

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Huachuca, Arizona 85613-7040

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IMPAIRED HEALTHCARE PERSONNEL PROGRAM (IHCPP)

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1. **HISTORY:** This issue publishes a revision of this publication.

2. **PURPOSE:** The organization has a responsibility to treat and rehabilitate staff in a non-punitive fashion. This memorandum provides key information that MEDDAC leaders and staff use to identify, treat, rehabilitate, and monitor clinical staff suspected of being impaired from a health problem.

3. **DEFINITIONS:** Impaired Healthcare Personnel (IHCP) refers to any clinical staff member, active duty, or civilian, licensed or non-licensed, paid or volunteer, who has a medical, psychiatric, or substance abuse disorder that adversely affects his or her ability to provide safe and competent patient care.

4. **SCOPE:** This memorandum applies to all licensed independent practitioners (LIHCP), licensed personnel, and clinical support staff, as well as their supervisors, leaders, peers, and treating providers.

5. **REFERENCES:** See Appendix A.

6. **RESPONSIBILITIES:**

*This memorandum supersedes MEDDAC Memo 600-3, 21 February 2001

6.1 The Impaired Healthcare Personnel Committee (IHPCPC) is comprised of the DCCS, the DCHS, the Chief of Behavioral Health, and the Army Substance Abuse Program (ASAP) Clinical Director. Other key leaders/staff members may also be required to attend IHPCPC meetings, depending on the specific needs of the IHCP and the IHPCPC (for example, senior medic representation may be required if a medic is referred to the IHPCPC/IHCPP). The IHCPP and IHPCPC will be conducted directly in accordance with the components of AR 40-68, Chapter 11 (Managing MTF Personnel with Impairments). The IHPCPC will:

6.1.1 Advise the MEDDAC Commander as needed regarding the management and oversight of IHCPs.

6.1.2 Serve as an advocate both for the provider and for the patients under his/her care.

6.1.3 Promote fair and equitable treatment of all IHCPs.

6.1.4 Assist in educating MEDDAC staff on their responsibilities in identifying possible impairment, while incorporating elements of impairment prevention, education about provider impairment, and well-being issues.

6.1.5 Ensure appropriate and timely coordination with the Credentials Committee.

6.1.6 Coordinate reporting of IHCPs through appropriate clinical and administrative channels.

6.1.7 Review the evaluations from the Army Substance Abuse Program (ASAP) and/or treating physician of staff members referred to the IHCPP for evidence of impairment.

6.1.8 Recommend facility-specific procedures for the management of IHCPs.

6.1.9 Recommend appropriate restrictions on the clinical practice for impaired providers who are LIPs and forward recommendations to the Credentials Committee.

6.1.10 Recommend appropriate restrictions on the clinical practice for all non-LIHCP clinical support staff and forward them to Quality Management, the MEDDAC Company Commander, and/or MEDDAC Commander as appropriate.

6.1.11 Monitor the progress of the impaired individuals during treatment, through aftercare, until the completion of the ongoing monitoring phase.

6.1.12 Recommend an individualized plan for the gradual return to full clinical practice for each IHCP staff member who has completed treatment.

6.1.13 Ensure the Department/Service Chief is informed and will serve as a resource to the Department/Service Chief regarding recommendations concerning monitoring or employee confrontation.

6.1.14 Ensure the Company Commander, Civilian Personnel Office, or Contracting Representative is notified for civilian personnel as appropriate.

6.1.15 Request/coordinate monitoring if there is no clear evidence of impairment.

6.1.16 Obtain a statement of diagnosis, prognosis, and implications on clinical performance from the treating or rehabilitating care provider.

6.2. The Deputy Commander for Clinical Services (DCCS) will:

6.2.1 Serve as the Chair of the IHCP and oversee the IHCPP.

6.2.2 Confront identified IHCPs with evidence of impairment and notify them of their enrollment in the IHCPP.

6.2.3 Meet with each IHCP before and after their treatment program intervention to clarify implications for future practice and the risks of treatment relapse.

6.3 The Medical Company Commander will:

6.3.1 Initiate personnel flagging, UCMJ action, or any investigations of possible criminal conduct involving IHCPs, as appropriate.

6.3.2 Pursuant to the recommendations of the IHCP, execute referrals of IHCPs to the Army Substance Abuse Program (ASAP).

6.3.3 Special considerations with regard to the management of active duty personnel who are intoxicated while on duty are covered in Appendix B.

6.3.4 Staff enrolled as IHCPs in the IHCPP will cooperate with the Program in accordance with AR 40-68. The MEDDAC Commander will institute enrollment of an active duty IHCP into a treatment program if that provider refuses to enter treatment. If the impaired HCP is a civilian employee, the civilian program coordinator of the ASAP and appropriate Civilian Personnel Activity Center (CPAC) representatives will be notified prior to the intervention. Consequences for refusal to enter treatment will be given in advance.

