAME OF FOUNDATION (OR FUNDING PARTNER) is in partnership with NAME OF MEDICAL SOCIETY, and is the fundraising body for the NAME OF PROGRAM.

Membership dues financially support the program until additional funds can be raised.

Donations come from sources located in the program area including; Individual physicians, hospital foundations, health systems, corporations, partnering organizations.

**SURVEY**

Participating physicians are asked to complete a short quality program analysis.

**STATISTICAL INFORMATION**

NAME OF MEDICAL SOCIETY/ABBREVIATION will collect limited data to prove the usage of the NAME OF PROGRAM including but not limited to;

Total wellness clients, total completed appointments, number of no-show appointments, number of urgent appointments, specialties represented, clients who are employed by systems who have EAP in place, clients credentials, counties represented, average age, and gender.

**WELLNESS COMMITTEE**

**Committee Members:** Wellness Committee consists of NAMES

**Frequency:** Wellness Committee Meeting Frequency;

**Mission:** The goal of the NAME OF PROGRAM Committee is help develop and facilitate the program. Initial steps to the committee are;

1) create policy and procedure which accurately and reasonably represents the needs and desires of the NAME OF PROGRAM,

2) initiate appropriate actions to achieve excellent results, and

3) continue to generate creative methods that enhance the program.

**Notice of Privacy Practices Form**

**This Notice describes how clinical information about you may be**

**used and disclosed, and how you can get access to this information.**

**This form is effective from DATE until replaced.**

If you have any questions or requests concerning this notice, please contact NAME, at 555-555-5555.

This notice describes the information privacy practices followed by the NAME OF PROGRAM, including any practitioner who might provide coverage or consultation.

This notice applies to the information and records we have regarding your health, health status, and the services you receive from the NAME OF PROGRAM.

The NAME OF PROGRAM is required by HIPAA law to give you this notice. It will tell you about the ways in which the consulting therapists may use and disclose health information about you and describes your rights and the NAME OF PROGRAM obligation regarding the use and disclosure of that information.

**How NAME OF PROGRAM Providers May Use and Disclose Health Information about You**

By State law and the ethics of the psychology profession, health care providers associated with this program must have your written, signed consent to use and disclose health information for the following purposes:

·  **For Treatment** Health information about you may be shared in order to provide you with clinical services. We may disclose health information about you to other NAME OF PROGRAM providers who are involved in working with you.

·  **For Health Care Operations**

You may revoke your consent at any time by giving written notice. Your revocation will be effective when received, during working days and hours but it will not apply to any uses and disclosures that occurred before that time.

If you are receiving substance abuse treatment, federal and state law requires your written authorization each time health information is released. The authorization will specify who is to receive the information, the purpose of the release of information and a time after which the Authorization will terminate. You may modify or revoke an authorization at any time. However, if we are unable to fulfill our requirements related to your treatment or program operations, we may choose to discontinue providing you with NAME OF PROGRAM services.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

· **To Avert a Serious Threat to Health or Safety** Based on professional judgment, NAME OF PROGRAM/ABBREVIATION providers may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

·  **Required By Law** Based on professional judgment NAME OF PROGRAM/ABBREVIATION providers will disclose health information about you when required to do so by federal, state or local law.

· **Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, NAME OF PROGRAM/ABBREVIATION providers may be asked to disclose health information about you in response to a court order. Subject to all applicable legal requirements, providers may also disclose health information about you in response to a subpoena. Such disclosures would be based on professional judgment.

·  **Law Enforcement** NAME OF PROGRAM/ABBREVIATION providers may release health information, if required to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

·  **Family and Friends** In situations where you are not capable of giving authorization (because you are not present or due to your incapacity or medical emergency), NAME OF PROGRAM/ABBREVIATION providers may, using their professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, if you were in a mental health crisis, providers might involve a family member or friend in helping you get to an appropriate care facility.

Additional disclosures are permitted under HIPAA regulation. These additional disclosures will not be made without your authorization; and they may be contrary to state law. However, once information leaves this office and becomes part of any data resource beyond our control, HIPAA permits disclosure in the following circumstances:

·  **Research** Health information about you can be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address or other information that reveals who you are.

· **Military. Veterans. National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you. HIPAA also permits release of information about foreign military personnel to the appropriate foreign military authority.

· **Workers' Compensation** Health information about you may be released for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

· **Public Health Risks** Health information about you may be disclosed for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

· **Information Not Personally Identifiable** Health information about you may be disclosed in a way that does not personally identify you or reveal who you are.

Other Uses and Disclosures of Health Information

This office will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *authorization*. We must obtain your *authorization* separate from any *consent* we may have obtained from you. If you give us *authorization* to use or disclose health information about you, you may revoke that *authorization*, **in writing**, at any time. If you revoke your original *authorization*, we will no longer use or disclose information about you for the reasons covered by your new written *authorization*, but it is acknowledged and understood we cannot take back any uses or disclosures already made with your permission prior to the time the new authorization is processed.

If we have HIV or substance abuse information about you, we cannot release that information without a special separate signed, written authorization (different from the *authorization* and *consent* mentioned above) from you. In order to disclose these types of records for purposes of *treatment or NAME OF PROGRAM operations*, we will require a special written authorization that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

·  **Right to Inspect and Copy**  You have the right to inspect and copy your health information, such as clinical records. You do not have the right to inspect and copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

You must submit a written request to the designated privacy contact in order to inspect and/or copy your health information.

We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

· **Right to Amend** If you believe health information we have about you is incorrect or incomplete, you may ask the treating therapist to amend the information. You have the right to request an amendment when the information is kept by this office.

To request an amendment, complete and submit a clear statement of the amendment you request to the designated privacy contact.

We may deny your request for an amendment if it is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

·  We did not create, unless the person or entity that created the information is no longer available to make the amendment

· Is not part of the health information that we keep

·  You would not be permitted to inspect and copy

· Is accurate and complete

· **Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of clinical information about you for purposes other than treatment and NAME OF PROGRAM operations.

To obtain this list, you must submit your request **in writing** to the designated privacy contact. Your request must state a time, which may not include dates prior to your treatment. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free.

· **Right to Request Restrictions** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not communicate with a certain family member, no matter what the circumstance.

***NAME OF PROGRAM/ABBREVIATION providers are not required to agree to your request.*** If they do agree, they will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may simply advise the NAME OF PROGRAM/ABBREVIATION provider in writing of specific limitations or restrictions you want placed on the use of health information for treatment or NAME OF PROGRAM operations. NAME OF PROGRAM/ABBREVIATION will not ask you the reason for your request. NAME OF PROGRAM/ABBREVIATION will accommodate all reasonable requests.

·  **Right to Request Confidential Communications** You have the right to request that we communicate with you about clinical matters in a certain way or at a certain location.

**To request confidential communications**, you may simply advise your NAME OF PROGRAM/ABBREVIATION provider, in writing, of specific limitations or restrictions you want placed on their communications with you. Your provider will not ask you the reason for your request. NAME OF PROGRAM/ABBREVIATION providers will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

·  **Right to a Paper Copy of This Notice** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes to this Notice

*We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. A summary of the current notice will be posted in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.*

Complaints

*If you believe your privacy rights have been violated, you may file a complaint with* NAME OF MEDICAL SOCIETY/ABBREVIATION *or with the Secretary of the Department of Health and Human Services.*