TORRANCE MEMORIAL MEDICAL CENTER

DEPARTMENT: MEDICAL STAFF

POLICY/PROCEDURE: MEDICAL STAFF CONFIDENTIALITY

POLICY: This policy applies to all records maintained by or on behalf of the TMMC Medical Staff including the records and minutes of all the Medical Staff Committees and Departments, the credentials and peer review files for individual practitioners, and the records of all Medical Staff credentialing, peer review and performance improvement activities.

PURPOSE: The Medical Staff recognizes that it is vital to maintain the confidentiality of Medical Staff records for reasons of both law and policy. Medical Staff members participate in credentialing, peer review and performance improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The members of the Medical Staff understand and agree that the confidentiality of these communications, information and records will only be disclosed only in the furtherance of those credentialing, peer review and performance improvement activities, and only as specifically permitted under the conditions described in this policy. This requirement of confidentiality extends to the records and minutes of all Medical Staff Departments and Committees, to the records of all Medical Staff credentialing, peer review and performance improvement activities, to the credentials and peer review files concerning individual practitioners, and to the discussion and deliberations which take place within the confines or under the aegis of the Medical Staff Committees.

PROCEDURE:

1. **Location and Security Precautions**: All Medical Staff records will be maintained in the Medical Staff Services Department, under the custody of the Vice President, Medical Staff Services/PI. The Medical Staff Services Department will be locked except during those times that the Vice President, Medical Staff Services/PI or an authorized representative is present and able to monitor access in accordance with this policy. Medical Staff records will only be released from that Office in accord with this policy.

2. Access by Persons Within the Hospital or Medical Staff

2.1 Means of Access: All requests for Medical Staff records by persons with the Hospital and Medical Staff shall be presented to the Vice President, Medical Staff Services/PI, who will keep a record of requests made and granted. Those requests, which require notice to, or approval by, other officials shall be forwarded to those persons by the Vice President, Medical Staff Services/PI. A person permitted access under this section shall be given a reasonable opportunity to inspect the records in question and make notes regarding them, but will not be allowed to remove them from the Medical Staff Services Department or to make copies of them. Removal or copying shall only be allowed upon the express written permission of the Chief of Staff or his/her designated representative.

2.2 **Access by Persons Performing Official Hospital or Medical Staff Functions**: Medical Staff Officers, Chiefs of Medical Staff Departments or Services, Medical Staff Committee members, members of the Board of Directors (Trustees), consultants, the Vice President, Medical Staff Services/PI, the Chief Executive Officer or authorized representatives, and any other person assisting in credentialing, peer review, or performance improvement activities will have access to Medical Staff records, other than their own, to the extent necessary to perform those functions. More particularly:

A. Medical Staff Officers: Medical Staff Officers shall have access to all Medical Staff records.

B. Department, Sub-Specialty Chiefs and Medical Directors: Department, Sub-Specialty Chiefs and Medical Directors shall have access to all Medical Staff Records pertaining to the activities of their department or sub-Specialty or service. Department, Sub-Subspecialty Chiefs and Medical Directors shall also have access to the credentialing, peer review and performance improvement files of practitioners whose qualifications or performance are reviewed as part of their official functions.

C. Medical Staff Committee Members: Medical Staff Committee members shall have access to the records of Committees on which they serve and to the credentials, performance improvement and peer review of practitioners whose qualifications or performance the Committee is reviewing as part of its official function.

2.2 **Access by Persons Performing Official Hospital or Medical Staff Functions**:

D. Consultants: Consultants (who may or may not be members of the Medical Staff) reviewing a practitioner's credentials or performance as part of a credentialing, peer review or performance improvement activity may be allowed access to the credentials and peer review files of the practitioner being reviewed, and to any other pertinent Medical Staff Committee records in the discretion of the Chief of Staff.

E. Chief of Executive Office/Designated Representative: The Board of Directors and the Chief Executive Officer as its designated representative, shall have access to the Medical Staff records to the extent necessary to perform their official functions.