6.4 MEDDAC staff will: Report staff members suspected of being impaired to their first-line supervisor, IAW AR 40-68.

6.5 Supervisors of clinical staff suspected of being impaired may contact the DCCS directly for further guidance.

6.6 The Clinical Director, ASAP will:

6.6.1 Serve as the clinical case manager for all IHCPs with impairment from alcohol or substance abuse.

6.6.2 Give progress reports to the IHCP on IHCPs under their care, IAW AR 600-85, Army Substance Abuse Program (ASAP).

6.6.3 Report to the DCCS any provider who self reports as having potential impairment.

7. PROCEDURES:

7.1 Case identification:

7.1.2 Identification by self: The primary responsibility for the identification of the impaired employee lies with the individual concerned. Self-reporting to a first-line supervisor or other appropriate authority is encouraged.

7.1.3 Identification by peers: Since denial is often a feature of many significant health problems, peers must be aware of the potential signs and symptoms of health impairment and notify their first-line supervisor when they identify a potential impairment issue (see Appendix B).

7.1.4 Identification by supervisors or other organizational leaders: Supervisors and leaders may elect to initially confront potential IHCPs about concerns of their impairment; however supervisors will be required to notify the DCCS if they have strong suspicion that an individual is impaired. Supervisors will provide the IHCP a copy of formal written counseling describing the symptoms observed or other evidence of impairment, along with the intent to refer the staff to the DCCS/IHCPP. Supervisors will then provide the DCCS/IHCP with a memorandum for record (MFR) describing the evidence of a staff member's impairment.

7.2 Notification of the IHCP: After the IHCP has met, made a recommendation for IHCPP enrollment, and obtained concurrence of the MTF Commander, the DCCS will meet with each IHCP to notify them that they are to be enrolled in the IHCPP, explain the purpose and role of the IHCP, and answer the provider's questions. This notification will be documented in writing and will be kept on file with other IHCPP documents in the Quality Management Office, RWBAHC.

7.3 Removal of the IHCP from patient care: The decision to remove a provider from direct patient contact requires the consensus of the IHCP and referral to the Credentials Committee for recommendation. Pursuant to the recommendations of the IHCP and Credentials Committee, the DCCS, with the consent of the MEDDAC Commander, will execute any actions involving the removal of a provider from patient care.

7.4 Treatment and rehabilitation: The IHCP will refer IHCPs to the appropriate treating service and clinical case managers. The DCCS will execute the referral and serve as the liaison between the IHCP and the treating service.

7.5 Aftercare/Follow-up Care: For IHCPs who are entered into a formal rehabilitation program for alcohol or substance abuse, their aftercare/follow-up care will be conducted directly in accordance with AR 600-85, Army Substance Abuse Program, ASAP. This AR provides detailed information pertaining to treatment duration and program requirements. In addition, information on stabilization of Active Duty tours for IHCPs enrolled in ASAP can be found in AR 614-5.

7.5.1 Return to clinical practice: IHCPs may return to modified/restricted clinical privileges upon completion of appropriate intervention and treatment. The IHCP will make recommendations on clinical practice limitations to the Credentials Committee, which will vote and make its recommendations to the MEDDAC Commander. The MEDDAC Commander will serve as the final approval authority for privileging actions and return to clinical care. HCPs who have abused controlled drugs are generally restricted from prescribing or administering controlled drugs after return from treatment. HCPs working in anesthesiology should generally not return to this specialty when their impairment has been addiction to drugs. If, in the opinion of the IHCP, a return to the previous specialty is not appropriate, a recommendation for change of specialty will be initiated. Final approval, in accordance with AR 40-68, will rest with the appropriate Corps chief (Medical Corps, Nurse Corps, etc.).

7.6 Ongoing monitoring. Ongoing monitoring of individuals enrolled in ASAP refers to the observations, reports, and meetings required over a 2-year period to assess the progress of the IHCP who has returned to duty. The ASAP is involved in monitoring during the first year of aftercare. The supervisor, department chief, and IHCP will continue monitoring for a second year. The committee will review the progress of each IHCP monthly in accordance with recommended timelines in ARs 40-68 and 600-85.

7.7 Relapse: Any individual treating or monitoring IHCPs will notify the IHCP upon any sign of relapse or failure to follow the treatment and/or aftercare plan. The IHCP will make appropriate recommendations to the Credentials Committee (for Licensed Independent Practitioners, LPs) or DCCS (non-LIPS).

7.8 Program Termination: The role of the IHCP generally ends after the second year following successful treatment or rehabilitation of an individual enrolled in ASAP. At this time the IHCP will recommend termination of monitoring unless review findings or relapse require further involvement. Service Separation Actions, if applicable, will be initiated in accordance with AR 600-85.

7.9 Reports, Records, and Minutes:

7.9.1 The clinical case manager will submit verbal or written reports to the IHCP at periodic IHCP meetings on a monthly basis for three months and then quarterly for a minimum of one year after entry into the treatment program or while in aftercare. These reports describe the results of drug and alcohol screens if appropriate, compliance with the treatment program, and progress with treatment and rehabilitation goals.