2.3 **General Access by Practitioners to Medical Staff Records**

A. Credentials and Peer Review Files: A practitioner will have access to the credentials and peer review files of other practitioners only as set in Paragraph 2.2 above. A practitioner may have copies of any documents in the credentials and peer review files regarding him which he submitted (that is, his initial appointment application, application for reappointment, request for privileges, or correspondence from him) or which were addressed to him or of which copies were earlier provided to him. A practitioner will be allowed access to further information in that credentials and peer review file only if, following a written request by the practitioner, the Medical Staff Executive Committee or its designated representative, find that the practitioner has a compelling need for such information and grants written permission. Factors to be considered include the reasons for which access is requested, whether the information could be obtained in specific reliance upon continued confidentiality, whether the practitioner will suffer serious adverse consequences unless the information is released, and whether a harmful precedent might be established by the release.

B. Medical Staff Committee Files: A practitioner shall be allowed access to Medical Staff Committee files (including Committee minutes) only if, following a written request by the practitioner, the Medical Staff Executive Committee or its designated representative find that the practitioner has a compelling need for such information and grants permission. Factors to be considered include the reasons for which access is requested, whether the practitioner might further release the information, whether the information could be obtained in less intrusive manner, whether the information was obtained in specific reliance upon continued confidentiality, whether the practitioner will suffer specific serious adverse consequences unless the information is released, and whether a harmful precedent might be established by the release.

3. Access by Persons or Organizations Outside of the Hospital or Medical Staff

3.1 Credentialing or Peer Review at Other Hospitals

A. The Hospital and the Chief of Medical Staff (or designee) may release information contained in a credentials and peer review file, or other information which is the subject of the policy, in response to a request from another hospital or its medical staff. That request must include information that the practitioner is a member of the requesting hospital, or is an applicant for medical staff membership or privileges at that hospital, and must include a release for such records signed by the concerned practitioner. No information should be released until a copy of a signed authorization, and release from liability, has been received. This often takes the form of the physician's signature on an application for Medical Staff membership. Disclosure shall generally be limited to the specific information requested.

B. If a practitioner has been the subject of disciplinary action at this Hospital which is required to be reported to the Medical Board of California, or has recently challenged an Executive Committee recommendation or action which, if upheld, will require a report to the Medical Board of California, special care must be taken. All responses to inquiries regarding that practitioner shall be reviewed and approved by the Chief of Medical Staff or his designee, and legal counsel should be consulted.

3.2 Requests by Hospital Surveyors

Hospital Surveyors (for example, the Joint Commission, the State Department of Public Health Services, or the California Medical Association (CMA)) shall be entitled to inspect records covered by this Policy on the Hospital premises in the presence of Hospital or Medical Staff personnel provided that (1) no originals or copies may be removed from the premises, (2) access is only with the concurrence of the Chief Executive Officer or the Hospital (or his designee) and the Chief of Medical Staff (or his designee), and (3) the surveyor demonstrates the following to Hospital and Medical Staff representatives:

A. Specific statutory or regulatory authority to review the requested materials.
B. That the materials sought are directly relevant to the matter being investigated.
C. That the materials sought are the most direct and least intrusive means to carry out the pending investigation, bearing in mind that credentials and peer review files regarding individual practitioners are considered the most sensitive of materials.
D. Sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff.
E. In the case of requests for documents with physician identifiers not eliminated, the need for such identifiers.

3.2 Requests by Hospital Surveyors

Additionally, the surveyor should be asked to sign the Confidentiality and Notification Statement attached to this policy and should be given a photocopy of the signed statement. If he declines to sign, it should be noted at the bottom of the prepared statement that the surveyor, identified by name, has declined to sign but has been provided a copy and dated by a Hospital or Medical Staff representative and a photocopy of the signed and annotated Statement should be given to the surveyor. The original will be preserved as a Medical Staff record.

3.3 Subpoenas

All subpoenas of the Medical Staff records shall be referred to the Vice President of Medical Staff Services/PI, who will consult with legal counsel regarding the appropriate response.

3.4 Requests from Licensing or Regulatory Agencies

Medical Staff documents will be released to licensing or regulatory agencies as required by federal or state laws and upon approval of Medical Staff legal counsel.

3.5 Other Requests

All other request by persons or organizations outside the Hospital for information contained in the Medical Staff records shall be forwarded to the Vice President of Medical Staff Services/PI. The release of any such information shall require the concurrence of the Medical Staff legal counsel.

Initial Approvals and Major Revisions:

Initial Effective Date:	04/90
Reviewed Date:	02/99
Revised Date:	01/93, 04/99, 12/2014, 12/2017

CONFIDENTIALITY AND NOTIFICATION STATEMENT

(To Be Signed By Surveyors to Whom Medical Staff Records Will Be Disclosed Prior To That Disclosure)

I have requested that I be allowed to inspect Medical Staff credentialing, peer review or performance improvement records. In recognition of the Torrance Memorial Medical Center's Staff policy of confidentiality and of the importance of such confidentiality to the performance of effective credentialing, performance improvement and peer review, and in recognition that the information in these records was both generated, and disclosed to me, in reliance upon that confidentiality, I understand that I am expected:

1. To preserve the confidentiality of those records to the extent allowed by law, disclosing that information only as necessary for completion of the survey process; and
2. To notify Torrance Memorial Medical Center prior to the further disclosure of that information outside the survey process, whether pursuant to a subpoena or otherwise, and to cooperate with any efforts of the Hospital to contest that disclosure.

Date Signature

TORRANCE MEMORIAL MEDICAL CENTER

PRIVACY AND CONFIDENTIALITY AGREEMENT
Visiting Observer

Torrance Memorial Medical Center has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their Protected Health Information (PHI), such as the patient name, birth date, diagnosis, treatment process, test results as well as the fact that the individual was a patient here. Additionally, Torrance Memorial must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information.

In the course of my visit or assignment at Torrance Memorial Medical Center, I may come into possession of confidential information. I agree that protecting confidentiality of PHI means protecting it from unauthorized use or disclosure in oral, fax, written or electronic form. When my visitation, affiliation or assignment with Torrance Memorial is completed, I will not take any PHI with me and I agree to continue to maintain the confidentiality of any information I might have learned or to which I was exposed to as a result of my visit or assignment.

INFORMATION USAGE REQUIREMENTS:
By signing this document, I understand and agree to the following:

1. I agree that any medical information I see or learn about regarding a patient at Torrance Memorial be kept confidential and not further discussed with anyone.
2. I agree not to disclose or discuss any patient information (PHI) with others, including friends or family, unless that individual is actively caring for that patient.
3. I agree not to discuss patient information (PHI), where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeterias, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used.
4. I agree not to disclose, discuss, email, text or post any information or photographs regarding patients on social networking sites such as face-book or on personal devices such as cellular telephones, computer or I-pad. etc.
5. I agree that I have no right or ownership interest in any confidential information.
6. I agree that at all times; I will safeguard and maintain the confidentiality of all confidential (PHI) information.
7. I agree that I will be responsible for misuse or wrongful disclosure of confidential information and for failure to safeguard PHI.
8. I understand that I may contact Torrance Memorial Medical Center Privacy Officer at 310-517-4721 or email: *privacy.officer@tmmc.com* regarding any questions I have regarding patient confidentiality issues or my obligations under this Confidentiality Agreement.
9. I understand that if I do not keep PHI confidential, or I allow or participate in inappropriate disclosure or access to PHI, I may be subject to federal and state penalties and laws.
10. I understand that all-human resource; payroll, fiscal, research or administrative information I learn of while at Torrance Memorial must also remain confidential and not further disclosed to anyone.

Visiting Observer Print Name	**Visiting Observer Signature and Date:**
Company or Vendor Name	
Date and Time of Visit	**Department Name ***
Department Host / Contact Signature and Date:	

* If additional departments are to be visited, please document on the reverse side of this form.