7.9.2 The IHCP's departmental supervisor will submit monthly verbal or written reports to the IHCP monthly for the first three months and quarterly thereafter for two years after entry into the PHP. These reports should focus on behavior and other applicable aspects of job performance (e.g. clinical care, interaction with colleagues, work habits, etc.).

7.9.3 The IHCP will submit progress reports to the Credentials Committee as needed on any IHCP who is an LIP. For LIPs or certified clinical staff (not LIHCP) whose practices are restricted, QM will submit DD Form 2499 to higher command, IAW AR 40-68. For active duty non-privileged clinical staff, the DCCS or DCHS, as the agent of the IHCP, will prepare quarterly MFRs or counseling statements as needed.

7.9.4 All IHCP records will be maintained in the Credentials Office. The confidentiality requirements of AR 600-85 and AR 40-68 apply to all reports, committee minutes, and discussions pertaining to IHCPs. The documents of the IHCP are considered Quality Assurance documents and as such are protected under Title 10 USC, Section 1102 (b). Unauthorized disclosure is prohibited.

7.9.5 Notification to professional regulating authorities: Notification will be made for privileged HCPs. For non-privileged HCPs, reports will be sent through the next higher headquarters to HQDA (SGPS-FP), 5109 Leesburg Pike, Falls Church, VA 22041-3258. Regional Medical Commands will notify their drug and alcohol clinical offices of all cases of impairment. Notification will be made for any IHCP who: (1) has clinical privileges suspended, limited, restricted, or revoked; (2) possesses, prescribes, sells, administers, gives, or uses any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes; (3) separates from active duty or Federal Service in a less than full (defined) clinical practice; (4) leaves at any time for any reason during the 2-year monitoring period.

The proponent of this publication is the Deputy Commander for Clinical Services. Users are invited to send comments and suggested improvements to the Deputy Commander for Clinical Services, ATTN: MCXJ-DCCS, USA MEDDAC, Fort Huachuca, AZ 85613

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APPENDIX A REFERENCES

1. References consulted in detail for this policy update:

AR 40-68, Quality Assurance Administration

AR 600-85, Army Substance Abuse Program (ASAP)

RWBAHC Memorandum 15-1, Committees & Minutes

RWBAHC Rules and Regulations of the Medical Staff, current edition.

2. References not specifically cited for this policy update but which may be consulted for more information as needed:

AR 614-5, Stabilization of Tours

MEDCOM Regulation 40-38, Command-Directed Mental Health Evaluations

Department of Defense Directive (DoDD) 6490.1, Mental Health Evaluations of Members of the Armed Forces

Department of Defense Instruction (DoDI) 6490.4, Requirements for Mental Health Evaluations of Members of the Armed Forces

Negotiated Agreement between USA MEDDAC and American Federation of Government Employees Local 1662.

Title 10 United States Code Section 1102, Confidentiality of Medical Quality Assurance Records: Qualified Immunity for ParticHCPants

Public Law 91-513, The Comprehensive Drug Abuse Prevention and Control Act of 1990.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO), current edition.

APPENDIX B
STAFF EDUCATION

Staff training on the Provider Health Program

1. At initial and annual organizational training, all MEDDAC employees will be educated on the basic purpose of the PHP - and trained to identify the key indicators of impairment*, and action for employees to take when the indicators are identified.

2. Indicators of impairment include, but are not limited to, the following:

- ★ An odor of alcohol on the breath.
- ★ Emotional lability.
- ★ Sleepiness or dozing off while on duty.
- ★ Lack of coordination, unsteady gait, falling.
- ★ Change in job performance e.g., sloppy/illegible hand writing.
- ★ Lapses in memory or confusion; slurred speech.
- ★ Pin-point/dilated pupils associated with hypo/hyperactivity.
- ★ Excessive absenteeism, i.e. abuse of leave and a pattern of being absent on
- ★ Mondays and Fridays.

APPENDIX C
BLOOD ALCOHOL DETERMINATION

Special Considerations involving active duty personnel who are intoxicated while on duty

1. Intoxication on duty is defined as a Blood Alcohol Test (BAT) of .05 or greater
2. If a MEDDAC Soldier is observed or suspected to be intoxicated while on duty, the Soldier's supervisor will notify the DCCS or DCHS immediately, who will make arrangements for the Soldier to receive an immediate medical evaluation. The Medical Company Commander will also be contacted to initiate necessary administrative actions.
3. The Medical Company Commander or, in his/her absence, the MEDDAC Commander, will initiate MEDDAC Form 185, Sobriety Exam and Blood Alcohol Determination.
4. The Commander may also request a command directed urinalysis. This is accomplished by the Unit Drug and Alcohol Coordinator.
5. The Commander will notify the MPs of drug/alcohol abuse suspected to have occurred on the Health Center grounds.
6. A qualified provider will perform an appropriate medical evaluation and fitness for duty determination. If the provider determines that the individual is fit for duty, he/she will be returned to duty. If the medical officer determines that the individual is impaired, he/she will be relieved from duty and dispositioned as appropriate.
7. If the Soldier is released to quarters, a family member or the Charge of Quarters will be notified to provide transportation. Under no circumstances will an impaired Soldier be permitted to drive home.